Consultation Response

New offence of ill-treatment or wilful neglect

March 2014

About MPS

1. The Medical Protection Society is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world.
2. We are a mutual, not-for-profit organisation offering more than 280,000 members help with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, complaints, medical council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal-accident inquiries.
3. We actively protect and promote the interests of members and the wider profession and promote safer practice by running risk management and education programmes to reduce avoidable harm.
4. MPS is not an insurance company. The benefits of membership are discretionary - this allows us the flexibility to provide help and support even in unusual circumstances.

Overview

5. MPS is opposed to the introduction of new criminal sanctions against healthcare professionals for wilful neglect or ill-treatment. We think that the government has focused too much on additional penalties for healthcare professionals and not enough on providing the support that can bring about genuine change.
6. Government's focus should be on the development of mentoring, training and leadership programmes to create an open environment of learning where clinical teams are supported and encouraged to discuss near misses and other patient safety incidents.
7. If a healthcare professional's behaviour is unacceptable they should face the consequences of their actions but we believe that the current regulatory, disciplinary and criminal framework is effective at achieving this when properly applied.
8. We recognise that there are additional criminal sanctions available to prosecute individuals who ill-treat or wilfully neglect children and adults without capacity. But if these sanctions are to be extended to cover adults with capacity then the need for them has to be clearly articulated and argued. The government have not done so and should not proceed with the proposals.

9. The proposals for a new offence are not sufficiently thought through; some elements need further justification and some of the arguments are inconsistent.

10. Specifically, we are concerned that the proposals:

- ignore the careful judgment in the National Advisory Group's report[1] regarding a harm threshold
- will impede the 'open, transparent learning culture' that the National Advisory Group sought to protect and that is vital to improving patient safety[2]
- will add to the current climate of fear amongst healthcare professionals
- are not clearly justified, on either the need for a deterrent, greater accountability, or on exceptional circumstances requiring greater punishments
- could potentially lead too easily to criminal allegations arising from civil proceedings
- would inappropriately use summary convictions
- might criminalise the appropriate and reasonable exercise of clinical judgment and decisions concerning the allocation of resources
- are excessively reliant on prosecutorial discretion
- are inconsistent between an offence for individuals and for organisations

11. If the government proceeds with these plans further consideration is needed to introduce additional safeguards. The offence for both individuals and organisations should require a threshold of harm for the offence to apply. It should also require that there be a duty of care owed to the individual and that there has been a breach of that duty that is both 'gross' and without 'reasonable excuse'.

12. We address each of these concerns in our general comments below, and then provide answers to the consultation questions. Finally, we provide comments on the consultation process itself.

[1] The National Advisory Group on the Safety of Patients in England, *A promise to learn – a commitment to act: Improving the Safety of Patients in England*, (August 2013).
[2] Ibid, p33

General Comments

Justification for new sanctions

13. When proposing new criminal laws we think it appropriate the government should articulate clearly the purpose of the new laws and the need they address, demonstrate that they are a proportionate response to the need and that the new laws are properly framed to address that need and fulfil that purpose.

14. We do not think that this has been adequately done for a new offence of ill-treatment or wilful neglect. The government's stated position is that there is a gap in the existing legislation which should be closed with a new offence.[3] We do not think the possibility of certain undesirable behaviours not being covered by existing criminal law means there is automatically a need to change the law and criminalise those behaviours. Any changes need to be carefully balanced against the negative impact the legislation may have.

Purpose of new criminal sanctions

15. The National Advisory Group recommended new criminal sanctions for two purposes: to 'assure accountability to the patient for egregious acts or omissions that cause death or serious harm' and 'primarily as a deterrent to wilful or reckless neglect or mistreatment'.[4]

16. In its interpretation of the National Advisory Group's recommendation it is not clear that the government has maintained these purposes in its policy objective. The government's stated policy objective is:

> *to establish a criminal offence to operate alongside those that already exist so that any health or social care worker or organisation whose conduct amounts to ill-treatment or wilful neglect can be held to account through analogous criminal proceedings. The intended effect is to close the gap in the current legislation to provide consistency of approach in relation to ill-treatment and wilful neglect. This offence will also send a strong message that poor care will not be tolerated and ensure that wherever ill-treatment or wilful neglect occurs, those responsible will be held to account.*[5]

17. It is no longer clear that deterrence is the primary function of the proposed legislation as recommended by the National Advisory Group. The other purpose in the National Advisory Group's recommendation was to ensure accountability to patients. The proposal reformulates this as holding perpetrators to account with a greater scope to punish them through criminal proceedings.

[3] Department of Health, *New criminal offence of ill-treatment or wilful neglect – Impact Assessment,* (February 2014) p1
[4] The National Advisory Group on the Safety of Patients in England, *A promise to learn – a commitment to act: Improving the Safety of Patients in England*, (August 2013) p33
[5] Department of Health, *New criminal offence of ill-treatment or wilful neglect – Impact Assessment,* (February 2014) p1

We are concerned the broader idea of accountability implied by the National Advisory Group's report is actually threatened by the introduction of the proposed criminal sanctions (see para. 28-32).

18. Clarity over the purpose of the proposals is needed. Different purposes will bring different considerations to bear on the proposals and the arguments for the way the law should be framed.

Deterrence

19. If the purpose of the new sanctions is to provide deterrence to wilful or reckless neglect or mistreatment, then the government needs to articulate why the extensive existing sanctions available are insufficient.

20. If a healthcare worker was found to have ill-treated or wilfully neglected a patient they would be subject to a series of processes, all of which would have serious consequences for them and their career. These include: professional regulatory proceedings, likely erasure from the relevant register and an end to their career; disciplinary proceedings by their employer and likely termination of employment; and, referral to the Disclosure and Barring Service and likely restrictions on future employment. These are strong sanctions and provide powerful influences on behaviour.

21. These mechanisms are considered appropriate to ensure professional standards of behaviour are met in all but the most extreme of circumstances. Most healthcare practitioners are already heavily regulated. However, the consultation paper makes minimal references to the professional regulators or disciplinary proceedings and the influence they have.

22. If the policy objective were deterrence alone, then it would be likely that professional regulation and disciplinary proceedings, and the associated threat to an individual's livelihood, would be sufficient to discourage wilful neglect or mistreatment.

Punishment

23. At least part of the government's policy intention seems to be to provide greater scope to punish those who provide poor care which amounts to ill-treatment or wilful neglect so that they can be demonstrably held to account through criminal proceedings and punishment.

24. There are additional sanctions in criminal law relating to behaviour of professionals in certain circumstances. They are designed to cover particular and exceptional circumstances. For example, sanctions for wilful ill-treatment or neglect of children, and ill-treatment or wilful neglect of adults who lack capacity or those subject to the Mental Health Act 1983 provide additional protection for particularly vulnerable groups. Another example is the law of gross negligence

manslaughter which provides additional punishment for serious professional failings that cause death.

25. However, the proposals for wilful neglect and ill-treatment are not justified by any particular and exceptional circumstances. This is contrary to the National Advisory Group's recommendation which identified the extreme circumstances in which the offence should apply as when 'egregious acts or omissions…cause death or serious harm'. Without a harm threshold the offence will merely create a parallel process to professional regulatory and disciplinary proceedings for many healthcare professionals in most circumstances. We think this is unjust and disproportionate as it could mean a professional may be pursued multiple times for the same incident. If new sanctions are to be created they should be deal with exceptional circumstances and be restricted to situations where death or serious harm has been caused and where there is a breach of a duty of care which is gross and without reasonable excuse.

26. The apparent justification for additional punishments to be available is based on the behaviour of an individual being 'wilful' and therefore suitable for punishment beyond what is available in regulatory or disciplinary proceedings. There are two principle problems with this justification. Firstly, it is not clear that the definition of 'wilful' will not include behaviour which is an accepted part of clinical practice and the exercise of clinical judgment and which should not be subject to any form of regulatory, disciplinary or criminal proceedings at all (see paras. 38-43). Secondly, it is not clear why, if the justification for additional punishments is that the behaviour is wilful, that the proposed offence is restricted to formal care settings. If it is ill-treatment or neglect that is wilful that the offence attempts to capture then it should apply as widely as possible and only be restricted by a duty of care (see paras. 64 & 67-74).

Accountability

27. As noted above, the government has focused on providing greater accountability by widening the scope to punish those responsible for ill-treatment or wilful neglect though additional criminal sanctions. However, if the need broader for accountability to patients is considered (as it was in the National Advisory Group's report) we think that the balance of considerations is against new legislation as criminal sanctions will inhibit the culture that can provide genuine accountability to patients (see para. 28-32).

Organisational culture and support for professionals

28. It was clear from the Francis report that it is the culture at senior management level in a Trust which will generally determine whether instances of neglect of patients can occur. Given an

appropriate working environment, where there is support provided to healthcare professionals rather than a culture of scrutiny and criticism, it is likely that wilful neglect would be rare.

29. We think that the likely consequence of new sanctions will be healthcare professionals becoming more fearful of the way their conduct may be later criticised, less open and willing to admit genuine errors to either patients or management and therefore make healthcare less responsive and accountable to patients. Reasonable clinical decision making and resource allocation could be severely affected as it could be within the scope of the proposed offence subject to prosecutorial discretion (see paras. 38-43).

30. There is also conflict with the new duty of candour which the government is introducing. Although this is targeted at an organisational level, it will be front line professionals to whom it will in effect apply. If these new criminal sanctions are introduced, doctors will understandably feel extremely worried about highlighting any errors that they may feel they have made if it means there is a potential criminal investigation. Consequently, new sanctions will undermine the claimed incentive of the duty of candour to be more open with patients and healthcare professionals may feel trapped by conflicting duties.

31. The appropriate way to support accountability is through development of programmes of mentoring, training and leadership to facilitate an open environment focused on learning, where clinical teams are supported and encouraged to discuss near misses and other patient safety incidents. Additional requirements could also be introduced for organisations to demonstrate how they support their healthcare staff to fulfil their existing ethical and professional obligations and be open with patients about failings in care.

32. Done properly this would be a more appropriate way to prevent situations of poor care by professionals and ensure proper accountability for patients. The consultation states that providing more support is the appropriate approach for carers.[6] It is unclear why this is not considered an appropriate approach for all health and social care settings, especially considering most healthcare professionals have the additional oversight of professional regulation.

33. If a new offence is introduced then we think that everything possible should be done to mitigate the risks of undermining the culture of transparency and learning. Safeguards should include restricting the offence to where death or serious harm is caused and where there is a breach of a duty of care which is gross and without reasonable excuse.

[6] Department of Health, *New criminal offence of ill-treatment or wilful neglect – Consultation Document,* (February 2014) para. 34

Harm threshold

34. The National Advisory Group's report recognised the need to balance greater accountability for patients against the need not to impede the 'open, transparent learning culture'.[7] The recommendation was that the offence should only apply to 'egregious acts or omissions that cause death or serious harm'.[8] The government's proposals go far beyond this recommendation and what the National Advisory Group apparently intended.

35. We think the government should recognise the judgment the National Advisory Group's report makes and put a harm threshold in the offence to mitigate the negative effects of the offence on the culture of transparency and learning in healthcare.

36. This would provide a better justification for the offences; they would be created to deal with exceptional circumstances.

37. This would also prevent the offence creating processes parallel to regulatory proceedings in most circumstances.

Definition of 'wilful' and criminalising appropriate and reasonable exercise of judgment

38. There is a risk that the proposed offence and the established definition of wilful neglect could criminalise behaviour the government does not intend to criminalise.

39. The consultation states that the offence must not act as an 'inhibitor to health and social care professionals exercising informed clinical judgment on priorities or appropriate treatment'.[9] It also implies that 'prioritisation and allocation' issues, for example when 'care or treatment has not been provided because these selection criteria were not met' should not fall in the scope of the offence.[10] However, both these scenarios appear to fall within the definition of 'wilful neglect' despite the consultation's assertion that they will not.

40. We have been advised[11] that '"Wilful neglect" means [see R v Sheppard [1981] A.C, HL] either an intentional/deliberate or reckless neglect. The term "neglect" means, in straightforward terms, a failure to act.' The meaning also encompasses knowing the risk involved.

41. In exercising reasonable judgment over the allocation of resources or the appropriate treatment or prioritisation of patients, an individual would be failing to act and doing so deliberately.

[7] The National Advisory Group on the Safety of Patients in England, *A promise to learn – a commitment to act: Improving the Safety of Patients in England*, (August 2013) p33
[8] The National Advisory Group on the Safety of Patients in England, *A promise to learn – a commitment to act: Improving the Safety of Patients in England*, (August 2013) p33
[9] Department of Health, *New criminal offence of ill-treatment or wilful neglect – Consultation Document,* (February 2014) para. 57
[10] Department of Health, *New criminal offence of ill-treatment or wilful neglect – Consultation Document,* (February 2014) para. 58
[11] Advice from Kieran Coonan QC, 18 March 2014

Furthermore, as these decisions involve an assessment of the relative risks and benefits to the patients the individual would also know that patients may suffer as a result of their decision.

42. It appears, therefore, that the exercise of judgements on treatments and prioritisation and the allocation of resources would fall within the scope of the proposed offence.

43. If the government does not intend for these activities to fall within the scope of the proposed offence then exclusions need to be provided for in the primary legislation (see our suggestions paras. 55-61). It will not be sufficient to leave excluding these issues to prosecutorial discretion as this will leave healthcare professionals uncertain as to whether their clinical decision making is captured by the criminal law (see paras. 52-54).

Criminal allegations arising from civil proceedings

44. In addition to potentially criminalising clinical judgments and decisions about resources, the proposed offence risks effectively criminalising behaviours currently dealt with solely by the civil courts in general.

45. A successful negligence claim in the civil courts requires a claimant to demonstrate that there was a duty of care owed to the claimant, that the duty was breached and that the breach caused harm.

46. Most individuals captured by the scope of the proposed offence would have a duty of care to the individual.[12] A breach of a duty of care in a clinical negligence case can be by act or omission, and we have been advised 'covers conduct, which may be described…as amounting to neglect or ill-treatment'.[13] Furthermore, as noted above, decisions in a healthcare context necessarily involve an assessment of the relative risks and benefits to patients and will satisfy the definition of wilful.

47. Consequently, many successful clinical negligence claims might also attract criminal allegations of wilful neglect under the proposals. (Note that this will still be the case if the offence were to incorporate an outcome element for the patient of a particular level of harm, as a successful negligence claim also has a harm element.)

48. For example, in our experience one of the most common reasons for clinical negligence litigation is an allegation of a delay in referral and diagnosis. Most clinical decisions involve an assessment of the relative risks and benefits to the patient. Therefore, an erroneous decision not to refer and/or investigate at a particular stage could be held to be not only neglect but also wilful on the basis that there would be recognised risks which the healthcare professional would have considered in formulating their treatment plan. The healthcare professional could then be sued for negligence. Under the proposals if the claim was successful (or at least as part of the claim it was

[12] Furthermore, we think it appropriate that the scope of the offence is explicitly defined by the existence of a duty of care (see para 64, 67-74 below)
[13] Advice from Kieran Coonan QC, 18 February 2014

demonstrated the healthcare professional was negligent) then the fact that the negligent decision was wilful, by virtue of being taken knowing the risk to the patient, might also open that professional up to a criminal prosecution.

49. We think it is disproportionate and inappropriate that a criminal allegation under the proposed offence might flow so easily from a clinical negligence case. It is already the case that a healthcare professional who has been the subject of a clinical negligence claim can be investigated by the relevant professional regulator (and/or face disciplinary proceedings from their employer) with the possibility that they will lose their career. We think it would be unjust that in all the same circumstances where a professional could be sued for clinical negligence and investigated by their regulator they might also face criminal prosecution and possible imprisonment.

50. This is especially the case given the proposal that penalties could be by summary conviction. We do not think it appropriate for a decision that would almost certainly end the career of the professional to be made in a magistrate's court (see para. 81-82).

51. Criminal investigations should only follow on from serious incidents and to ensure this the offence should have additional safeguards. It is not sufficient to leave it to prosecutorial discretion to ensure that civil cases do not routinely lead to criminal allegations. The offence should only apply to a breach of a duty of care that is gross and without reasonable excuse and where the breach causes death or serious harm.

Prosecutorial discretion

52. The legitimate exercise of clinical judgment must be excluded from the offence. It is also disproportionate that a claim for clinical negligence might potentially lead so easily to a criminal allegation.

53. It is not sufficient for the government to say that these are the 'sorts of situations which we would expect investigating and prosecuting authorities to take into consideration when deciding whether it is in the public interest to pursue an allegation'.[14] Investigating and prosecuting authorities will be bound by the words of the Act and it is the responsibility of government to outline properly the scope and extent of the offence and any defenses in legislation.

54. MPS has experience of confusion caused when primary legislation does not set out in sufficient detail the scope of criminal offences. Failure to provide the right level of detail will lead to confusion and fear amongst healthcare professionals and the government should carefully review the offence.

[14] Department of Health, *New criminal offence of ill-treatment or wilful neglect – Consultation Document,* (February 2014) para. 60

Additional safeguards in the offence

55. We do not think that the government has sufficiently justified the need for a new offence for wilful neglect or ill-treatment and should not proceed with its plans. We think the current regulatory, disciplinary and criminal framework when properly applied provides a deterrent, suitable punishment and accountability for patients.

56. However, if the government is to introduce a new offence it should contain additional safeguards to protect clinical judgment, decisions about resource allocation and to prevent criminal allegations arising too easily from civil proceedings.

57. The additional safeguards in the offence for both organisations and individuals could be:

- the offence should require a breach of a duty of care
- the breach should be 'gross'
- the breach should be 'without reasonable excuse'
- the breach caused death or serious harm.

58. We have been advised that in order to protect those making difficult clinical decisions properly the definition of the proposed offence should include a 'requirement that such neglect should be assessed in circumstances where there is a duty of care to act and a breach of that duty by failing to act….To do so would provide a safeguard or safety valve which would enable an objective assessment to be made of the doctor's acts or omissions and a determination whether such acts or omissions were reasonable or not in the light of the scope of his duty'.[15]

59. We have been further advised that an appropriate solution would be 'incorporating a term such as "without reasonable excuse" in the definition of the proposed offence'.

60. We also note that the proposed offence for organisations includes a requirement that activities of the organisation amount to a 'gross breach of a relevant duty of care owed by the organisation to that person'.[16] We see no reason why this additional requirement should apply to the organisational offence and not the offence for individuals. We think that the offences should be consistent with one another and that there should be a requirement for there to be a breach of a duty of care and for that breach to be gross in the individual and organisational offences. This addition would also help differentiate the criminal offence from civil proceedings for clinical negligence by establishing that only more serious allegations are subject to criminal investigation.

[15] Advice from Kieran Coonan QC, 18 March 2014
[16] Department of Health, *New criminal offence of ill-treatment or wilful neglect – Consultation Document,* (February 2014) para. 48

61. Finally, there should also be a harm threshold of death or serious harm as recommended by the National Advisory Group's report to mitigate the negative effects of the legislation on the culture of transparency and learning.

Questions

62. We do not think that the government has sufficiently justified the need for a new offence for wilful neglect or ill-treatment and should not proceed with its plans. We think the current regulatory, disciplinary and criminal framework when properly applied provides a deterrent, suitable punishment and accountability for patients.

63. However, if the government is to introduce a new offence it should contain additional safeguards to protect clinical judgment, decisions about resource allocation and to prevent criminal allegations arising too easily from civil proceedings.

Scope of the offence

i) NHS or wider

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 answer.

64. We agree that if the government is to introduce an offence it should apply across health and social care and both the private and public sectors. However, we do not think that the offence should be restricted to formal provision. The consultation notes that 'section 44 of the Mental Capacity Act 2005, which the National Advisory Group cites as the model it wants the new offence to emulate, is applicable in any health or social care setting'.[17] However, it fails to note that the Mental Capacity Act applies if the perpetrator 'has the care' of the victim rather than in 'formal' settings. Therefore, the legislation the proposals aim to be modelled on (the Mental Capacity Act) applies more broadly than to just formal health and social care settings and we think this should be approach should be adopted for the proposed offence (see paras. 67-74).

ii) Children

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 answer.

65. Yes. There is no reason why the offence should not apply in all settings used by children. The offence should be as widely applicable as possible.

[17] Department of Health, *New criminal offence of ill-treatment or wilful neglect – Consultation Document,* (February 2014) para. 21

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.

66. Yes. There is no reason why the offence should not apply in all settings used by children. The offence should be as widely applicable as possible.

iii) Formal service provision

We propose that only formal health and social care arrangements should be within scope of this offence.

Do you agree with this approach? Please explain your view.

67. No, we disagree with this approach. We think that this is ill-considered and that the offence should apply in the same way as the Mental Capacity Act to anyone who 'has the care' of an individual, that is, where there is a duty of care.

68. We appreciate that many of the individuals captured by this formulation would be the same as those captured under the proposals but there are important differences. A qualifying element of a duty of care would provide for a wider offence that is specifically and appropriately defined. The consultation does not justify the decision not to follow this provision of the Mental Capacity Act.

69. The consultation document implies that bringing informal health and social care settings within the scope of the offence would not be a proportionate response.[18] However, the consultation and the proposals at no point justify this assertion. It is not made clear why it would be disproportionate to bring informal settings into the scope of the offence and why those cared for in those settings are not deserving of the protection of the proposed offence.

70. We acknowledge that there is a difference between someone employed or contracted to provide care (and any associated professional obligation that would carry) and care provided based on a familial relationship. But the consultation does not justify the assertion that this difference is 'significant and important'[19] in deciding to whom a deterrent offence for ill-treatment and wilful neglect would apply and holding those individuals to account.

71. We also acknowledge the concerns that the offence can jeopardise informal caring arrangements by making relatives fearful of prosecution. But these concerns are equally true for those choosing whether or not to enter a caring profession and therefore we think they should carry no weight in determining the scope of the offence. We note the consultation does not explore whether

[18] Department of Health, *New criminal offence of ill-treatment or wilful neglect – Consultation Document,* (February 2014) para. 31
[19] Department of Health, *New criminal offence of ill-treatment or wilful neglect – Consultation Document,* (February 2014) para. 32

prosecutorial discretion would be an appropriate way to limit the scope of the offence in relation to informal caring arrangements (see paras. 91-92).

72. The model legislation recommended by the National Advisory Group and used throughout the consultation is the Mental Capacity Act.[20] This provides for an offence where an individual 'has the care of a person'. We think that this is an appropriate way to define the scope of an offence and our independent legal advice agrees, recommending that 'in order to regulate the ambit of [the offence's] reach a precondition of liability should be the existence of a duty of care owed by the accused to the victim'.[21] This would also meet with the government's aim of providing a consistent approach to wilful neglect modelled on the Mental Capacity Act.

73. If the current proposals were adopted there would be perverse results in the way the offence applied. For example, for an adult that lacked capacity in an informal care setting the possibility of prosecution in relation to wilful neglect of that individual would continue to be available under the Mental Capacity Act but for an adult with capacity no prosecution would be available. This is exactly the type of situation the consultation states the government wishes to avoid.[22]

74. It is contrary to the government's stated policy intention to have the offence apply in this inconsistent way.

B. Elements of the offence

i) Conduct or outcomes

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.

75. No we strongly disagree. We think that the judgment of the National Advisory Group that the offence should be restricted to extreme circumstances of serious harm or death was correct considering the likely implications on the culture of fear that the sanctions will create and the effect of prosecutions on the healthcare professionals involved (see paras. 28-37).

76. We think that the proposed offence will add to the climate of fear amongst healthcare professionals, reduce transparency and diminish their ability to learn from error. Restricting the

[20] For example see: Department of Health, *New criminal offence of ill-treatment or wilful neglect – Consultation Document,* (February 2014) para. 21
[21] Advice from Kieran Coonan QC, 18 February 2014
[22] Department of Health, *New criminal offence of ill-treatment or wilful neglect – Consultation Document,* (February 2014) para. 15

offence to circumstances where death or serious harm is caused would reduce, although not eliminate, this problem.

77. Regulatory (and disciplinary) processes deal with issues of professional behaviour regardless of the harm caused. The proposed offence, without any need for harm to have been caused, merely creates a parallel process which is unreasonable for professionals to have to face in addition to regulatory proceedings. If there are to be new criminal sanctions they should be created to deal with extreme cases (see paras. 20-21 & 49).

C. Describing the offence for organisations

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

78. Yes. We think that the proposals as set out in paragraph 48 of the consultation are well formed. We note, however, that this would make the offence for organisations very different to that proposed for individuals and no justification is made in the proposals for this disparity.

79. It would be unreasonable for the organisational offence to apply where there is a gross breach of a duty of care but for the individual offence to apply without the need for a duty of care or any assessment of the severity of their actions. This effectively creates entirely different offences when they should be consistent with one another.

80. As discussed above, we propose that the individual offence requires a duty of care to act and a breach of that duty by failing to act, and that this could be achieved by incorporating a term such as ‘without reasonable excuse’ into the definition of the act. We also think that if the organisational offence includes a requirement that there is a breach of a duty of care, and that that breach is ‘gross’ then this should also be the case for the individual offence.

D. Other issues

i) Penalties

We propose that penalties for individuals convicted of this offence should mirror those set out in section 44 of the Mental Capacity Act 2005.

Do you agree? Please explain your view.

81. No. Summary conviction would be inappropriate. A conviction would almost certainly end the career of the professional involved and we think it would not be appropriate for this decision to be made in a magistrate’s court.

82. Additionally, we think that if the government decides that there should be a requirement for a gross breach of a duty of care for organisations then there should be the same requirement for individuals. If this is the case then conviction would require a jury trial since what amounts to a gross breach is a matter decided by a jury in comparable legislation.[23]

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?

83. No. We do not think that the penalties should include removal or disqualification of managers.

84. It should be the remit of a professional regulatory process to disqualify an individual from being able to perform a particular professional role.

ii) Matters for prosecutorial discretion

We propose adopting the same approach to referral of private prosecutions to the Director of Public Prosecutions 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?

85. Yes. We agree with the approach in relation to private prosecutions but we are disappointed that there are no questions on the other issues raised in this part of the consultation, especially protecting a transparent learning culture, protecting proper exercise of clinical judgment, the definition of wilful neglect, and prosecutorial discretion in general. We have outlined our views on these issues above but think it inappropriate that the consultation does not draw greater attention, or ask explicit questions, on such important and unresolved issues.

Equality issues

86. **Do you think that any of the proposals set out in this consultation document could have equality implications? If so, please tell us about them**.

87. We have no comment on the equality issues.

[23] For example, for an offence of gross negligence manslaughter it is the jury that determines whether the breach of a duty of care should be characterised as gross negligence and therefore a crime.

The consultation and process

The consultation document

88. Our comments on the proposed offences are extensive. This partially reflects our view that the proposals as they stand appear to be rushed, and ill thought through. The document fails to draw the attention of the reader to some considerations (as noted below in para. 90) and fails to ask questions on unresolved and important issues (as noted in para. 85).

89. It is particularly concerning that the proposals do not follow a consistent approach in relation to wilful neglect and ill-treatment. This is a stated aim of the proposals and we think that the proposals do not follow this objective.[24] We give several examples below.

90. The consultation implies the absence of an element of harm in the Mental Capacity Act is a reason for not including one in the proposed offence despite being part of the recommendation of the National Advisory Group.[25] However, when discussing the scope of the proposed offence it fails to mention that the Mental Capacity Act provides a model for defining the scope. The consultation mentions that the Mental Capacity Act applies in any health or social care setting but did not go on to explain that it applies if the perpetrator 'has the care' of the victim. This is a reasonable model for the scope of the proposed offence, which we think should be followed, and it is unreasonable for the consultation not to mention it. If the government has considered this model and decided against it, the reasoning for this should be set out in the proposals.

91. The proposal is also inconsistent in its approach to prosecutorial discretion. The consultation relies heavily on prosecutorial discretion to restrict the offence's effect on clinical decision making and judgments concerning the allocation of resources. However, the consultation does not explore whether prosecutorial discretion would be an appropriate way to limit the scope of the offence in relation to care provided by, for example, family members. It would appear plausible that prosecutorial discretion would be an appropriate mechanism to deal with these concerns given the precedent in relation to the Director of Public Persecution's guidance on Assisted Suicide.[26]

92. We think the most appropriate way to create a new offence is for the government to carefully detail the scope and extent of the offence and any defenses in legislation. However, if the government continues with the intention to rely on prosecutorial discretion to protect clinical decision making and the decisions about the allocation of resources it should also rely on it to ensure that informal care arrangements are not disrupted (see para. 67-74). If public interests arguments are sufficient

[24] Department of Health, *New criminal offence of ill-treatment or wilful neglect – Consultation Document,* (February 2014) paras. 13 and 46; and, Department of Health, *New criminal offence of ill-treatment or wilful neglect – Impact Assessment,* (February 2014) p1
[25] Department of Health, *New criminal offence of ill-treatment or wilful neglect – Consultation Document,* (February 2014) para. 38
[26] Crown Prosecution Service, *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide,* (February 2010)

to prevent a prosecution in the former then these are also sufficient in the latter. This would also mean that the scope of the offence could be defined by a duty of care owed to the individual as we have suggested, which would be more appropriate and consistent with the Mental Capacity Act.

The Consultation process

93. Whilst we have provided extensive comments on the proposals we think that the consultation period was far too short. We think the consultation period should have been 12 weeks.

94. It is not reasonable for the government to say that 'many of the key stakeholders are already aware' of the proposals and therefore the consultation period can be short.[27] The proposals are far-reaching and could have a variety of unintended consequences. Anyone affected must be given adequate time to gather evidence and reflect on the proposals. One month was an insufficient period.

95. Inadequate consultation will inevitably lead to poor quality legislation or extensive need to amend the proposals later.

[27] Department of Health, *New criminal offence of ill-treatment or wilful neglect – Consultation Document,* (February 2014) p22

CONTACT

Should you require further information about any aspects of our response to this consultation, please do not hesitate to contact me.

Oliver Rawlings
Policy and Public Affairs Officer

Email: oliver.rawlings@mps.org.uk

The Medical Protection Society Limited
33 Cavendish Square
London W1G 0PS
United Kingdom

Tel: +44 (0)20 7399 1300
Fax: +44 (0)20 7399 1301

info@mps.org.uk

www.mps.org.uk
www.medicalprotection.org

The Medical Protection Society
A company limited by guarantee
Registered in England no. 36142
at 33 Cavendish Square, London
W1G 0PS