RCN response to the
Department of Health consultation
‘Ill-treatment or wilful neglect in health and social care’

Introduction

With a membership of over 415,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

The RCN submission

1. The RCN would never condone the wilful neglect of a patient by a nurse. However our primary concern about the creation of a new criminal offence, even if it intended for only the most exceptional cases of neglect or ill-treatment, is that it will detract from the wider aim of encouraging greater openness in health care by individuals and organisations, when something goes wrong, which we know enhances patient safety. There is a lack of evidence that the wide range of existing criminal, civil and professional sanctions, for addressing neglect or ill-treatment, have proved to be inadequate to deal with the most serious failings in health care delivery. Nor has any evidence been produced that individual health professionals and organisations are not currently being held accountable in these circumstances, and that this gap needs to be closed by the new offence. We are concerned that there is a significant risk that the threat of criminal proceedings against the individual would be counterproductive, inhibiting the type of culture change that Robert Francis called for. If individuals are fearful of being blamed they are less likely to report concerns and speak out openly and honestly. Whereas Francis identified the need to incentivise a culture of transparency, learning and improvement, this new offence has the potential to be a major disincentive to the creation of such a culture.

2. There is still a ‘culture of blame’ in the NHS (and independent health care sector), and a focus on individuals when errors occur. Once again, whilst we acknowledge that the intention is to focus, through this offence, on the most serious incidents of deliberate harm, we believe that the further criminalisation of health care (as demonstrated by the
press coverage for this proposal, for example), will indeed encourage organisations, staff, and patients, their families and carers, to ‘look for someone to blame’. Staff need to be supported and helped to improve systems of care when mistakes are made, or care falls short of optimum. Staff need to be comfortable about raising concerns about standards of care. Further criminalisation of health care risks contributing to a ‘climate of fear’.

3. As is widely recognised in all of the recent reviews following the Francis Report, when errors or harm occurs to patients in the vast majority of cases, this is as the result of some form of system breakdown and failure rather than the wilful neglect of one individual. The legal focus on the individual has the potential to detract attention away from system learning and improvement. When care falls below the required standards nurses most commonly report to us that this is as a consequence of factors such as low staffing levels, lack of training and development, poor support, ineffective or misguided leadership. It is crucial that individual and organisational responsibilities are equally considered when allegations of wilful neglect are being investigated. Again if this balance is lost it has the potential to fatally undermine the culture change Francis called for.

4. From a nursing perspective it is extremely important to be crystal clear that poor nursing standards do not automatically equate to wilful neglect. The Nursing Profession strives to deliver the best care possible but when this does not happen it is most frequently the result of some of the broader organisational issues already identified, not any deliberate or reckless act by an individual nurse. In addition it may be entirely appropriate, following a clinical assessment and prioritisation decision making process, that some patients may have to wait for care and or treatment. It is crucial that there are no automatic assumptions of wilful neglect and that individual patient perceptions and experiences of care are considered in the context of the clinical environment and decision making at the time. The RCN stress this point because we were concerned to note in a recent HSJ news article (Wilful neglect offence extended, 7 March 2013 p8) that the DH response as to why this new criminal offence was being introduced was, “this offence will send a strong message that poor care will not be tolerated”.

5. The personal stress on a health professional being investigated for an alleged criminal offence cannot be underestimated. The process is often lengthy and the rates of successful prosecution in relation to existing criminal offences such as manslaughter have been very low. For this reason there must be absolute clarity about the definition of all elements of the offence, and we urge that consideration is given to a requirement that DPP consent is required for any prosecution.

6. The emphasis throughout the National Advisory Group’s report and in this consultation document is on the need to address deliberate (intentional) acts of harm caused to patients. There are already a range of criminal offences, civil law and professional disciplinary measures and sanctions to address a wide range of instances of ‘patient
abuse’ or ill-treatment, whether the victims are mentally ill, lack capacity or are simply vulnerable through age and/or ill-health, even though possessing full capacity. Nowhere is it stated why the creation of a new offence is likely to add something of value to those existing remedies, nor is there any evidence presented of instances where perpetrators, of such neglect or ill-treatment, have gone unpunished or not otherwise been held accountable. The emphasis is on the ‘deterrent’ effect, but given the above, the RCN is concerned that the disadvantages probably outweigh the advantages of the new offence.

7. To underline the exceptional nature of this new criminal offence, RCN recommends that consent is required from DPP for any prosecution. This will, among other things, prevent misconceived private prosecutions which, given the nature of this offence, the RCN considers to be a real risk.

8. Subject to the general views expressed above, we respond to your particular questions as follows:

**Responses to particular questions:**

**We propose that the new offence should apply in all formal adult health and social care settings, in both the public and private sectors. Do you agree with this approach? Please explain your view.**

- We agree that any new offence should only apply to formal adult health and social care settings, in both public and private sectors, for reasons given in consultation.

**Should the new offence apply in all formal health settings in both the public and private sector used by children (including services used by both children and adults)? Please explain your view.**

- We agree that it should apply in all formal health settings in both public and private sector used by children, for reasons given in consultation.

**Should the new offence apply in any other settings used by children (including services used by both children and adults)? Please explain your view and what sorts of services you believe should or should not be included.**

- We agree that it should apply in any other settings used by children, for reasons given in consultation.

**We propose that only formal health and social care arrangements, as described above, should be within scope of this offence. Do you agree with this approach? Please explain your view.**
• We agree that it should only apply to formal provision of services i.e. where a person is employed or contracted to provide particular services. It would be, in our view, wholly impracticable to extend the offence to services provided informally, by families or friends, as well as being a major disincentive to family members etc volunteering as carers.

**We propose that the new criminal offence should focus entirely on the conduct of the provider/practitioner, rather than any consideration of the harm caused to the victim of the offence. Do you agree with this approach? Please explain your view.**

• We do not accept that the new offence should focus entirely on the conduct of the provider/practitioner, rather than give any consideration to the harm caused to the victim of the offence. We accept the recommendation of the National Advisory Group that the offence should only apply where ‘egregious acts or omissions cause death or serious harm’. We reject the assumption of this consultation that it is essential, either in interests of consistency or otherwise, for this new legislation to align with existing legislation on ill-treatment or wilful neglect, such as section 44 Mental Capacity Act 2005 or section 127 Mental Health Act 1983. This doesn’t follow, neither logically nor practically. Both of those Acts are concerned with the most vulnerable members of society, who have long been afforded this type of protection, given the risks of abuse. The new offence is, according to this consultation, intended to act as a deterrent against the most extreme and rare cases of wilful neglect, and in our view this would be better achieved through requiring the conduct to have actually caused some serious harm to the patient. Harm caused to patients may generally be covered by existing common law or statutory offences. There is a risk that focusing entirely on the conduct, and ignoring the consequences, may catch a much wider range of actions, beyond those envisaged by the National Advisory Group or authors of this consultation, and draw in the situations where the consultation explicitly says the offence should not apply (paragraphs 56-58). Finally, we do not accept that ‘technical’ breaches, prosecutions and convictions of even existing neglect or ill-treatment offences, such as under the Mental Capacity Act 2005 (as in *R v Parulben Patel (2012)*) contribute to the public interest or the enhancement of patient safety.

**Do you agree that an approach based on the way in which an organisation managed or organised its activities is the best, most effective way to establish the offence in respect of organisations? Please explain your view.**

• In the light of the difficulties in holding organisations accountable for criminal offences and, for example, convicting an organisation of manslaughter, which led to the passing of the Corporate Manslaughter and Corporate Homicide Act 2007, we accept the approach based on the way in which an organisation managed or organised its activities is best. However, we have serious doubts whether this in practice is likely to make it any easier to pursue an organisation in a situation where its management causes a person to be subject to ill-treatment or neglect.
Do you agree with our proposals in relation to penalties in respect of organisations? Do you think there are other penalties which would be appropriate?

- We accept the recommendations on penalties for individuals and organisations should reflect existing penalties for similar offences.

We propose adopting the same approach to referral of private prosecutions to the DPP as is available in respect of the section 44 offence in the Mental Capacity Act 2005. Do you agree? Are there other ways to address this issue?

- We have already indicated that we believe that for a prosecution to proceed for this new offence the consent of the DPP should be obtained.

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