Written evidence from Margaret Flynn, Chair of the National Mental Capacity Forum (HSC0053)

Further to the 12 January meeting, the Joint Committee is interested in, *inter alia,* (i) the Right to Family Life and (ii) effective complaints mechanisms. I noted during the meeting that discouraging families' visits to their relatives in care settings pre-dated, COVID guidance. It is a frustration that I know well.

My family was excluded from the decision to remove our brother from his flat for "a week to try a course of lithium" was not upheld by the local authority. It found that the family "did not like some aspects of the way the 'home' in which he had been placed was managed and didn't feel it was a suitable place." We had been led to believe that this 'home' was a registered care facility with trained and experienced staff. We discovered later that it was supported accommodation. It was not perceived as sufficiently serious that my brother had lost his tenancy of 20 years or was prescribed increasing dosages of lithium which resulted in [redacted] [a loss of bodily functions]. Staff failed to tell the family that the toxic effects of his medication were not being monitored. Similarly, when he scalded his foot, the 'home' did not follow medical advice and his wound became noxious. I accompanied my brother to a MIU and was advised that he was likely to lose his foot. Fortunately, this did not happen. However, it took over 12 months for us to effect his discharge from this 'home' into a tenancy with support.

Mine is not the only family to find itself without footholds when services abruptly excluded us from decision-making with far reaching implications for my brother's life. You attempt to hold things together as professionals rebuff your questions; you find a way of supporting your relative that you know cannot compensate for poor services; and you hope that repair is possible by discussing and writing about the harms that result from being silenced.[1] It matters that we tell stories of injustices, injuries and the poor stewardship of public finances. Our experience underlines the power of stubborn family advocacy in the face of bureaucratic obstruction and yet the exclusion of families is not perceived as a breach of the *right to respect for private and family life.*[2]

Panorama's *Undercover Care: The Abuse Exposed,* broadcast during May 2011, was unflinching. It triggered disbelief concerning the circumstances of people with learning disabilities at Winterbourne View Hospital, an Assessment and Treatment Unit.[3] The suffering, injustices and humiliations endured were so considerable that politicians' expressions of horror and promises to learn lessons were prolific. These fell short, despite the regret expressed by the hospital's parent company Castlebeck Care (Teesdale) Ltd, armfuls of parallel information-gathering activities and the £10.4m subsequently invested in "transformation." Little success attended these efforts. Patients' families asked questions prompted by their relatives' experiences, most particularly their long-term inactivity, boredom and the hospital's restrictions.

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[1] Flynn, M. (2004) Challenging poor practice, abusive practice and inadequate complaints procedures: a personal narrative. The Journal of Adult Protection, 6, (3) 34-44

[2] Under S.6 of the Human Rights Act 1998 it is "…unlawful for a public authority to act in a way which is incompatible with a Convention right"

[3] In the media it is also referred to as a care home. A service's "Statement of Purpose" is more revealing. The CQC are stewards of a service's Statement of Purpose

Without a credible understanding of people's biographies there can be no life course perspective. It takes time and trust to gather information about a person's life. In deliberately creating distance between residents, patients and their families, by discouraging contact or making this contingent on good behaviour (at Winterbourne View Hospital and Atlas Homes in Devon,[4] for example) the possibility of synthesising what is in records with what matters is limited, e.g. people's personal qualities and resources, social circumstances, interests and "at home support". Knowing residents as loved family members, with roles within and outside the family, is critical to valued care and support.

The abusive practices at Atlas Homes were unchallenged by the commissioners, the inspectorate, social workers or psychiatrists. The limited training received by staff was "in-house" and delivered by the owner and other managers. During the criminal trials the service was described as "inward looking…a closed culture resistant to external advice" in which staff used "Atlas-speak" as they exerted power over residents. Adult abuse hurts families too because the admission of a relative to a care setting does not herald the end of care-giving. It prompts a hunger for justice and a more realistic consideration of what safe and responsive care is. Families have developed skills, expertise and powerful advocacy over time and yet these are not perceived as complementing those of professionals, untrained and unsupervised support workers, or even the "experts by experience" commissioned by the Care Quality Commission. The confident knowledge of families that things are not right begins when placements are being considered, at the outset of these placements and during reviews when marginalisation is commonplace. Families have a deep desire to demonstrate the worth of their relatives to hospital and care home staff and to ensure that they are not harmed.

Similarly, in the wake of such scandals, criminal justice processes are experienced as bewildering and highlight unanticipated shortcomings (see the Safeguarding Adult Review of 2019 concerning Atlas Homes). Adults with learning disabilities and mental health problems are likely to be perceived as *vulnerable witnesses,* eligible for special measures,[5] since their evidence may be diminished on account of their *mental disorder* or significant impairment of intelligence and social functioning. The families of Atlas residents recalled hearing glowing character references of the former staff employees, yet there was no parallel means of describing the essence and vitality of their relatives' lives. Although they matter a great deal to their families, during the trial, their individual qualities were reduced to accounts of aggressive or destructive behaviour and how they gave expression to their distress by non-compliance – usually described as *challenging.* Crucially for families, the trial was silent on the implications of the European Convention on Human Rights[6] for residents. Families want the criminal justice system to cease to 'explain' abusive practices as a by-product of residents' distressed behavioural patterns, the onset of mental health problems or even their age. People with learning disabilities, mental health problems and older people with dementia are not the principal problem. There was no sense that former residents had difficulties in making themselves understood and were likely to be frustrated and upset by not being able to

[4] https://devoncc.sharepoint.com/sites/PublicDocs/AdultSocialCare/DevonSafeguardingAdultsBoard/Forms/AllItems.aspx?id=%2Fsites%2FPublicDocs%2FAdultSocialCare%2FDevonSafeguardingAdultsBoard%2FAtlas%2FAtlas%20SAR%20Report%20Summary%20%2D%20Appendix%201%2Epdf&parent=%2Fsites%2FPublicDocs%2FAdultSocialCare%2FDevonSafeguardingAdultsBoard%2FAtlas&p=true (accessed 25 January 2022)

[5] Youth Justice and Criminal Evidence Act 1999, s.16

[6] A civil trial or a judicial review may have provided better options in terms of securing answers from the home and its staff about harms in addition to false imprisonment

communicate directly what had happened to them. It is possible that some patients have memories of previous events at unknown times which are resistant to forgetting. It is also possible that some behaviours are "trauma-specific" yet the traumas themselves are not known. Such silencing leaves families grieving and feeling aggrieved.

Similarly, "In Search of Accountability"[7] outlines the wrong and indifferent care home practices which harmed older people with dementia and resulted in 63 "suspicious deaths." Although the poor reputations of these care homes featured in TV programmes during 1995, 2005 and 2015, and a police investigation was estimated to have cost c.£15m, no prosecutions resulted. The irony is that if homes are perceived by inspectors to have improved, their registration is safe.

I noted during the 12 January meeting that regulation has decreasing legitimacy – not least because of (i) its procedural rigidity and (ii) the wrongs which result in harm and tragedies are inappropriately regarded as acts which should be prohibited via regulatory intervention. Potential remedies[8] may reside in:

- A regulatory system that (i) ensures the suitability of providers and (ii) deters and punishes corporate wrongdoing.
- Gives legislative expression to the primary principle of the welfare and wellbeing of people receiving care, including their health needs and the need to be protected from harm.
- 'Failure to prevent' offences, which are currently a feature of financial crimes, should be adopted within the regulation of the health and care sector.
- The need for arm's length dealings is paramount. It is not achieved when the Care Quality Commission is engaged in parallel improvement and enforcement/ prosecution activities. These functions remain to be structurally separate.
- The penalties of the CQC should be commensurate with those of regulatory bodies such as the Health and Safety Executive – which is not tasked with nurturing companies.
- There should be greater clarity in relation to the co-ordination of criminal and regulatory proceedings.
- There is a case for reversing the burden of proof, that is, a provider service should demonstrate how it is delivering its "Statement of Purpose."
- The CQC's Enforcement document notes that it has a Memorandum of Understanding in relation to how it proceeds with the Health and Safety Executive. This should state how decisions are managed in relation to offences which are both regulatory and mainstream common law offences and potentially subject to prosecution by the Crown Prosecution Service.
- A regulatory equivalent to the intermediate Administration provision under the Insolvency Act 1986. This provides a means for earlier intervention and potential partial rescue. Alternative approaches could include something akin to the Supplier of

[7] https://gov.wales/sites/default/files/publications/2019-06/flynn-report-executive-summary.pdf (accessed 25 January 2022

[8] Aled Griffiths, Laura Pritchard-Jones and Margaret Flynn gave evidence to the Law Commission on 14 October 2021, in response to its consultation concerning *Corporate Criminal Liability.* These remedies summarise proposals made in our written submission

Last Resort as demonstrated in relation to the ongoing electricity supplier crisis, or the earlier public law default provisions provided for under the founding National Assistance Act 1948.

- The CQC requires powers to take enforcement action against companies owned by the same directors, that is, the corporate arrangements behind the providers. Arguably, the Regulatory provisions in Wales are more potent in this respect as they provide direct license to consider issues beyond the scope of the particular registered company being investigated (See Regulation and Inspection of Social Care (Wales) Act 2016; Sec 7(1) (a-d) and 15(2)(a-c).

The interests of the citizens who are dependent on health and care services and their families require attention. As presently constituted, there is no formal recognition of their interests within corporate and legislative models. Although the statutory provision refers to 'customers' and 'the community,' it falls short of the provision of a credible platform for families and external challenges to operational practice.

The abuse and neglect of adults who depend on private care companies to meet their needs are often driven by toxic corporate cultures which originate from the upper echelons of the company, see, for example, Operation Jasmine. Attributing criminal liability on the basis of corporate culture would more closely reflect the causes of this abuse and neglect, while also better serving the interests of justice for adults and their families who have been subjected to such abuse.

All care providers – public or private – are considered to be exercising functions of a public nature for the purposes of the Human Rights Act 1998. A failure to perform their duties should be regarded as somewhat akin to the common law tort and crime of misfeasance in public office.

A sector-specific breach of duty in a public office that is reckless as to the risk of serious injury or death would be grounds for director disqualification and prosecution. However, director disqualification is not currently a reality in health and social care.

The regulator has the power to take civil and criminal enforcement action against care providers in breach of regulations. In terms of scale, the CQC has brought 37 prosecutions since 2019 against, 28 of which were private or not-for-profit providers – out of 50,262 providers in England, including hospitals. The regulator is unable to take action against providers owned by separate legal entities – even though they may have the same directors. That is, its focus is on individual providers rather than the corporate arrangements of providers – even though neglect may be prevalent across homes owned by the same directors. While financial viability is a criterion for successful regulation, CQC has no powers to review or monitor the finances "leaking" from companies or the financial benefits received by directors. Prosecutions under the Corporate Manslaughter and Corporate Homicide Act 2007 are rare. There have been around 80 successful prosecutions under s.127 Mental Health Act 1983, s.44 Mental Capacity Act 2005 and s.20 of the Criminal Justice and Courts Act 2015. There are no reported cases of criminal prosecutions under s.21 of the CJCA.

Finally, there are deficiencies in company law and corporate governance provision. Private providers may be fronted by big businesses with corporate structures that undermine

accountability or, more commonly, by small businesses that are not subject to corporate scrutiny – specifically the monitoring codes introduced to promote effective corporate governance or even corporate social responsibility provisions. Typically, professionals who are physically providing care and support bear the brunt of malpractice condemnation whilst key corporate players, even in smaller companies, side-step accountability. Corporate governance has failed to adapt to changes in corporate delivery in the health and social care sectors since the current legal framework hardly recognises the public interest and public investment involved.

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