CARE AND CORPORATE NEGLECT

Corporate Accountability
and Adult Safeguarding

Edited by Rt Hon Paul Burstow MP

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EXECUTIVE SUMMARY

> *Winterbourne View was a shocking example of what happens when people with learning disabilities are failed by bad management and poor care*
>
> *There is already law on corporate manslaughter.....I think there is a strong case for extending the scope to wilful neglect so there is accountability for when care goes drastically wrong.*[1]

This briefing paper intends to explore how corporate bodies could be held criminally responsible for abuse and neglect that takes place in hospitals and care homes. The paper explores current domestic and international law and seeks to find precedents and guidance that would allow the Government to create a new criminal sanction for corporate neglect.

The paper also looks at how adult safeguarding and Serious Case Reviews could be strengthened in order to ensure stronger corporate accountability for when things go drastically wrong.

This paper argues that corporations whom by their actions facilitate abuse or neglect in care institutions must be held criminally accountable. This paper will explore what legislation and safeguards are currently in place for the protection of vulnerable adults and what legislative solutions could be introduced to enable "Corporate Neglect" to become a criminal offence.

This paper also seeks to draw together the views of three experts in the field of residential care and adult safeguarding: former Care

[1] Larisa Brown & Chris Brooke, Culture of Cruelty, *Daily Mail*, Friday 26th October, http://www.dailymail.co.uk/news/article-2223514/Winterbourne-View-11-care-home-workers-sentenced-abuse-exposed-BBC-Panorama.html

Services Minister Rt. Hon Paul Burstow MP, Margaret Flynn and Vic Citarella, the authors of the Winterbourne View hospital Serious Case Review and Peter Kinsey, chief executive of the Care Management Group.

In conclusion this paper proposes that the Health and Social Care Act 2008 be amended to include a new section under Part 1, Chapter 3, the Quality of Health and Social Care entitled *Corporate Neglect* whereby:

> *A corporate body delivering services covered by sections 8 and 9 of the Act are guilty of an offence if the way in which its activities are managed or organised by its board or senior management neglects or is a substantial element in the existence and or possibility of abuse or neglect occurring.*

Furthermore, to ensure that the punishments for these offences act both as appropriate sanction and a suitable deterrent for corporations, we propose that new offences should be implemented to include unlimited fines, remedial orders and publicity orders.

In terms of adult safeguarding more generally, we address how Adult Safeguarding Boards and Adult Serious Case Reviews can be strengthened so that corporations and others have a duty to supply information and to co-operate. In the wake of Winterbourne View – whereby the owners of that hospital, Castlebeck Ltd, refused to supply certain financial information to the Review – we believe these measures are both necessary and proportionate. We argue that legislation should be introduced to reflect existing safeguarding laws in Scotland, along with commensurate updates to statutory guidance – thus compelling all organisations to supply information to Adult Safeguarding Boards.

As a means of ensuring all of these proposals are enacted in law – we call on the Government to include the relevant provisions in the draft Care and Support Bill, so that the shocking events at Winterbourne View are never again repeated without justice being served to both the individuals and corporations accountable.

BACKGROUND

A nation's greatness is measured by how it treats its weakest members[2]

Mahatma Gandhi

The abhorrent abuses that came to light at Winterbourne View hospital brought into sharp focus the hidden care crisis in our midst. Unfortunately, what happened at Winterbourne View was not the first example of abuse in a care setting - but the latest in a line of instances where a care provider has failed its patients. Yet while care homes like Summer Vale Care Centre, Arden Vale and Winterbourne View have been closed, their parent companies Castlebeck Care (Teeside) Ltd and Minster Care Management have never been brought before a criminal court.

In the Serious Case Review undertaken by South Gloucestershire Safeguarding Adults Board, the author Margaret Flynn stated that management failings at Winterbourne View "resulted in the arbitrary violence and abuses exposed"[3] by the BBC Panorama programme *Undercover Care* in May 2011 and that "the hospital has become a case study in institutional abuse"[4].

Therefore, while the Care Quality Commission has enforced or overseen the closure of these institutions, it is powerless to undertake enforcement action against corporations commensurate to the level of their institutional negligence.

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[2] The Gandhi Foundation - http://gandhifoundation.org/
[3] Margaret Flynn, *Winterbourne View Hospital: A Serious Case Review*, 2012, pX, http://hosted.southglos.gov.uk/wv/report.pdf
[4] Margaret Flynn, *Winterbourne View Hospital: A Serious Case Review*, 2012, p143 http://hosted.southglos.gov.uk/wv/report.pdf

Patients or their families are only able to seek appropriate justice through civil litigation.

It is against this backdrop that has led many to argue the criminal law provides insufficient reprimand for companies who have a duty of care to our most vulnerable members of society.

INSTITUTIONAL NEGLECT AND ABUSE

Surrey County Council describes institutional abuse as "when the lifestyles of individuals are sacrificed in favour of the rituals, routines and/or restrictive practices of the home or care setting"[5]. Age Concern Wales' report *Safeguarding Older People 2009,* discusses institutional abuse and the possible cultural and management indicators, as well as contributory factors to institutional abuse such as under-staffing and high turnover of staff, low morale and lack of management oversight[6].

Matthew Colton[7], examines the factors that can culminate in institutional abuse and states issues such as failings in relation to staff recruitment, training, supervision and ineffective management are important contributory factors to situations of institutional abuse. As highlighted by Care Services Minister Norman Lamb MP:

> *Staff whose job was to care for people instead routinely mistreated and abused them. Management allowed a culture of abuse to flourish*[8].

Therefore when corporations run an institution in an unsuitable manner, they can directly or indirectly cause abuse to take place. As Peter Kinsey states in his think piece for this paper:

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5 Surrey County Council, *Institutional Abuse,* http://www.surreycc.gov.uk/social-care-and-health/adult-social-care/protecting-adults-from-harm/adult-abuse-and-different-types-of-abuse/institutional-abuse

6 Age Concern Cymru, *Safeguarding Older People, January 2009*, 2.3.7.2, p16 http://www.ageuk.org.uk/pagefiles/7767/safeguarding%20older%20people%20resource.pdf

7 Matthew Colton, Factors associated with abuse in residential child care institutions, *Children & Society*, Volume 16, Issue 1, January 2002, pp33–44.

8 *Hansard*, Column 49, 10th December 2012, http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121210/debtext/121210-0002.htm#1212108000001

Senior executives have a responsibility to ensure that appropriate quality systems are in place. If there is a systematic failure, as at Winterbourne View, then senior managers and ultimately the Board are responsible.

CURRENT PROTECTIONS IN DOMESTIC LAW

In this section we summarise what current relevant legislation there is in the area of neglect and abuse of vulnerable adults, and identifies what gaps exist in legislation.

Violence on a Person

Offences Against the Person Act 1861

Sections 18 & 20 of the Offences Against the Person Act 1861[9], creates an offence for a person inflicting bodily injury or grievous bodily harm on another.

Criminal Justice Act 1988

Section 39 of the Criminal Justice Act 1988[10], makes provision for common assault and battery of a person to become a summary offence.

Domestic Violence, Crime and Victims Act 2004

Section 10 of the Domestic Violence, Crime and Victims Act 2004[11], makes provision for common assault to be an arrestable offence

The Elderly

Domestic Violence, Crime and Victims Act 2004

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[9] Offences Against the Person Act, 1861, contents, http://www.legislation.gov.uk/ukpga/Vict/24-25/100/contents

[10] Criminal Justice Act, 1988, Section 39, http://www.legislation.gov.uk/ukpga/1988/33/section/39

[11] Domestic Violence, Crime and Victims Act, 2004, Section 10 http://www.legislation.gov.uk/ukpga/2004/28/section/10

Section 5 of the Domestic Violence, Crime and Victims Act 2004[12], states that it is an offence for a person to cause or allow the death of a child or vulnerable adult through their actions.

Mental Health

Mental Health Act 1983

The Mental Health Act covers the care, accommodation and treatment of people with a mental illness[13]. In particular, it provides the legislative platform by which people can be detained in hospital or police custody and have their disorder assessed or treated against their wishes, known as sectioning.

Section 127 of the Mental Health Act 1983[14] is a very important piece of legislation for the protection of vulnerable adults, as it makes it an offence for staff of a hospital or care home to ill-treat or wilfully neglect its patients receiving mental health treatments. The penalty for this was increased under the Mental Health Act 2007[15] to a maximum of five years imprisonment or a fine or both.

Mental Capacity Act 2005

Section 44 of the Mental Capacity Act 2005[16], states that it is an offence for any person to ill-treat or wilfully neglect someone who is covered by the Act. Section Two states that the Mental

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12 Domestic Violence, Crime and Victims Act, 2004, Section 5, http://www.legislation.gov.uk/ukpga/2004/28/section/5

13 Mental Health Act, 1983, Contents http://www.legislation.gov.uk/ukpga/1983/20/contents

14 Mental Health Act, 1983, Section 127, http://www.legislation.gov.uk/ukpga/1983/20/section/127

15 Mental Health Act, 2007, Section 42, http://www.legislation.gov.uk/ukpga/2007/12/section/42

16 Mental Capacity Act, 2005, Section 44 http://www.legislation.gov.uk/ukpga/2005/9/section/44

Capacity Act is applied to those that lack "capacity" to make a decision for themselves both in the short and long term[17]. Therefore the Mental Capacity Act is important as it not only covers patients with a mental illness but covers those people who lack capacity of judgement as well.

Sexual Offences Act 2003

Sections 30-44 of the Sexual Offences Act 2003[18], specifically covers sexual relations with people of diminished mental capacity. Sections 30-33 covers offences against a person with a mental disorder impeding choice, sections 34-37 covers inducing a person with a mental disorder into participating or watching sexual acts and sections 38-44 specifically covers care workers having sex or inducing sexual activity with people who have mental disorders.

As this section demonstrates, the criminal law covering the assault, neglect or abuse of adults in vulnerable situations is quite comprehensive. For example, the eleven people convicted of neglect and abuse at Winterbourne View were charged under section 127(1) of the Mental Health Act 1983[19], and Jonathan Aquino in the case of abuse in Ash Court Care Home was convicted of common assault under section 39 of the Criminal Justice Act 1988 and ill treatment of a vulnerable person under section 127(1) of the Mental Health Act 1983.

However, none of the current legislation covers abuse or neglect by corporate bodies and only covers person to person contact. Therefore, it is necessary to look at the legislation governing care

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[17] Mental Capacity Act, 2005, Section 2
http://www.legislation.gov.uk/ukpga/2005/9/section/2
[18] Sexual Offences Act, 2003, Contents
http://www.legislation.gov.uk/ukpga/2003/42/contents
[19] Crown Prosecution Service, *Eleven sentenced for hate crimes at Winterbourne View,* 26th October 2012,
http://www.cps.gov.uk/southwest/cps_southwest_news/eleven_sentenced_for_hate_crimes_at_winterbourne_view/

homes to see if any existing safeguards are in place that would allow corporate bodies to be prosecuted.

People in Care:

Care Standards Act 2000

The Registered Homes Act 1984 was replaced by the Care Standards Act 2000[20], which legislated for the registration and regulation of care homes, children's homes and independent hospitals, whilst bringing in national minimum standards. Section 11 requires a care home to have a registered person[21], section 22 covers the regulation of establishments and agencies[22] and section 23 sets national minimum standards of care[23]. The most relevant section of the Act however is section 30, titled *Offences by Bodies Corporate*, which states that **if an offence is proven to have been committed "with the consent or connivance of, or to be attributable to any neglect on the part of "a director, manager or someone working for the corporate body" then the registered person as well as the corporate body "shall be guilty of the offence and shall be liable to be proceeded against and punished accordingly"[24].**

Section 23(1) provides for the establishment of the National Care Home Standards[25] and The Care Homes Regulations Act 2001[26] was enacted to introduce the more specific regulations for the areas introduced within the Care Standards Act 2000.

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[20] Care Standards Act, 2000, Contents, http://www.legislation.gov.uk/ukpga/2000/14
[21] Care Standards Act, 2000, Section 11
http://www.legislation.gov.uk/ukpga/2000/14/section/11
[22] Care Standards Act, 2000, Section 22
http://www.legislation.gov.uk/ukpga/2000/14/section/22
[23] Care Standards Act, 2000, Section 23
http://www.legislation.gov.uk/ukpga/2000/14/section/23
[24] Care Standards Act, 2000, Section 30
http://www.legislation.gov.uk/ukpga/2000/14/section/30
[25] Care Standards Act, 2000, Section 23(1)
http://www.legislation.gov.uk/ukpga/2000/14/section/23
[26] Care Homes Regulations Act, 2001, Contents
http://www.legislation.gov.uk/uksi/2001/3965/contents/made

The Health and Social Care Act 2008

The Health and Social Care Act 2008[27] created the Care Quality Commission and updated many of the provisions under the Care Standards Act 2000. It repealed the Care Homes Regulations Act 2001, which was subsequently replaced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010[28]. Regulation 11 states that the registered person must safeguard service users from abuse[29] and Regulation 27[30] states that a registered person can be fined up to £50,000 for being in contravention of Regulation 11. What is significant again is that **section 91 of the Health and Social Care Act[31] reaffirms the previous section 30 in the Care Standards Act 2000 and states that a corporate body can be guilty of offences caused within Part 1 of the legislation which covers the activities that occur within care homes**. Therefore, the current legislation does seem to allow for the prosecution of corporate bodies due to failings in their institutions.

At this point it is important to understand the role of the Care Quality Commission (CQC) and how it holds corporations to account. Chapter One of the Health and Social Care Act 2008[32], merged the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission into a single body, the Care Quality Commission. The role of the CQC in care homes is therefore to administrate and regulate the

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27 Health and Social Care Act, 2008, Contents
http://www.legislation.gov.uk/ukpga/2008/14/contents

28 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Contents
http://www.legislation.gov.uk/ukdsi/2010/9780111491942/contents

29 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 11,
http://www.legislation.gov.uk/ukdsi/2010/9780111491942/regulation/11

30 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 27
http://www.legislation.gov.uk/ukdsi/2010/9780111491942/regulation/27

31 Health and Social Care Act, 2008, Section 91
http://www.legislation.gov.uk/ukpga/2008/14/section/91

32 Health and Social Care Act, 2008, Contents
http://www.legislation.gov.uk/ukpga/2008/14/contents

registration and inspection of care homes, to ensure that the national standards are implemented and to ensure the protection of vulnerable people under the Mental Health Act 1983.

The CQC under its powers within the Health and Social Care Act 2008, has the powers of enforcement to issue compliance actions, warning notices, penalty notices (fines), simple cautions and where appropriate undertake prosecutions. However, these enforcement powers are limited to actions against the registered person, who the CQC states is the person who is in day-to-day charge of one or more regulated activities of the care home and has legal responsibilities in relation to that position, not a corporation itself. Indeed, point 66 of its own enforcement policy April 2012 admits that "our most powerful sanction is to cancel a registration"[33]. This is despite the fact that section 91 of the Health and Social Care Act 2008 states corporate bodies are also liable for prosecution. Indeed, **it appears the powers referred to in section 91 are not utilised at all, despite the fact it effectively replaces section 30 of the Care Standards Act.**

The powers of enforcement by the CQC are further diminished by section 27(2a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010[34], which states that the CQC must issue a warning notice before any further enforcement action can be undertaken. Therefore without first issuing a warning notice, even the most severe breaches cannot be prosecuted by the CQC, further undermining their capacity to act quickly and decisively as the regulator of care homes.

Health and Safety

[33] Care Quality Commission, *Enforcement Policy*, April 2012, point 66, p16 http://www.cqc.org.uk/sites/default/files/media/documents/20120321_final_enforcement_policy_for_publication.pdf

[34] Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 http://www.legislation.gov.uk/ukdsi/2010/9780111491942/regulation/27

Our examination of current legislation so far demonstrates there are insufficient penalties in place to hold corporations to account in instances of corporate neglect. Yet, the all encompassing provisions under the Health and Safety at Work Act 1974, might hold some hope for us.

Section 3 of the Act states that companies must ensure they are undertaking their practices in such a way as to ensure that persons not in their employment and who they have a duty of care towards, are not exposed to risks to their health or safety[35]. Therefore, by a company's actions, if this infringes or exposes people to situations that harm their health and safety then this is a breach of the law. Furthermore, Section 37 of the Act titled *Offences by bodies corporate* states that where an offence has been committed with the consent or connivance or be attributable to any neglect on the part of any director or senior company official then that person as well as the body corporate shall be guilty of that offence and shall be liable to be prosecuted accordingly[36].

Therefore it appears that people in a care home or hospital setting are covered under this Act, as a company would have a duty of care towards them. The Health and Safety Executive (HSE) is responsible for investigating and prosecuting breaches of the Health and Safety Act. The HSE have an enforcement policy statement criteria used for the selection of cases for prosecution whereby the key principles cover proportionality, targeting, consistency, transparency and accountability[37]. **According to these criteria instances of abuse in care homes would be liable for prosecution by the HSE under Health and Safety legislation**.

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[35] Health and Safety at Work Act, 1974, Section 3
http://www.legislation.gov.uk/ukpga/1974/37/section/3
[36] Health and Safety at Work Act, 1974, Section 37
http://www.legislation.gov.uk/ukpga/1974/37/section/37
[37] Health and Safety Executive, *Enforcement Policy Statement,* 2009, p3
http://www.hse.gov.uk/pubns/hse41.pdf

Most of the cases the HSE investigates are covered within the RIDDO[38] (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995) regulations. The HSE have an incident selection criteria for possible RIDDO investigations whereby section five and section seven of the policy do seem to cover incidents that would have major national effects or concerns, which could be seen to be relevant to incidents of care home abuse or neglect[39].

However, cases where care homes have been successfully prosecuted by the HSE have always involved deaths or incidents caused by accidents in buildings, the incorrect use of machinery or faulty machinery (which are the kinds of instances you would expect the HSE to investigate), rather than any institutional or long term abuse or neglect. Therefore, **whilst the interpretation of the legislation does seem to allow for the prosecution of corporations for facilitating neglect or abuse in their institutions, it appears the HSE do not seek to prosecute abuse or neglect under Health and Safety legislation.**

The HSE in their evidence to the Mid Staffordshire NHS Foundation Trust Enquiry expands on this point to state **that there is a "regulatory gap" in the enforcement of care[40] and suggests that the solution lies either in giving more comprehensive powers of prosecution to the CQC or giving the HSE the responsibility for prosecutions across a much wider range of health and social care activities[41].**

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[38] The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, Contents
http://www.legislation.gov.uk/uksi/1995/3163/contents/made

[39] Health and Safety Executive, *Incident Selection Criteria Guidance,*
http://www.hse.gov.uk/lau/lacs/22-13.htm

[40] The Mid Staffordshire NHS Foundation Trust Public Enquiry, Transcript, 5th July 2011
http://www.midstaffspublicinquiry.com/sites/default/files/transcripts/Tuesday_5_July_2011_-_transcript_with_correction.pdf

[41] Health and Safety Executive, Improving Health and Safety in the Health and Social Care Sectors,
http://www.hse.gov.uk/aboutus/meetings/hseboard/2012/290212/pfebb1219.pdf

Therefore, whilst the powers to close a care home ensure some form of corporate censor, we argue this is an insufficient penalty in the most extreme cases of abuse and neglect. It is also the case that this is an inappropriate method of ensuring true corporate accountability in instances of institutional abuse.

This point is further emphasised by the fact that after the abuse at Winterbourne came to light, the CQC conducted an investigation into all 23 of the care homes Castlebeck Ltd ran. Out of these homes, 11 were not compliant with the minimum standards and four of these were deemed to be of "serious concern"[42]. Many have since argued that the enforcement powers of the CQC are not an effective deterrent to bad care standards. This view is further underlined by the Department of Health in their final response report to the events at Winterbourne View late last year – where it stated that the CQC "has not always held organisations to account at a corporate level"[43].

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[42] Care Quality Commission, *CQC calls on Castlebeck to make root and branch improvements*, 2nd August 2011
http://www.cqc.org.uk/media/cqc-calls-castlebeck-make-root-and-branch-improvements

[43] Department of Health, *Transforming care: A National response to Winterbourne View Hospital*, point 5.5, p31
https://www.wp.dh.gov.uk/publications/files/2012/12/final-report.pdf

AN INTERNATIONAL PERSPECTIVE

In this section we seek to demonstrate the international evidence for legislating against corporate neglect in the criminal courts.

Much of the federal legislation in the **United States** on this issue deals with enabling laws and preventative measures in elderly abuse. Chapter Three of the Older Americans Act 1965[44] deals with the prevention of elder abuse, neglect, and exploitation and obliges prevention programmes to be established in every state, whilst the Elder Justice Act 2010[45], is designed to provide federal resources to States for the prevention, understanding and detection of elder abuse and exploitation.

Legislation on vulnerable adults is predominately undertaken at State-level in the US and there was an interesting case in the State of Missouri, ***State v. Boone Retirement Centre inc***[46]**, where the court dismissed the retirement centre's appeal against a conviction of two counts of a class D felony of neglect of a nursing home resident under section §198.070.11 of the Missouri penal code (dealing with the reporting of abuse and neglect and the prohibition of retaliatory actions to those that report a violation of abuse in health care facilities) , where the court found it suitable to deem the corporation criminally guilty of an offence as the offence was authorised or knowingly tolerated by the board of directors or by a senior manager**.

[44] Older Americans Act, 1965, Section 721, United States Government http://www.aoa.gov/AoA_programs/OAA/oaa_full.asp#_Toc153957799
[45] Elder Justice Now, *Elder Justice Act Summary,* http://elderjusticenow.org/wp-content/uploads/2010/04/EJA-Summary.pdf
[46] Find Law, *State v. Boone Retirement Center Inc,* http://caselaw.findlaw.com/mo-court-of-appeals/1407150.html

In this case the court found there was sufficient evidence in this case, based on the combined acts and knowledge of the high managerial agents involved, to establish criminal liability for the corporation[47]. Therefore, this is our first example of a case where a company has been criminally prosecuted for corporate neglect.

However, some of the most comprehensive protections in place for vulnerable adults can be found in **Canada** where, like America, much of the legislation is created at a Federal level. Section 20.1 of the Vulnerable Persons Living with a Mental Disability Act 1993[48] (Manitoba State) makes it an offence for anyone to abuse or neglect a vulnerable person and section 20.2 states that **service providers have a duty to protect vulnerable adults**. A person in contravention of this under section 164 of this act is guilty of an offence and can be jailed for up to two years and/or fined up to $50,000[49].

In 2010 the State of Manitoba increased these protections to vulnerable adults and enacted the **Protection for Persons in Care Act 2010 (Manitoba).** Section 2 of this Act[50] states that operators of health facilities have a duty to protect patients from abuse and to maintain a reasonable level of safety for them. Under section 12(1)[51] both corporations and an individual can be found guilty of an offence with a corporation liable for a $30,000 fine or an individual up to $2,000. **This is the first legislation that we have found where corporations can be found guilty**

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47 American Prosecutors Research Institute, *Prosecution of Elder Abuse, Neglect, & Exploitation,* July 2003, p15
http://www1.cj.msu.edu/~outreach/mvaa/Elder%20Abuse/Prosecution%20of%20Elder%20Abuse,%20Neglect,%20&%20Exploitation%20Crimina.pdf

48 The Vulnerable Persons Living with a Mental Disability Act, 1993, State of Manitoba, Section 20.1,
http://web2.gov.mb.ca/laws/statutes/ccsm/v090e.php#20.1

49 The Vulnerable Persons Living with a Mental Disability Act, 1993, State of Manitoba, Section 164 http://web2.gov.mb.ca/laws/statutes/ccsm/v090e.php#164

50 The Protection for Persons in Care Act, 2010, State of Manitoba, Section 2,
http://web2.gov.mb.ca/laws/statutes/ccsm/p144e.php#2

51 The Protection for Persons in Care Act, 2010, State of Manitoba, Section 12
http://web2.gov.mb.ca/laws/statutes/ccsm/p144e.php#12

of an offence within legislation (rather than precedent) due to abuse or neglect occurring within their own institutions.

The State of Alberta goes even further than Manitoba under the **Protection for Persons in Care Act 2010 (Alberta),** whereby section 24.2 provides for **a $100,000 fine for corporations** or $10,000 for an individual found guilty of an offence under section 10, where a person or **service provider has a duty to take reasonable steps to protect the client from abuse while providing care or support services and needs to maintain a reasonable level of safety for the client[52].** Therefore, from an international perspective it is clear that a precedent has been created for such legislation.

[52] Protection for Persons in Care Act, 2010, State of Alberta, Section 24.2, http://www.qp.alberta.ca/1266.cfm?page=P29P1.cfm&leg_type=Acts&isbncln=9780779749904&display=html

CORPORATE LAW

If we are to hold corporations to account for neglect or abuse that occurs in their care homes, it is imperative to look at current corporate law and how this could apply. Perhaps the most relevant piece of legislation is to be found under Section One of the Corporate Manslaughter and Corporate Homicide Act 2007, which states that an organisation can be found guilty of manslaughter or homicide if in the way that they are run, managed or organised by its senior management, there is a substantial element of the death in question[53]. The Act came into force in 2008 and there have been three successful prosecutions so far - against Cotswold Geotechnical Holdings[54], Lion Steel Ltd[55] and JMW Farms Ltd in Northern Ireland[56]. In the Sentencing Guidance Council guidelines for this offence, it states that in a successful prosecution the fine should be proportionate to the size of the company and the offence in question[57]; whilst the HSE clarifies that a successful prosecution will include unlimited fines, remedial orders and publicity orders[58].

Additionally, section seven of the Bribery Act 2010 creates a new corporate liability for bribery, whereby a corporation is guilty of an offence if a person associated with the company is guilty of

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[53] Corporate Manslaughter and Corporate Homicide Act, 2007, Section 1 http://www.legislation.gov.uk/ukpga/2007/19/section/1

[54] Crown Prosecution Service, *Cotswold Geotechnical Holdings convicted of first corporate manslaughter charge under new Act*, 15th February 2011 http://www.cps.gov.uk/news/press_releases/107_11/

[55] Crown Prosecution Service, *Second ever conviction for corporate manslaughter*, 3rd July 2012, http://www.cps.gov.uk/news/press_statements/second_ever_conviction_for_corporate_manslaughter/index.html

[56] Safety and Health Practitioner, *Record fine in first NI corporate manslaughter case*, 9th May 2012. http://www.shponline.co.uk/incourt-content/full/record-fine-in-first-ni-corporate-manslaughter-case

[57] Sentencing Guidelines Council, *Corporate Manslaughter & Health and Safety Offences Causing Death: Definitive Guidance*, 2010, Section C p5, http://sentencingcouncil.judiciary.gov.uk/docs/web__guideline_on_corporate_manslaughter_accessible.pdf

[58] Health and Safety Executive, *FAQ's* http://www.hse.gov.uk/corpmanslaughter/faqs.htm#penalties

bribery and the corporation does not have adequate procedures designed to prevent persons associated with it from undertaking such conduct[59]. The Bribery Act therefore attempts to legislate to ensure the existence of a corporate anti-bribery ethos especially as 7(2) of the act states that it is for the company to prove that they had the necessary procedures in place to prevent bribery occurring[60]. Therefore, the Bribery Act is of interest to our research as it highlights the importance of procedures and safeguards and how the lack of these can help create or nurture the existence of an offence, much like a care home not having the correct safeguards or corporate ethos in place to protect vulnerable adults.

Clearly the Corporate Manslaughter Act is particularly relevant as it directly creates criminal accountability for how a company is run and recognises that the standard or lack thereof of suitable practices and procedures has a direct effect on the probability or possibility of a death occurring. As the Home Office stated in its 2005 *Command Paper on Corporate Manslaughter,* the Act aims to enable more prosecutions to proceed by tackling the difficulties created by the common law "identification principle" whereby the requirement is to identify a "directing mind" within the company that is guilty of gross negligence manslaughter, and change it to a test that considers the adequacy of the way in which an organisation's activities are overseen by its senior managers[61].

Unlike the Bribery Act, which still requires the existence of a "directing mind", **the negation of the "directing mind" principle in the Corporate Manslaughter Act is crucial for us as it sets a precedent in domestic law for faceless**

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[59] Bribery Act, 2010, Section 7
http://www.legislation.gov.uk/ukpga/2010/23/section/7
[60] Ibid.
[61] The Home Office, *Corporate Manslaughter: The Government's Draft Bill for Reform*, Cm6497, 2005 p8&9,
http://www.parliament.uk/documents/upload/draftbillcorporateman.pdf

prosecutions and validates our intention of holding corporations to account for neglectful practices and procedures that directly or indirectly nurture or enable abuse against vulnerable adults to take place. Should it be possible to mirror the relevant sections of the Corporate Manslaughter Act within current legislation covering the care of vulnerable adults, then this would address our calls for legislation to hold corporations criminally responsible for corporate neglect.

LEGISLATING FOR CORPORATE NEGLECT

Our research has demonstrated that the existing body of domestic legislation protects vulnerable adults from neglect or abuse and contains criminal penalties against individuals. It is also the case that in civil law, a corporate body can be held responsible for such events. However, when such abuse or neglect is attributable to the practices and procedures of a company, there are no active criminal sanctions in place in domestic law.

Yet, from our international research we can demonstrate how countries such as Canada have directly legislated for corporations to be held to account for abuse or neglect that occurs in their institutions. Should we be able mirror the regulations set out within the Corporate Manslaughter Act 2007 within a care situation, then we could hold corporations criminally accountable for their actions in cases such as Winterbourne View.

Therefore, we propose the Health and Social Care Act 2008 be amended to include a new section under Part 1, Chapter 3, the Quality of Health and Social Care entitled *Corporate Neglect* whereby:

> *A corporate body delivering services covered by sections 8 and 9 of the Act are guilty of an offence if the way in which its activities are managed or organised by its board or senior management neglects or is a substantial element in the existence and or possibility of abuse or neglect occurring.*

Furthermore, to ensure that the punishments for these offences act both as a suitable sanction and deterrent for corporations, as with offences for corporate manslaughter, we propose that **new**

offences should be implemented to include unlimited fines, remedial orders and publicity orders.

CORPORATE NEGLECT: A POLITICIAN'S PERSPECTIVE

By Rt Hon Paul Burstow MP

What was so sobering about the abuses at Winterbourne View Hospital was that it was not an isolated case instigated by one rogue member of staff, but a sustained campaign of abuse and mistreatment perpetrated by more than ten employees.

This sustained culture of abuse and mistreatment was so endemic that many have asked whether the responsibility for such heinous crimes should rest simply with the staff involved. People have rightly been calling out for greater corporate accountability in these cases.

If another Winterbourne View happened tomorrow, there is no criminal sanction to hold a corporate body to account for enabling or fostering abuse in a care setting. I believe that such a new offence under criminal law should be introduced. It would not only close a loophole in our criminal law, but would also address what many see as an injustice. Above all it would act as a deterrent and serve as a spur to weak boards of directors to improve.

As highlighted by this paper, the CQC has the powers to act where it finds bad standards of care but they are hampered by the fact they are not able to utilise them - with the CQC's own board members stating that in practice they do not have an adequate "portfolio" of enforcement powers[62].

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[62] Sarah Calkin, CQC's 'hands are tied' on enforcement action, *Health Service Journal*, 24th September 2012, http://m.hsj.co.uk/5049625.article

It is therefore encouraging that in the Department of Health's final report into Winterbourne View, they called upon the CQC to take steps to "strengthen the way it uses its existing powers to hold organisations to account for failures to provide quality of care"[63]. In this report they propose to consult on whether to strengthen CQC's powers or to introduce criminal legislation to ensure corporate accountability. The publication of this paper sets out my stall on this issue and aims to propose a sensible solution to the problem.

In addition to changing statute by implementing a *Corporate Neglect law*, it is equally important to ensure that should failures in safeguarding arrangements occur, that Adult Safeguarding Boards have the correct tools in place to be able to independently investigate instances of abuse and recommend valuable improvements in safeguarding arrangements.

Whilst undertaking Adult Serious Case Reviews, investigators do not have statutory powers to compel information from other public institutions. In contrast Scottish Adult Protection Committees do have this power. In England, the powers of Children's Safeguarding Boards go even further and enabls a Children's Serious Case Review to compel the supply of pertinent information from any relevant institution. Powers to compel the release of information should be a prerequisite to an effective serious case review system and therefore the present gap in adult safeguarding legislation should be fixed by inserting the appropriate powers in the draft Care and Support Bill.

But we must not lose a sense of perspective. I also want to take this opportunity to champion the fantastic work that takes place in most care settings on a daily basis. Most of the people who

[63] Department of Health (2012) *Transforming Care: A National response to Winterbourne View Hospital,* p32, https://www.wp.dh.gov.uk/publications/files/2012/12/final-report.pdf

work in the care sector are remarkable and provide our most vulnerable adults with the high quality care and treatment they deserve.

However, whether unwittingly or by design, institutions can foster or enable abuse to occur. Ignorance of the consequences of one's direct or indirect actions within a care setting is not an adequate defence; under natural justice we all have responsibility for our actions. We therefore must be accountable for when we do not live up to our responsibilities, and corporations are no different.

My call for a change in the law builds on international experience and on the thinking behind the Corporate Manslaughter Act 2007 – which enables faceless corporations to be held criminally accountable for their practices. The Corporate Manslaughter Act removed the need to prove there was a directing mind in such cases. By taking a similar approach in cases of institutional neglect and abuse, a *Corporate Neglect law* could be an effective way of bringing care providers to account.
As this publication demonstrates, there is an international precedent for a criminal office of Corporate Neglect in the US and in Canada; in framing our domestic legislation it is important we draw on this experience.

The Department of Health's commitment to rethink the way that we care for adults with learning disabilities[64] is welcome, so is the idea of having a fit and proper test for the registered care provider[65] and the acknowledgement that there is a gap in the

[64] Department of Health (2012) *Transforming Care: A National response to Winterbourne View Hospital,* Point 6, p832, https://www.wp.dh.gov.uk/publications/files/2012/12/final-report.pdf
[65] Department of Health (2012) *Transforming Care: A National response to Winterbourne View Hospital, Point 5.9,* p32, https://www.wp.dh.gov.uk/publications/files/2012/12/final-report.pdf

regulatory framework which needs addressing[66]. But there is still a lot of work to do.

While it would be foolhardy to say that a change in law would ensure we never saw a Winterbourne View again, I believe it would enact an important culture change. It would send out a strong signal that this Coalition Government is serious when it comes to rooting out poor and neglectful care.

The ability to bring corporations criminally to account for the level of care they provide will also act as important deterrent to ensure the most vulnerable members of our communities receive the high quality care they deserve.

[66] Department of Health (2012) *Transforming Care: A National response to Winterbourne View Hospital, Point 3,* p8, https://www.wp.dh.gov.uk/publications/files/2012/12/final-report.pdf.

CORPORATE RESPONSIBILITY: A PROVIDER'S PERSPECTIVE

By Peter Kinsey, chief executive of Care Management Group

The leaders of social care provider organisations have a responsibility to ensure they have systems in place that monitor the quality of their services and to keep vulnerable people safe. A chief executive cannot be expected to be held responsible for the foolish actions of a support worker, but they should be held to account if their organisation does not have robust quality assurance processes in place.

In the same way that we are expected to have effective health and safety systems in place and can be personally prosecuted if we fail to do so, senior executives have a responsibility to ensure that appropriate quality systems are in place. If there is a systematic failure, as at Winterbourne View, then executives and ultimately the Board are responsible for not having measures in place to pick up concerns and failings in quality.

As chief executive at CMG I have worked hard to ensure that we have effective systems in place to monitor our services. These include a Quality Assurance Forum with an independent chair that oversees all our quality assurance activity and a Safeguarding Board. This also includes an independent chair, who reviews all safeguarding cases across the organisation, both to ensure that individual cases are being managed appropriately and to identify patterns and trends or any lessons to be learned. In addition to regular quality audits by regional directors, we have trained and employ a team of service user quality checkers who review the quality of our supported living services using the *Reach* standards

in supporting living[67]. Following Winterbourne View, we have also recruited a team of relatives, who act as quality checkers who carry out unannounced inspection visits.

In addition to systems, it is very important that organisations have the right leadership and culture. At CMG, we believe strongly in management visibility and senior managers are encouraged to visit services regularly and spend time with service users. As chief executive, I visit ten different services every week - which helps me to remain grounded in the reality of service provision and understand what matters to our service users and staff. We have a strong culture of service users being at the heart of what we do and people joining CMG have commented on this in a very positive way. We have a range of initiatives to ensure that we have a strong service user voice, including our service user parliament. Service user 'MPs' are elected by their peers and are supported to hold surgeries where they can hear the concerns and priorities of service users which are then communicated to senior managers in CMG.

This is about making sure that those with the most important voices are heard – and that their wishes are acted upon. It is only through this kind of openness that we can properly safeguard against poor care.

[67] Paradigm, *SALE - Reach - Standards in Supported Living*, http://www.paradigm-uk.org/articles/SALE__Reach__Standards_in_Supported_Living_/2946/42.aspx

CORPORATE ACCOUNTABILITY: AN EXPERT'S PERSPECTIVE

By Margaret Flynn and Vic Citarella, of CPEA Ltd (and authors of Winterbourne View's Serious Case Review)

In early 2011 staff at Winterbourne View Hospital in South Gloucestershire were secretly filmed by a journalist for the BBC's *Panorama* programme. They were caught mistreating and assaulting patients with learning disabilities and autism. These acts triggered public revulsion at the cruelties perpetrated at this hospital, and exposed the hospital's poor management and external oversight structures.

Knowledge that the average weekly fee for care at Winterbourne View was £3500 prompted questions over the stewardship of public money. In 2010, the 24 bed hospital had an annual turnover of £3.7 million. Considering the lack of financial transparency and co-operation that we experienced when compiling the Adult Serious Case Review (ASCR) established in the wake of the scandal, it is still hard to determine how much of this revenue was actually used for the running of the hospital and how much was consumed by the hospital's parent company Castlebeck Ltd.

So, why couldn't an Adult Serious Case Review (ASCR) access this kind of information? The answer is threefold:

1) An ASCR is a non-statutory instrument commissioned by a local Safeguarding Adults Board and whilst there are advantages to its current model as, unlike children's SCRs where template reviews have not resulted in the promised learning envisaged, and therefore they can maintain their

independence and ingenuity, co-operation with ASCR is a voluntary process, so neither individuals nor agencies can be compelled to contribute or to accept the recommendations.

2) Because of the non-statutory nature of ASCRs, where there is no compulsion to co-operate or provide evidence, Castlebeck's circumscribed their more significant contributions under the guises of "commercial sensitivity and confidentiality". This therefore limited the scope of our investigation.
3) It requires forensic accountancy skills of the variety summarised by *Private Eye* (1327, 16 November 2012) to make sense of Castlebeck's operations, "The company that owns Winterbourne View…is itself part of a group called CB Care Ltd, which itself is owned, via Jersey, by Swiss-based private equity group Lydian, backed by a group of Irish billionaires."

Winterbourne View's ASCR expressed concern that Castlebeck appeared to have made decisions about profitability, over and above decisions about the effective and humane delivery of a service. Whilst former staff were tried and convicted, Castlebeck's opaque organisational hierarchy has been spared the attentions of the criminal justice system.

We argue, therefore, that perhaps there is a case for developing a "hierarchy of liability" to buttress the concept of "corporate neglect". Had there been such a hierarchy, ex-patients' families might have challenged the commissioning PCTs for failing to ensure patients' health and wellbeing, and the commissioning PCTs might have challenged Castlebeck for such a bracing indictment of "assessment and treatment."

Many commissioners placing adults in Winterbourne View Hospital used Castlebeck's own contract. In the future this inattentive place-hunting has to be replaced by intelligence-led

commissioning which does not fund a service that declines to share information about how monies are spent on the basis of "commercial sensitivity." Contracts with providers should specify, *inter alia,* that co-operation with any investigation concerning the safety and wellbeing of patients is a prerequisite.

One of the main recommendations from our review, which Castlebeck failed to ever respond to, is that corporations should be liable for the costs associated with the ASCR, which in this case were wholly borne by South Gloucestershire Council. Surely it is wrong that a local council paid for an ASCR into abuse in a private hospital owned by a corporate body making phenomenal operating profits largely funded by the tax payer?

STRENGTHENING ADULT SERIOUS CASE REVIEWS

As the authors of the Adult Serious Care Review (ASCR) into Winterbourne View Hospital, Margaret Flynn and Vic Citarella experienced a lack of co-operation from Castlebeck Ltd. This was by no means the first instance of non-cooperation in an ASCR. In some instances even public bodies and health officials have been reticent in ensuring full and unwavering collaboration. This poses a threat to the legitimacy and effectiveness of ASCRs and undermines the important role they play within the field of adult safeguarding. As part of our analysis into the protection of vulnerable adults it is important to explore this issue in more depth and determine how this could be addressed.

To understand the problems that ASCRs have had with the non-disclosure of information, it is essential to understand the basis on which ASCRs are constituted. In 2000, under section 7 of the Local Authority Social Services Act 1970[68], the Department of Health and the Home Office jointly published a document called *No Secrets*[69], designed to provide guidance to local authorities on implementing multi-agency policies and procedures to protect vulnerable adults from abuse. *No Secrets* contained guidance on good and effective practices on the establishment of Adult Safeguarding Boards (ASBs). It is crucial to understand that whilst this established ASBs on a voluntary and good practice basis, and even though local authorities were assessed on the existence and effectiveness of ASBs as part of the Comprehensive

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[68] Local Authority Social Services Act, 1970, Section 42 http://www.legislation.gov.uk/ukpga/1970/42

[69] Department of Health, *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults,* 2000, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4074540.pdf

Performance Assessment (CPA), which itself acted as a strong incentive for local authorities, ASBs are not currently on a statutory footing and nor is it mandatory for a local area to implement one.

On the issue of data sharing, the *No Secrets* **guidance clearly states that it expects co-operation and data sharing between all agencies within the Adult Safeguarding Boards but there are no powers to compel this nor offences for not doing so**. The guidance also assumes co-operation from care facilities such a private care homes but does not contain any penalties for non-disclosure due to its non-statutory basis – as this is merely an aspiration. Therefore, ASBs do not have any statutory powers themselves, save naming and shaming providers.

Between 2008 and 2009, the Department of Health launched a consultation on possible revisions to the *No Secrets* guidance and in July 2009 they produced a report[70]. As p122 of this document states in the replies received to question 9d: '*Should we introduce a wider duty to cooperate in relation to safeguarding?*, **180 respondents or 86% supported the introduction of this duty of cooperation**, with near unanimous support from the three main partners: social care, Police and the NHS[71].

In addition, **the Law Society supported the introduction of a wider duty for agencies to co-operate in principle**, particularly given reports of some significant agencies refusing to co-operate as highlighted by contributors to this paper[72].

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[70] Department of Health, *Safeguarding Adults: Report on the consultation on the review of 'No Secrets'*, 2009, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102981.pdf
[71] Department of Health, *Safeguarding Adults: Report on the consultation on the review of 'No Secrets'*, 2009, p122 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102981.pdf
[72] Department of Health, *Safeguarding Adults: Report on the consultation on the review of 'No Secrets'*, 2009, Section 7.86, p85

Under the current draft Care and Support Bill 2012[73] sections 34-36, will put ASBs on a statutory footing and make it compulsory for every local authority to have an ASB in its area or share one with a neighbouring authority. Section 36(2) also makes it compulsory for members of an ASB to co-operate with each other and assist in the undertaking of an ASCR[74]. Section H, p43-44, of the Care and Support White Paper, *Caring for our future*[75], clearly states that local authorities will be empowered to make safeguarding enquiries, and Boards will also have a responsibility to carry out safeguarding adults reviews.

However, **the draft bill does not contain any provisions in terms of a statutory duty to compel organisations not part of an ASB to provide information to it, nor includes any further powers which would address calls for ASBs to be put on the same statutory footing as CSBs**.

It is telling that in **Scotland**, the Adult Support and Protection Act (Scotland) 2007[76] gives more comprehensive protections to vulnerable adults than in England currently. Section 42 of the Act places Adult Protection Committees, Scotland's equivalent to Adult Safeguarding Boards, on a statutory footing - thus compelling all local authorities to establish a committee[77]. Section 5 of the act, places a duty on all relevant public bodies to co-

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http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102981.pdf

73 Draft Care and Support Bill, 2012 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134740.pdf

74 Draft Care and Support Bill, 2012, Section 36(2), p52, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134740.pdf

75 Her Majesties Government, *Caring for our future: Reforming care and support*, July 2012, 75. Section H, p43-44 http://www.dh.gov.uk/health/files/2012/07/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf

76 Adult Support and Protection (Scotland) Act 2007, Contents, http://www.legislation.gov.uk/asp/2007/10/contents

77 Adult Support and Protection (Scotland) Act 2007, Section 42, http://www.legislation.gov.uk/asp/2007/10/section/42

operate with Adult Protection Committees[78] and even more importantly section 45 places a duty on these bodies to provide information to an Adult Protection Committee[79]. This goes further than the planned sections under the draft Care and Support Bill as it compels all relevant public bodies to supply information rather than just those who sit on the ASB itself. **This demonstrates there is a precedent for the obligation to provide information to adult safeguarding institutions and provides for a very powerful inducement for similar legislation to be enacted in England**.

Children's Safeguarding Boards

To further legitimise our calls for a statutory duty to provide information to ASBs, it is essential to analyse the statutory basis and powers of CSBs. The Children Act 2004 placed CSBs on a statutory footing[80]. Sections 13-16 of the Act enshrines the statutory basis of CSBs and like the draft Care and Support Bill, section 13 (7) compels all participating bodies in a CSB to co-operate with each other[81]. However, more importantly due to an amendment implemented by section 8 of the Children, Schools and Families Act 2010[82], **section 14(b) of the Children Act 2004 provides CSBs with an express power to require a person or body to comply with a request for information whereby the information relates to their functions - for example the carrying out of a serious case review[83].** As this demonstrates (along with several other Acts of Parliament and statutory guidance issued by the Department of Education), the current

[78] Adult Support and Protection (Scotland) Act 2007, Section 5 http://www.legislation.gov.uk/asp/2007/10/section/5
[79] Adult Support and Protection (Scotland) Act 2007, Section 45 http://www.legislation.gov.uk/asp/2007/10/section/45
[80] Children Act, 2004 http://www.legislation.gov.uk/ukpga/2004/31/contents
[81] Children Act, 2004, Section 13(3), http://www.legislation.gov.uk/ukpga/2004/31/section/13
[82] Children, Schools and Families Act 2010, Section 8 http://www.legislation.gov.uk/ukpga/2010/26/section/8
[83] Children Act, 2004, Section 14(b) http://www.legislation.gov.uk/ukpga/2004/31/section/14B

statutory protections and duties for CSBs currently far exceed that of ASBs.

To conclude, **in order to ensure Adult Safeguarding Boards and serious case review investigations are more effective and robust, sections 34-36 of the Draft Care and Support Bill[84] must be significantly expanded in order to compel any person or organisation to supply information to Adult Safeguarding Boards should they be requested to do so.** Such an addition to the Act should mirror section 14(b) of the Children's Act 2004[85] accompanied by new and relevant statutory guidance. This would go some way to increasing the safeguarding protections around vulnerable adults.

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[84] Draft Care and Support Bill, 2012, Sections 34-36, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134740.pdf

[85] Children Act, 2004, Section 14(b) http://www.legislation.gov.uk/ukpga/2004/31/section/14B

POLICY RECOMMENDATIONS

Scottish legislation establishes a precedent for corporations to be obliged to provide information to adult safeguarding institutions and provides for a helpful model for similar legislation to be enacted in England.

The relevant sections on safeguarding in the Draft Care and Support Bill should be amended in order to compel any person or organisation to supply information to Adult Safeguarding Boards should they be requested to do so.

The UK Government should draw on the experience of other countries in adopting and framing a corporate neglect statute, and we believe the experiences of Canada in particular adds weight to the UK Government setting its own legislation as soon as possible.

The removal of the "directing mind" principle in the Corporate Manslaughter Act sets a precedent in domestic law for faceless prosecutions and supports our aim of holding corporations to account for neglectful practices and procedures that directly or indirectly nurture or enable abuse against vulnerable adults to take place.

We propose the Health and Social Care Act 2008 be amended to include a new section under Part 1, Chapter 3, the Quality of Health and Social Care entitled *Corporate Neglect*, whereby a corporate body can be found guilty of an offence if the way in which its activities are managed or organised by its board or senior management neglects or is a substantial element in the existence and or possibility of abuse or neglect occurring.