CPS

Guidance on prosecuting crimes against older people

Contents

1 Introduction

1. This guidance deals with older people as victims and witnesses – not as offenders. It should be read in conjunction with the Public Policy Statement: *Prosecuting Crimes against Older People.*

2. For the purposes of the Policy and the Guidance, an older person is someone aged 60 or older.

3. Where appropriate, cross-reference should also be made with other CPS Policies and Guidance (for example, where the case involves issues of disability, racist or religious hate crime, homophobic and transphobic hate crime or domestic violence) and with other existing CPS commitments, such as those contained in the Code of Practice for Victims of Crime[1].

Reasons for having a policy on crimes against older people

4. The CPS is committed to taking age equality issues into account in all our prosecution policies. The development of a policy for prosecuting crimes against the older person is a key commitment in the Age Equality Action Plan, contained within the CPS Single Equality Scheme, 2006-2010.

5. A survey, *"The UK Study of the Abuse and Neglect of Older People"*[2], found that some 2.6% of those responding had experienced mistreatment involving a family member, close friend or care worker (that is, those in a traditional "expectation of trust" relationship) during the previous year. When the context of mistreatment was broadened to include incidents involving neighbours and acquaintances, the overall prevalence increased to around 4%. The survey did not include people in care homes or institutional settings.

6. A new study investigating the dignity and safety of older people being cared for in institutional settings has been launched by the Department of Health. The final stages of the work will be completed in April 2011.

Relevance of age to case review and management

7. Whatever the age of a victim or witness, their needs and case management issues should be assessed on an individual basis. Reliance should not be placed on pre-conceived or stereotypical notions and norms about older people in general. However, having some degree of information about older people **generally**, may be useful to ensure that appropriate consideration is given to relevant issues.

[1] http://www.homeoffice.gov.uk/documents/victims-code-of-practice
[2] O'Keefe et al., 2007 – National Centre for Social Research and King's College

8. For example, older people generally may be vulnerable; not because they are older, but because of the circumstances in which they find themselves. Some may experience age-related illness or disability; some may be hard of hearing or have difficulties with their sight; for some, their speed of thought, mobility or movement may be slower than in younger people.

9. On the other hand, we recognise the diversity of circumstances for older people and that while some older people must rely on help to manage their affairs, the amount of help will differ and many older people will not consider themselves to be frail, vulnerable or in need of support in any way. Indeed, they may be offended by any such suggestion of frailty or vulnerability, which is why each victim and witness must be treated as an individual.

Abuse, criminal offences and hate crime

10. There is not an offence simply of "neglect" of an older person other than in those circumstances set out in the Mental Capacity Act 2005 or the Mental Health Act 1983. However, the term "abuse" is used to describe a wide range of behaviours, many of which in fact amount to criminal offences. To raise awareness of this, we included a table of Behaviours/Possible Criminal Offences in our Public Policy Statement.[3]

11. Prosecutors will be mainly concerned with criminal offences and hate crimes. However, where a prosecutor considers that the abusive behaviour does not amount to a criminal offence, or to a criminal offence that can be prosecuted by the CPS, it may still be appropriate to ensure that the matter is brought to the attention of other regulatory or disciplinary bodies, so that criminal proceedings can be instituted by, for example, the Health and Safety Executive or the Commission for Social Care and Inspection, or other steps can be taken to protect the vulnerable adult and to hold the abuser to account.

12. Hate crime – where an offender deliberately targets an older person because of his/her hostility towards older people – will amount to an aggravating factor.

13. The way in which hostility based on age is demonstrated towards older people may be less obvious or less overt than in cases of, for example, homophobia or racism. But it is, nevertheless, hostility.

14. As set out in the Policy, older people experience discrimination and inequality in our society. Many older people also find themselves dependent on others for their care and for support. Taken together, these factors of dependency and discrimination contribute towards older people being vulnerable to criminal victimisation and abuse.

15. When considering the evidence in a case involving a crime against an older person, prosecutors should be alive to the possibility that the perpetrator may be motivated by hostility towards the older person because of his/her prejudicial attitudes towards older people generally as well as because of their vulnerability. In such cases, the fact that the older person is in a vulnerable situation may not be the sole cause of, or reason for, victimisation, but it may provide the **opportunity** for the offender to manifest his/her age-related prejudice and hostility.

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[3] Copy attached at Annex A. See also at Annex D the definitions of Abuse used by the Department of Health in No Secrets and by Action on Elder Abuse.

16. Evidence, such as previous convictions for offences where the offender has targeted older people, repeat victimisation of the victim targeted in the particular case or evidence from other witnesses of a perpetrator's prejudicial attitudes (for example, other care home staff, other family members, or neighbours), may support the prosecutor to build the case that a crime was motivated by hostility on the part of the perpetrator instead of, or in addition to, any inherent vulnerability of the older person or their situation.

17. It is vital that this element of hate or hostility is fully explored so that, where it is possible to show its existence, the victim and/or their family can benefit from the enhanced service from the criminal justice system that this type of case warrants (for example, the Direct Communication with Victims meeting) and the court may sentence appropriately and send the message that such hostility is not to be tolerated.

2 Victims and witness care

18. Prosecutors will be familiar with our existing commitments to victims and witnesses as contained in the Code for Crown Prosecutors, the Code of Practice for Victims of Crime, the Prosecutors' Pledge and the Victim Focus Scheme.[4]

Support

19. Many older people who are victims of, or witnesses, to criminal offences are reluctant to report the crime, because they fear the consequences of reporting.

20. For example, they may think that they will be deemed to be unreliable witnesses; that they will not be taken seriously; that they may be victimised, lose their independence or be placed into an institution or care home as a result of giving evidence. They may also be embarrassed or ashamed. They may have internalised ageism themselves, that is, they may have a lower expectation of what is fair or right. Fear, power and loyalty are factors that can prevent abuse being reported.

21. Through the way in which we handle the case, we must try to ensure that the older person has the confidence, knowledge and support to enable the necessary action to be taken to prevent further offences and to hold the offender accountable.

22. Our response and that of other statutory, voluntary and independent agencies should be collaborative. The variety, context and prevalence of crimes against older people mean that we must work closely with Social Services, social care and health care inspection and regulatory bodies, and advocacy/other specialist services for older people when handling cases.

23. We should treat each person as an individual, offering a personalised service and, within the necessary constraints of criminal justice system procedures, enable people to maintain the maximum possible level of independence, choice and control.

24. For example, where a person is accompanied by a carer or advocate or intermediary, we should give thought to the appropriateness of addressing remarks to the person rather than to the carer or other person.

"Whistle blowers"

25. Whistle blowing is when an employee raises concerns about ethically questionable, dangerous or illegal activities by their employer which affect others, whether they are customers, members of the public or their employer.

[4] Code for Crown Prosecutors - http://www.cps.gov.uk/victims_witnesses/code.html
Victims' Code - http://www.homeoffice.gov.uk/documents/victims-code-of-practice
Prosecutors' Pledge - http://www.cps.gov.uk/publications/prosecution/prosecutor_pledge.html
Victim Focus Scheme - http://www.cps.gov.uk/victims_witnesses/focus_scheme.html

26. It can be very difficult for witnesses to come forward when they may fear for their job and their career or fear the reactions of colleagues. This scenario has often arisen in care-home cases.

27. The Public Interest Disclosure Act 1998 protects workers from being subjected to what the Act describes as a 'detriment' by their employer (for example, denial of promotion or training) as a result of raising concerns, and workers who blow the whistle on wrong doing in the workplace may complain to an employment tribunal if they are dismissed or victimised for doing so. However, these safeguards do not necessarily make it any easier for a witness to give evidence against their employer and/or fellow employees.

28. Appropriate support will need to be given to such witnesses, both to ensure their continuing commitment to the particular case and to increase public confidence so that others are encouraged to reveal serious wrong doing in their workplace.[5]

[5] See also Public Concern at Work at Annex C of this guidance

3 Review

Case-building

29. Where a victim or witness is vulnerable or intimidated, prosecutors should look for evidence other than theirs so that, in appropriate cases and where possible, the case may proceed without relying on their evidence.

30. This may involve seeking information or evidence from other agencies, for example, Social Services, NHS, specialist charities supporting older people or the Commission for Social Care Inspection.[6]

31. Care plans, visitor records, medication records may provide useful sources of information or evidence.

32. Prosecutors should be pro-active in seeking information from the police to identify properly any aggravating features. This may include looking at previously reported incidents involving the same victim or suspect.

33. Prosecutors will want to be aware of any other investigations or proceedings pending or concurrent, in which other agencies may be involved, for example, the Health and Safety Executive, Local Authority or the Commission for Social Care Inspection.

The Code for Crown Prosecutors

34. In the Code, the examples given of common public interest factors in favour of prosecution include the defendant being in a position of authority or trust (5.9e) and the victim of the offence being vulnerable (5.9i).

35. Breach of trust implies reliance upon the integrity of a person when providing a service or carrying out a task entrusted to them. Betrayal of trust or abuse of authority in the context of older people could therefore include a wide range of service providers, such as, mini-bus drivers, cleaners, council contractors, carers, tradesmen etc.

36. At paragraph 5.9k of the Code, reference is made to offences motivated by discrimination. Although age is not specifically mentioned, the list is not exhaustive, and therefore offences motivated by discrimination based on the victim's age or where the defendant demonstrated hostility towards the victim based on age, should be considered under this category.

[6] See further in this guidance at Annex C

Distinguishing mental capacity from competence of the witness

37. It is important to recognise that the competence of a witness is a separate issue to that of the mental capacity of a witness. It is also important not to make assumptions about the credibility or reliability of a witness.

38. A person's capacity to take decisions can be affected by, for example, a stroke or brain injury; a mental health problem; dementia; a learning disability; confusion, drowsiness or unconsciousness because of an illness or the treatment for it; substance misuse.

39. However, having an illness such as Alzheimer's disease does not mean that a person lacks capacity to take **all** decisions. And capacity can vary over time, even over the course of a day.

40. Under the Mental Capacity Act 2005, the people who decide whether or not a person has capacity to take a particular decision are called assessors. Anyone can be an assessor – for example, a family member, a care worker, a nurse or social worker. However, health and social care practitioners or other relevant professionals and experts must be involved when an assessment and/or decision has significant consequences. These include when the person's capacity may be challenged by someone; when reporting abuse or a crime; or where the decision has legal complications or consequences.

41. Prosecutors and police should discuss, at an early stage, whether the witness is likely to be accepted as a competent witness by the courts, taking into account information provided by others, for example, a doctor, family members, or a social worker etc.

42. The Youth Justice and Criminal Evidence Act 1999 sets out the general rule that people are competent to act as witnesses unless they cannot understand questions asked of them at court and answer them in a manner which can be understood (with, if necessary, the assistance of special measures).

43. Mental capacity is only relevant to the competence of the witness in terms of assessing the witness' ability to understand questions asked and to give replies that can be understood.

44. Medication issues may be relevant when considering the timing of giving evidence and the need for maximum lucidity. This factor may be equally relevant to any witness taking medication, whether mental capacity is an issue or not.

Relevance of competence to admissibility

45. In R v Sed (Ali Dahir) [2004] EWCA Crim 1294, the Court of Appeal held that competence was not a criterion for admissibility of a hearsay statement under s.23 of the Criminal Justice Act 1988 Act; it was a factor for consideration under s.26 of the Act when deciding if it was in the interests of justice to admit it: R v D (Video Testimony) [2002] EWCA Crim 990 followed.

46. The Court held that competency test under s.53 of the Youth Justice and Criminal Evidence Act 1999 did not require a person to understand all questions or give understandable answers to all questions. It was sufficient if there was an intelligible thread in responses to questions, even if patchy, which could be evaluated for cogency and reliability by the jury.

47. The court said that the alleged vulnerable victim also had a right to justice and it was part of the process of justice that her voice should be heard.

48. This complainant in this case was an 81 year old Alzheimer's sufferer.

49. In DPP v R [2007] EWHC 1842 Admin, the court held that it was correct, when determining whether a witness was competent, to consider competence at the time of the interview and at the time when the witness was called upon to give evidence, where the evidence in chief was given via a video recording under the provisions of s.19 of the Youth and Criminal Evidence Act 1999. The fact that a witness now had no independent recollection of the facts, such that he/she was unable to give intelligible answers did not mean that he/she was no longer competent.

50. The court also held that where a video interview was already in evidence it could not be retrospectively unadmitted and that where it had been admitted pursuant to a perfectly proper special measures application under s.27 of the 1999 Act, it did not need consideration as hearsay evidence. The video interview was admissible independently of any question of hearsay under the quite separate provisions for special measures.

51. In the case of supervening loss of memory, as distinct from supervening loss of competence, the court found that sections 139 and 120 of the Criminal Justice Act 2003 would also apply, and the video interview would be admissible as evidence of its contents as a means of refreshing the memory of the witness who had forgotten. The court did not determine whether sections 139 and 120 had any application in the event of supervening incompetence.

52. Where the video recorded interview was admissible for all those various reasons, and independently of s.114, it did not mean that the video had to be accepted at face value. On the contrary, the assessment of it was a matter for the trial court.

Pre-trial witness interviews

53. Pre-trial witness interviews are conducted by prosecutors for the purpose of assisting the prosecutor to assess the reliability of a witness's evidence or to understand complex evidence.

54. They can take place at any stage of the proceedings (including before a defendant is charged) until the witness starts to give evidence at trial. However, an interview should not be conducted until the witness has provided to the police a signed witness statement or has taken part in a video recorded evidential interview. A pre-trial interview should take place as soon as reasonably practicable after a prosecutor has decided that one is appropriate.

55. An interview may be conducted **in any case** where a prosecutor considers that it will enable him/her to reach a better informed decision about how a case should proceed. Participation in a pre-trial witness interview is entirely voluntary on the part of the witness.

56. The witness may be asked about the content of his/her statement or other issues that go to their reliability. This may include taking the witness through his/her statement, asking questions to clarify and expand evidence, asking questions relating to character, exploring new evidence or probing the witnesses account.

57. There can be particular sensitivities in conducting pre-trial witness interviews with vulnerable witnesses. In reaching a decision to hold such a pre-trial interview, prosecutors must give careful consideration to the age and degree of vulnerability of the witness.

Direct communication with victims

58. In an extension of the existing policy, victims of crimes that are motivated by hostility based on age, or where the offender demonstrated hostility based on age, should be offered a meeting so that the prosecutor may explain the reason for the discontinuance of, or a substantial alteration to, the charge in which they are involved.

Special measures

59. Where an older victim or witness meets the criteria of sections16 or 17 Youth Justice and Criminal Evidence Act 1999, prosecutors and police will need to have early discussions to determine which special measures should be applied for that will assist the vulnerable or intimidated person to give their best evidence. The views of that person (or, in appropriate cases, their carers) should be taken into account. In some cases, it will be useful for the prosecutor to meet the witness in a Special Measures Meeting to discuss what arrangements have been made with the court.

60. The use of **remote** video links under section 24, or an intermediary under section 29 or Aids to Communication under section 30 of the 1999 Act may be of particular relevance in appropriate cases.

No prosecution cases

61. In appropriate cases, for example, those involving a vulnerable person receiving social care, where a decision has been made not to prosecute but there is cause for concern, consideration should be given to asking the police to inform local social services so that their vulnerable adult safety procedures may be invoked for the protection of that vulnerable person and others.

Expert evidence

62. Clearly, where an expert is required, care must be taken to find an appropriately qualified and experienced expert and that, where it is essential to do so, the expert must be able to make a firm declaration of fact, opinion or findings. Experience has shown that some experts can express a view robustly in a statement but are significantly less certain when giving evidence in court.

63. Prosecutors may wish to meet the expert to ensure that all reasonable avenues have been properly explored and satisfactory explanations given or, alternatively, they may wish to ask the police to do so. For example, one question that a medical expert should be asked, is along the lines of: "Tell me why [the injuries/behaviour/reaction to medication or treatment etc] could not have been caused otherwise".

4 Other regulatory / disciplinary bodies

64. A Safeguarding Adults Protocol has been agreed by the Association of Directors of Social Services (ADSS), the Association of Chief Police Officers (ACPO) and the Commission for Social Care Inspection (CSCI).[7]

65. The protocol is not one to which the CPS is a signatory and we are not under any formal obligation to inform the regulatory authority of any proposed prosecution; it is for the police to do so. However, the general principle, and one with which all prosecutors should comply, is that if there is any possibility of regulatory offences or the involvement of any other investigator/prosecutor, we should ask the police whether they have made contact with those others and ask what the other authority is proposing to do. If necessary, prosecutors should speak directly with the other authority.

66. The CSCI, ADSS, ACPO Protocol was published to demonstrate CSCI's commitment to working with other agencies to ensure that people within regulated services were appropriately safeguarded.

67. The protocol confirms that, whilst working in partnership with other agencies, CSCI will not suspend its own statutory enforcement responsibilities pending the outcome of another (for example, criminal) process where to do so would run counter to the safety and well-being of the people who use the service. In such circumstances, CSCI will aim, wherever possible, to co-ordinate actions in order to preserve evidence and avoid impeding each other's investigations or enforcement action.

68. CSCI has published guidance on sharing information gained during regulatory activity, within the multi-agency context.[8]

69. The protocol confirms that, if a Safeguarding Alert referral form indicates any criminal activity, there must also be a referral to the police and thought given to how the evidence is to be preserved.

70. In such cases, the police are to be involved in Strategy Meetings. The meetings should address: risk assessment; an interim safeguarding plan during the investigation; inter-agency communication strategy; support for the alleged victims, relevant family/carers, staff who are whistleblowers; and a wider media communication strategy where required.

71. Investigations may be led by, for example, the police, Social Services, Healthcare organisations, the Healthcare Commission or a registered provider. There may be concurrent investigations.

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[7] The Commission for Social Care Inspection, ADSS, ACPO Safeguarding Adults Protocol and Guidance http://www.adss.org.uk/publications/guidance/safeguarding.pdf

[8] Available from its website http://www.csci.org.uk

72. The CSCI can prosecute offences and/or take civil enforcement action. Their general approach is to look at the outcome for service users. More often than not, they will use civil procedures which provide them with effective remedies. However, when they do prosecute or formally caution, only those offences with potential custodial sentences are recorded on the PNC. Prosecutors may therefore need to ask the police to check with CSCI whether there have been any other proceedings, criminal or civil, in relation to the defendant.

73. Where CSCI has been involved in an investigation and taken statements from witnesses, prosecutors will wish to liaise with the police to ensure that the prosecution team's CPIA disclosure responsibilities have been met.

Disclosure of information

74. Other prosecuting or disciplinary agencies may request access to the material gathered by the police in the course of their criminal investigation. Clearly, where parallel proceedings are contemplated, that is, before the conclusion of the criminal proceedings, careful consideration will have to be given to the timing of such disclosure in order to avoid prejudicing the criminal proceedings.

75. Where there are not any criminal proceedings, or the proceedings have been concluded, the police material may still be of relevance to other agencies and can, in appropriate circumstances, be passed to those other agencies.

76. Where regulatory bodies, operating in the field of public health and safety, seek access to confidential material in the possession of the police being material which the police are reasonably persuaded is of some relevance to the subject matter of an enquiry being conducted by the regulatory body, then a countervailing public interest is shown to exist, which entitles the police to release material to the regulatory body on the basis that save in so far as it may be used by the regulatory body for the purposes of its own enquiry, the confidentiality which already attaches to the material will be maintained. Woolgar and Chief Constable of Sussex Police & UKCC [2000] 1 WLR 25, [1999] 3 All ER 604

5 Issues concerning restraint, neglect and misuse of medication

77. In some cases, issues may arise as to how a suspect has dealt with an older person's challenging behaviour or sexual behaviour[9] or how a suspect has dealt with restraint or medication of the older person, or how a suspect has handled clients'/patients' money. Institutions ought to have policies dealing with these issues, but non-professional carers may not.

78. The Commission for Social Care Inspection (CSCI) has published a range of Guidance/Professional Advice, for example, on the administration of medicines in care homes and residences and the use of restraint in care services.[10]

The use of restraint

79. Improper use of restraint may amount to criminal offences of assault and/or false imprisonment and/or choking. It may also amount to a criminal offence of breach of Regulation 24 or 25 under the Care Standards Act 2000, for which the CSCI is the prosecuting authority.

80. The Mental Capacity Act 2005 defines restraint as: "*the use or threat of force to help do an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.*"

81. CSCI's guidance on restraint says: "*Restraint is illegal unless it can be demonstrated that for an individual in particular circumstances not being restrained would conflict with the duty of care of the service. And that the outcome for the individual would be harm to themselves or for others.…Restraint can take many forms. It is not limited to a physical intervention by another person stopping someone doing something. It can include amongst other things the use of drugs, environment or surveillance to restrict people's actions. Where people in care homes have capacity, restraint may only take place with their consent or in an emergency to prevent harm to themselves or others or to prevent a crime being committed.*"

82. The Care Standards Act 2000 and associated Regulations such as the Care Homes Regulations 2001 and the Domiciliary Care Agencies Regulations 2002 refer to the use of restraint.

83. For example, Regulation 13(7)(a) of the Care Homes Regulations 2001 states: *"the registered person shall ensure that no service user is subject to physical restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other*

[9] For example, how a suspect might have inappropriately dealt with an older person's sexual behaviour by locking the older person in their room to prevent them having a (consensual) sexual relationship with another resident.
[10] http://www.csci.org.uk/professional/default.aspx?page=7178

service user and there are exceptional circumstances." And Regulation 13(8) states "on any occasion on which a service user is subject to physical restraint, the registered person shall record the circumstances, including the nature of the restraint."

84. Similar provision is made at Regulation 14(9)-(11) of the Domiciliary Care Agencies Regulations 2002.

85. The Department of Health published statutory guidance in July 2002, describing good practice for restrictive physical interventions.[11]

86. When considering matters such as whether a criminal offence has been committed or whether the public interest requires a prosecution, prosecutors may find these Regulations and guidance helpful in assessing whether the use of restraint was appropriate and proportionate.

Neglect

87. Neglect tends to have a physical impact. The development of pressure sores should be considered a primary indicator of neglect or poor care practice, but by no means a conclusive indicator.

88. Neglect may amount to a criminal offence under section 44 of the Mental Capacity Act 2005 or section 127 of the Mental Health Act 1983 (see Annex E of this guidance) But in cases where the victim has not died, and does not have a loss of capacity under the Mental Capacity Act 2005 and is not being treated as a patient for the purposes of the Mental Heath Act, prosecutors may find it difficult to identify an appropriate criminal offence.

89. Where possible, in such cases, prosecutors should ensure appropriate inter-agency discussions are held (for example, with the Local Authority or with the CSCI) to determine how the vulnerable adult can be protected and how the person responsible for the neglect might be held to account.

90. For assistance on what constitutes "wilful neglect", please refer to Archbold 2008.[12]

Misuse of medication

91. Where a person is medicated to enable an indictable offence to be committed, section 22 of the Offences Against the Persons Act 1861 may be relevant. Where a person is medicated or over-medicated for non-therapeutic reasons, such as to control their behaviour, a number of other offences may be relevant, such as unlawfully administering medication contrary to section 58 Medicines Act 1968, or failure to comply with conditions contrary to section 24 of the Care Standards Act 2000 or contravention of Regulations contrary to section 25 of the Care Standards Act 2000.[13]

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[11] Guidance for Restrictive Physical Interventions. How to Provide Safe Services For People With Learning Disability And Autistic Spectrum Disorder
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_4015317

[12] Archbold 2008 17-47, 17-48; 19-300 to 303.

[13] See table at Annex A

6 Fatalities

92. For full guidance on cases involving suicide pacts, aiding and abetting suicide, corporate manslaughter, medical manslaughter and familial deaths, see the Homicide chapter in the Legal Guidance on the infonet.[14]

93. Cases involving "mercy killings", aiding and abetting suicide, or requiring consideration of gross negligence manslaughter and any case involving a fatality in which the investigation is being conducted in accordance with the "Deaths at Work" protocol should be dealt with by the Area Complex Casework Unit (CCU).[15]

Medical manslaughter

94. Medical manslaughter is legally no different from Gross Negligence manslaughter. The term refers to medically qualified individuals who are performing acts within the terms of their duty of care, when the act or omission occurs.

95. A medical individual who is appointed to take charge of a person takes on a duty of care towards them. Simply being a doctor or nurse in a hospital or care home will not necessarily mean there is a duty of care to a specific patient (see s7 Health and Safety at Work Act 1974 in the Legal Guidance chapter on Corporate manslaughter).[16] See also the Legal Guidance chapter on Homicide, which contains advice on the assumption of a duty of care.[17]

96. The prosecution of medical manslaughter cases has now been devolved to Areas. However, only those prosecutors whom the Director has specifically authorised may take responsibility for dealing with these cases. Any queries about how to deal with such cases should be addressed to the Special Crime Division at CPS Headquarters.

[14] http://www.cps.gov.uk/legal/section5/chapter_a.html
[15] Note that a separate referral practice is in place for offences under the Corporate Manslaughter and Corporate Homicide Act 2007. See legal guidance on Corporate Manslaughter. http://www.cps.gov.uk/legal/section5/chapter_b.html
[16] See HSE work related deaths protocol http://www.hse.gov.uk/foi/internalops/fod/oc/100-199/165_9.pdf
[17] http://www.cps.gov.uk/legal/section5/chapter_a.html

7 Legislation

97. In addition to more common criminal offences with which prosecutors will be fully aware, the following legislation may be relevant:

- **Section 44 Mental Capacity Act 2005** – wilful neglect or ill-treatment of a person lacking mental capacity;
- **Section 127 Mental Health Act 1983** – wilful neglect or ill-treatment of a patient;
- **Sections 135 and 136 Mental Health Act 1983** – removal to a place of safety;
- **Mental Health Act 1959** – offences pre-dating implementation of the Sexual Offences Act 2003, unlawful sexual intercourse with patients/residents suffering mental disorder;
- **Corporate Manslaughter and Corporate Homicide Act 2007**- gross breach of duty of care causing a person's death;
- **Sections 58 and 63 Medicines Act 1968** – supplying / administering / altering the substance of medicinal products;
- **Section 4 Fraud Act 2006** – abuse of position;
- **Section 5 Domestic Violence, Crime and Victims Act 2004** – causing or allowing the death of a vulnerable adult;
- **Health and Safety at Work Act 1974;**
- **Sections 24 and 25 Care Standards Act 2000** – failing to comply with conditions / contravention of regulations;
- **Safeguarding Vulnerable Groups Act 2006** - created the Independent Safeguarding Authority (ISA) and new vetting / barring scheme for those working with children / vulnerable adults. Replaces POVA and POCA schemes;[18]
- **Public Interest Disclosure Act 1998** – protection for whistleblowers;
- **National Assistance Act 1948** – removal of a person from their home if suffering chronic disease or unsanitary conditions and not receiving proper care or attention;
- **Health and Social Care Bill** - seeks to create a new integrated regulator, the Care Quality Commission, to regulate health and adult social care and to introduce greater penalties for breach of regulations offences.

98. See Annex E of this guidance for further details.

[18] See also at Annex C of this guidance under Independent Safeguarding Authority

8 Sentencing

Hostility

99. In cases of hostility based on age, there is not any statutory equivalent to sections 145 or 146 of the Criminal Justice Act 2003 (racial or religious hostility or hostility based on sexual orientation or disability). However, where there is evidence of hostility based on age, prosecutors should, nevertheless, ensure that the court is made aware of this, so that the sentence can reflect this aggravating factor.

The Sentencing Guidelines Council's Overarching Principles: Seriousness

100. The Sentencing Guidelines Council's *Overarching Principles: Seriousness* state that a court is required to pass a sentence that is commensurate with the seriousness of the offence. The seriousness is determined by two main factors: the culpability of the offender; and the harm caused or risked being caused by the offence. Culpability will be greater: *"where an offender targets a vulnerable victim (because of their old age or youth, disability or by virtue of what they do"* (see paragraph 1.17); factors indicating a more than usually serious degree of harm include the fact that the *"victim is particularly vulnerable"* (see paragraph 1.23).

101. See Annex F of this guidance for examples of sentencing in cases involving older people as victims. Prosecutors will also wish to refer to sources such as Current Sentencing Practice, Banks on Sentence, Westlaw, and the CPS Sentencing Manual.

Ancillary orders

102. Where there is a risk of further offences, prosecutors should consider what ancillary orders might be appropriate, for example, Anti-Social Behaviour Orders or restraining orders.

103. In the absence of a decision to implement section 12 of the Domestic Violence, Victims and Crime Act 2004 (restraining orders on conviction for any offence and on acquittal), prosecutors might wish to ask the police, in appropriate cases, to liaise with the victim or their carer or the social services and suggest that, for example, a civil injunction under section 3 Protection from Harassment Act 1997, or a Part IV order under the Family Law Act 1996, or an Anti-Social Behaviour Injunction under the Housing Act 1996 be sought.

104. In appropriate cases, the police should be asked to make a referral to the Protection of Vulnerable Adults (POVA) list. The POVA list was set up by the POVA scheme under the Care Standards Act 2000. It contains the names of care workers who have harmed a vulnerable adult, or placed a vulnerable adult at risk of harm, whether or not in the course of their employment. These persons are then banned from working in a care position with vulnerable adults.

9 Monitoring

105. The CPS is committed to monitoring the impact of its public statement on cases involving crimes against older people. The purpose is to identify cases and to examine how they were dealt with and whether all relevant issues were addressed appropriately.

106. Local senior management teams will want to ensure that they have set up systems which identify all cases that fall within the Public Policy Statement and that they are able to demonstrate that they have implemented the Policy in all key regards, such as dealing with cases in which the victim has fluctuating capacity.

107. Having an overall picture helps to identify trends and needs for action that otherwise may be being dealt with in isolation or not at all.

108. All cases in which the victim of the crime is aged 60 or over and where the crime falls into one of the categories set out in paragraph 3.6 of the Crimes Against Older People Policy Statement should be flagged on COMPASS. Some cases will require more than one flag, for example, cases that involve domestic violence, rape, or racist, religious, homophobic or disability hate crime elements.

Annex A

Examples of behaviours	Examples of possible offences / relevant legislation
Hitting, slapping, pushing, kicking	Common assault s.39 Criminal Justice Act 1988; actual bodily harm s.47 Offences Against the Person Act 1861; grievous bodily harm / with intent s.20 and 18, OAPA 1861
Misuse of medication to manage behaviour	Assault; false imprisonment; applies stupefying / overpowering drugs/matter or thing with intent to commit indictable offence s.22 OAPA; poisoning with intent to injure, aggrieve or annoy, s23/24 OAPA; unlawfully administering medication s.58 Medicines Act 1968; injuriously affecting the composition of medicinal products, s63 Medicines Act 1968; failure to comply with conditions / contravention of regulations s.24, 25 Care Standards Act 2000
Inappropriate restraint	False imprisonment; common assault; ABH; GBH; choking s.21 OAPA; kidnap; failure to comply with conditions / contravention of regulations s.24, 25 Care Standards Act 2000
Inappropriate sanctions	False imprisonment; assault; ill-treatment/wilful neglect s.44 Mental Capacity Act 2005; ill-treatment/ wilful neglect of a patient s127 Mental Health Act 1983; failure to comply with conditions / contravention of regulations s.24, 25 Care Standards Act 2000
Sexual assaults, sexual acts to which the victim has not consented or could not consent or was pressured into consenting	(offences committed post May 2004) Rape, penetration, assault, causing sexual activity without consent s1-4 Sexual Offences Act 2003; sexual activity with a person with a mental disorder impeding choice or causing, inciting, engaging in the presence of/causing to watch, inducing by deception, threat or inducement s.30-37 SOA 2003; sexual offences by care workers against a person with a mental disorder impeding choice, causing, inciting, engaging in the presence of/causing to watch s.38-41 SOA 2003; administering a substance with intent s61; exposure s.66; voyeurism s.67; sexual activity in a public lavatory s.71 SOA 2003 Pre May 2004 Sexual Offences Act 1956 offences and unlawful sexual intercourse with patients/residents suffering mental disorder s.128 Mental Health Act 1959
Threats of harm or abandonment	Threats to kill s.16 OAPA; blackmail s.21 Theft Act 1968; common assault; ill-treatment/wilful neglect s.44 Mental Capacity Act 2005; ill-treatment/ wilful neglect of a patient s127 Mental Health Act 1983
Deprivation of contact, isolation or withdrawal from services or supportive networks	False imprisonment; ill-treatment/ wilful neglect s.44 Mental Capacity Act 2005; ill-treatment/ wilful neglect of a patient s127 Mental Health Act 1983; failure to comply with conditions / contravention of regulations s.24, 25 Care Standards Act 2000

Examples of behaviours	Examples of possible offences / relevant legislation
Humiliation, intimidation, emotional blackmail, verbal abuse, being shouted or sworn at.	Fear of violence s.4 Public Order Act 1986; intentional harassment, alarm or distress s.4A POA; harassment, alarm or distress s.5 POA; course of conduct amounting to harassment / causing another to fear s.1 and 4 Protection from Harassment Act 1997; harassment of a person in his home s.42A Criminal Justice and Police Act 2001; blackmail s21 Theft Act 1968; common assault
Theft, fraud, exploitation, pressure in connection with wills, powers of attorney, financial transactions, or the misuse or misappropriation of property, benefits or possessions	Theft/robbery s.1 and 8 Theft Act 1968. Blackmail s.21 Theft Act; Fraud by false representation, by failure to disclose information, by abuse of position s.2, 3 and 4 Fraud Act 2007; forgery s.25 Identity Cards Act 2006 and Forgery and Counterfeiting Act 1981
Ignoring medical or physical care needs, failure to provide access to appropriate health services, withholding medication, adequate nutrition or heating, unmet physical needs such as bedding or clothing soaked in urine or faeces, decaying teeth, overgrown nails.	False imprisonment; Wilful neglect or ill treatment of a person lacking mental capacity s. 44 MCA 2005;ill treatment or wilful neglect of mentally disordered patients within hospital or nursing homes or otherwise in a person's custody or care s.127(1)and (2) Mental Health Act 1983; failure to comply with conditions / contravention of regulations s.24, 25 Care Standards Act 2000
The impairment of, or an avoidable deterioration in physical or mental health; the impairment of physical, intellectual, emotional, social or behavioural development.	Wilful neglect or ill treatment of a person lacking mental capacity s. 44 MCA 2005 or of a patient s.127 MHA 1983 failure to comply with conditions / contravention of regulations s.24, 25 Care Standards Act 2000
Actions resulting in death	Murder; manslaughter; Corporate Manslaughter; causing or allowing death of a vulnerable person in a domestic setting s.5 Domestic Violence, Victims and Crime Act 2004; aiding or abetting suicide s.2 Suicide Act 1961;failure to comply with conditions / contravention of regulations s.24, 25 Care Standards Act 2000

Annex B

THE MENTAL CAPACITY ACT 2005

The Act has five key principles:

1. A person must be assumed to have capacity unless it is established that he/she lacks capacity.

2. A person is not to be treated as unable to make a decision unless all practicable steps to help him/her do so have been taken without success.

3. A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.

4. An act done or decision made under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests.

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

The Mental Capacity Act 2005 Code of Practice provides that a person's capacity should only be assessed if there is evidence that they are unable to take a particular decision.

The Code of Practice provides a two stage test of capacity:

1. Is there an impairment of, or disturbance in, the functioning of the person's mind or brain? If so

2. Is that impairment or disturbance sufficient that the person lacks capacity to make that particular decision?

A person lacks capacity to take a particular decision if they cannot:

- Understand information relevant to the decision;
- Remember that information long enough to make the decision;
- Weigh up information relevant to the decision;
- Communicate their decision – by talking, using sign language or by any other means.

Annex C

AGENCIES / APPOINTMENTS

The Commission for Social Care and Inspection (CSCI)

CSCI inspects and regulates registered care homes and domiciliary services. It also regulates nurse agencies, adult placement schemes and local authority social services departments.

The Care Standards Act 2000 and the Health and Social Care (Community Health and Standards) Act 2003 place specific duties and responsibilities on CSCI. The CSCI works within those statutory frameworks.

There are three significant levels of engagement for CSCI in response to a safeguarding alert or referral:

- Where an alert or subsequent findings suggest serious risk to a person's life, health or well-being – then CSCI will consider what regulatory action is needed in addition to the investigation undertaken by other agencies (including the police).
- Where a referral suggests serious breaches of regulations or standards, the CSCI may decide to conduct enquiries.
- Where there are no indications of serious risk requiring immediate regulatory action, the outcome of any other investigation undertaken by others will inform a CSCI decision about any necessary regulatory action.

Action that can be taken by CSCI include: varying or imposing conditions of registration (breach of which is a criminal offence); cancelling registration; prosecution; formal caution; referral to relevant regulators where professional codes of conduct have been breached.

If a service provider has committed an offence for which they could otherwise be prosecuted, but they make the improvement required without prosecution, CSCI might issue a formal written caution to record the offence and warn that more serious action might be taken if further offences are committed. A formal caution is only made if a) there is sufficient evidence to show that an offence has been committed b) it is not in the public interest to prosecute and c) the person cautioned admits the offence and is willing to be cautioned.

See CSCI's website[19] for guidance on, for example, information sharing, managing service users' finances, administration of medicines in care homes, the use of restraint and enforcement options.

[19] www.csci.org.uk

The Independent Safeguarding Agency

The ISA was established in January 2008. It was created by the Safeguarding Vulnerable Groups Act 2006, following the Bichard report. It is to be the sole agency (for England, Wales and Northern Ireland) with responsibility for vetting all individuals who wish to work / volunteer with vulnerable people. It will work with the Criminal Records Bureau. The existing barred lists (List 99 – under section 142 Education Act 2002; POCA List – under the Protection of Children Act 1999; and POVA List (Protection of Vulnerable Adults) under Part 7 of the Care Standards Act 2000) and Disqualification Orders made by a court under Part 2 of the Criminal Justice and Court Services Act 2000 will now be replaced by a new vetting and barring scheme.

Independent Mental Capacity Advocates (IMCAs)

The Mental Capacity Act 2005 introduced into legislation the concept of independent mental capacity advocates (IMCAs) to safeguard the interests of people who lack capacity to take important decisions, where they have no one except paid staff to advise, support or represent them. Section 36 of the Mental Capacity Act and IMCA regulations set out the functions of IMCAs.

Where a person who lacks capacity does not have friends or relatives to consult, decision makers in local authorities, NHS Trusts and care homes have a duty to consult an IMCA. Examples of a decision maker could include a care home or ward manager, treating doctor, community psychiatric nurse, or a social worker.

The relevant decision (for which the person lacks capacity) must relate to long term changes in accommodation, serious medical treatment, care reviews, the protection of vulnerable adults.

IMCAs have the authority to challenge decisions affecting persons who lack capacity. The Mental Capacity Act 2005 (Independent Mental Capacity Advocate) (General) Regulations 2006 provide at Regulation 7 that where an IMCA has been instructed to represent a person ("P") in relation to any matter, and a decision affecting P (including a decision as to his capacity) is made in that matter, the IMCA has the same rights to challenge the decision as he would have if he were a person (other than an IMCA) engaged in caring for P or interested in his welfare.

Director of Adult Social Services (DASS)

The DASS should ensure there are protocols in place for dealing with adults identified as being at risk. S/he should ensure that the local Adult Protection Committee (where one exists) or similar arrangements are working effectively and that the POVA requirements are met.

The Healthcare Commission (HC)

(also known as the Commission for Healthcare Audit and Inspection (CHAI))

Regulates and inspects all NHS trusts and primary care trusts, which are responsible for hospitals, GP practices, community teams, intermediate care services in hospital. Hospices, private clinics and private hospitals are licensed by the HCC. It is responsible for complaints about the NHS and independent health care services that have not been successfully resolved at local level.

The Mental Health Act Commission

Monitors key aspects of the operation of the Mental Health Act 1983 in England and Wales. It interviews patients and investigates complaints.

Professional bodies

These aim to protect the public by setting and maintaining standards within the professions by publishing codes of conduct, registering individuals and monitoring continuous professional development. Serious misconduct by an individual can be reported to those bodies.

- The General Medical Council – registers all doctors
- The Nursing and Midwifery Council – registers nurses and midwives
- The General Social Care Council – registers social workers
- The Royal Pharmaceutical Society of Great Britain – registers pharmacists and their premises
- The Committee on Standards in Public Life - monitors the standards of people working in public office, including councils.

The Office of the Public Guardian

The OPG replaced the Public Guardianship Office in October 2007. Its main statutory duties are to register Enduring Powers of Attorney and Lasting Powers of Attorney; supervise deputies appointed by the Court of Protection; investigate allegations or concerns; and report to the Court of Protection when required.

The Court of Protection

The Mental Capacity Act 2005 provides for a new Court of Protection to make decisions in relation to the property and affairs and healthcare and personal welfare of adults (and children in a few cases) who lack capacity. The Court also has the power to make declarations about whether someone has the capacity to make a particular decision. The Court has the same powers, rights, privileges and authority in relation to mental capacity matters as the High Court. It is a superior court of record.

Public Concern at Work (PCaW)

PCaW is a charitable, independent organisation that offers support to whistleblowers. It is also a legal advice centre designated by the Bar Council. Information that is communicated to them is subject to lawyer-client privilege and is also protected under the Public Interest Disclosure Act 1998. The type of public interest or whistleblowing concerns upon which they advise include fraud, abuse in care, risks to consumers and significant regulatory breaches.

Annex D

DEFINITIONS OF ABUSE

No Secrets

No Secrets is the Department of Health's Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.[20] It is currently being revised.

In Safe Hands is the equivalent guidance published by the National Assembly for Wales.

Abuse is defined in No Secrets in the following terms:

"Abuse is a violation of an individual's human and civil rights by other person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm, or exploitation of, the person subjected to it".

This definition has received criticism from some commentators as it is linked to the *No Secrets* definition of a "vulnerable adult", which refers only to individuals requiring community care services.

Elder Abuse

Elder abuse is defined by Action on Elder Abuse as *"a single or repeated act, or lack of appropriate action occurring in any relationship where there is a reasonable expectation of trust, that causes harm or distress to an older person."*

Again, this definition has received criticism from some commentators as a person could be distressed by an appropriate act which is not abuse.

[20] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486

Annex E

LEGISLATION

Section 44 Mental Capacity Act 2005

With effect from 1 April 2007, a person commits an offence if he/she ill-treats or wilfully neglects a person who lacks mental capacity or whom he/she believes lacks mental capacity and that person has the care of the other person or is the donee of a lasting power of attorney, or an enduring power of attorney created by the person who lacks capacity, or is a deputy appointed by the court for the person who lacks capacity.

The offence is triable either way and carries a maximum penalty on indictment of 5 years imprisonment and/or a fine.

A person lacks mental capacity if, at the material time, he/she is unable to make a decision for him/herself because of an impairment of, or a disturbance in the functioning of, the mind or brain: section 2(1)

It is immaterial if the impairment or disturbance is permanent or temporary: section 2(2).

A lack of capacity cannot be established merely by reference to a person's age or appearance, or by a condition, or an aspect of behaviour, which might lead others to make unjustified assumptions about capacity: section 2(3).

The question of whether a person lacks capacity within the meaning of the Act is to be decided on the balance of probabilities: section 2(4). Accordingly, there must be evidence to support the fact that the person lacked mental capacity at the time the offence was committed against him/her.

Even if the victim has capacity, it will still be an offence if the person who has the care of him/her reasonably believed he/she lacked capacity and ill-treated or neglected him/her.

Reasonable belief' means that, in all the circumstances, a reasonable person would believe that the victim lacked capacity.

The Act applies to everyone who looks after or cares for someone who lacks mental capacity. This includes both those who have the day-to-day care of that person as well as those who only have very short term care, whether they are family carers, professional carers or other carers: see Annex B of this Guidance and see also the Code of Practice for the Mental Capacity Act[21] for further guidance.

The Act does not define 'ill-treatment' and 'wilful neglect'; therefore, these concepts should be given their ordinary meaning. For assistance on what constitutes 'wilful neglect', reference should be made to Archbold 2008 paragraphs 17-47/48 and 19-300/303 which deal with 'wilful neglect' and 'ill treatment' of children.

[21] http://www.justice.gov.uk/guidance/mca-code-of-practice.htm

A person who has genuinely failed to appreciate that, for example, the other person needed medical care, through for example personal inadequacy, is not guilty of the offence of wilful ill-treatment/neglect: see Archbold 2008 17-48.

Offences of ill-treatment and wilful neglect are continuing offences: *R. v. Hayles [1969] 1 Q.B. 364, 53 Cr.App.R. 36, CA.*

For the indictment, 'ill-treatment' and 'wilful neglect' should feature in separate counts.

Under the Code for Crown Prosecutors, if the evidential test is met in wilful neglect or ill-treatment cases, the public interest will nearly always demand that a prosecution occurs, due to the position of trust that the suspect held in relation to the victim, as well as the extreme vulnerability of the victim.

See also the Legal Guidance chapter Offences Against the Person for further guidance on section 44 Mental Capacity Act 2005.[22]

Mental Health Act 1983

A person lacking capacity will have a mental disorder; the converse however is not necessarily true.

Where a person with a mental disorder has been the victim of ill-treatment or wilful neglect but does not lack capacity for the purposes of s.44 Mental Capacity Act 2005, prosecutors may wish to consider whether s.127 of the Mental Health Act 1983, is applicable to the facts of the case.

Section 127 deals with the ill-treatment or wilful neglect of mentally disordered patients within hospitals or nursing homes or otherwise in a person's custody or care. **The Director's consent is required for such prosecutions:** section 127(4).

"Patient" is defined in s.145 of the Act[23] as "a person suffering or appearing to be suffering from a mental disorder".

"Mental disorder" is defined in s.1(2) of the Act (as amended by the 2007 Mental Health Act) as "any disorder or disability of the mind".

Section 127(1) provides that it is an offence for any person who is an officer on the staff of, or otherwise employed in, or who is one of the managers of, a hospital, independent hospital or care home

a) to ill-treat or wilfully to neglect a patient for the time being receiving treatment for mental disorder as an in-patient in that hospital or home; or

b) to ill-treat or wilfully to neglect on the premises of which the hospital or home forms part, a patient for the time being receiving such treatment there as an out-patient.

Sections 127(2) and (2A) make similar provision for patients subject to after-care under supervision and patients subject to guardianship under this Act, or otherwise in the custody or care (whether by virtue of any legal or moral obligation or otherwise) of the person.

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22 http://infonet.cps.gov.uk/infonet/Legal/legal_guidance/index.htm

23 Except for the purposes of Part VII of the 1983 Act. Part VII is not relevant to the s.127 offences.

The offences are triable either way and carry a maximum penalty on indictment of 5 years imprisonment and/or a fine for offences committed after 1 October 2007, or 2 years and/or a fine for offences committed before then.

Section 135 allows a warrant to be obtained from a justice of the peace authorising the police to enter any place within the jurisdiction of the justice and remove any person suffering from a mental disorder, to a place of safety, if the police suspect the individual is unable of caring for themselves or is being ill-treated or neglected.

Section 136 provides for the removal to a place of safety of a mentally disordered person found in a public place.

Mental Health Act 1959

For offences pre-dating the implementation of the Sexual Offences Act 2003, section 128 deals with unlawful sexual intercourse with patients/residents suffering mental disorder.

Corporate Manslaughter and Corporate Homicide Act 2007

This Act came into force throughout the United Kingdom on 6 April 2008. Where any of the conduct or events alleged to constitute the offence occurred before 6 April 2008, the pre-existing common law will apply.

Section 1(1) provides that an organisation to which this section applies is guilty of an offence if the way in which its activities are managed or organised (a) causes a person's death and (b) amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased.

Section 1(3) provides that an organisation is guilty of an offence under this section only if the way in which its activities are managed or organised by its senior management is a substantial element in the breach referred to in subsection (1).

The offence is triable only in indictment and on conviction the court may impose an unlimited fine: section 1(6)

The Director's consent is required for proceedings: section.17.

Full guidance can be found in the Legal Guidance on the infonet.[24]

Cases which may result in proceedings for corporate manslaughter, with the exception of unincorporated partnerships, must be referred to Special Crime Division, CPS Headquarters, so that an overview of all cases can be maintained. Casework location thereafter will then depend on the complexity and sensitivity of each individual case.

The new offence is intended to work in conjunction with other offences, such as, gross negligence manslaughter for individuals and other health and safety breaches.

[24] http://infonet.cps.gov.uk/infonet/Legal/doc_020942

Medicines Act 1968

Section 58 provides that: subject to the following provisions of this section;

(a) no person shall sell by retail, or supply in circumstances corresponding to retail sale, a medicinal product of a description, or falling within a class, specified in an order under this section except in accordance with a prescription given by an appropriate practitioner; and

(b) no person shall administer (otherwise than to himself) any such medicinal product unless he is an appropriate practitioner or a person acting in accordance with the directions of an appropriate practitioner

Section 63 provides that: no person shall

(a) add any substance to, or abstract any substance from, a medicinal product so as to affect injuriously the composition of the product, with intent that the product shall be sold or supplied in that state, or

(b) sell or supply, or offer or expose for sale or supply, or have in his possession for the purpose of sale or supply, any medicinal product whose composition has been injuriously affected by the addition or abstraction of any substance.

Fraud Act 2006

Section 4(1) provides that, with effect from 15 January 2007, a person commits fraud by abuse of position if he

(a) occupies a position in which he is expected to safeguard, or not to act against, the financial interests of another person,

(b) dishonestly abuses that position, and

(c) intends, by means of the abuse of that position -
(i) to make a gain for himself or another, or
(ii) to cause loss to another or to expose another to a risk of loss.

Section 4(2) provides that a person may be regarded as having abused his position even though his conduct consisted of an omission rather than an act.

Domestic Violence, Crime and Victims Act 2004

Section 5 of this Act creates an offence of causing or allowing the death of a child under the age of 16 or of a vulnerable adult. This stand-alone offence imposes a duty upon members of a household to take reasonable steps to protect children or vulnerable adults within that household from the foreseeable risk of serious physical harm from other household members. It is an offence triable only on indictment and carries a maximum sentence of 14 years imprisonment or a fine, or both: section 5(7).

The phrase: 'member of same household' is defined in section 5(4)(a) of the Act. People who live together in a family arrangement will clearly be members of the same household. Additionally, a person can be a member of a particular household even if he or she does not live there, provided that they visit it so often and for such periods of time that it is reasonable to regard them as a member of that household. This is a question to be judged on the particular facts of the case. Where V lives in different households at different times, 'the same household as V' refers to the household in which V was living at the time of the act that caused V's death.

To establish D's liability under this offence, the prosecution must prove not only that D was a member of the same household as V but also that he or she had frequent contact with V. Until some case law develops on the point, what amounts to 'frequent' contact will also remain a question of fact and degree in each case.

The term: "household" is not defined in the Act. It is possible that the facts of a particular case could lead to, for example a small, private care home being considered to fall within the term, given that the offence was: *"drafted with the idea that member of the household will know enough about the activities of other members that they can be expected to be aware of the risk to the victim and take action. They are "complicit" in the offence, either directly or by proximity, through standing by during the preceding abuse or neglect and doing nothing."* (Minister of State, Home Office, House of Lords).[25]

For the purposes of this offence, a vulnerable adult is defined as a person aged 16 or over whose ability to protect themselves from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, old age or otherwise: section 5(6). This is a wider definition than that applied to vulnerable witnesses in the Youth Justice and Criminal Evidence Act 1999.

For further information, see the Homicide chapter in the Legal Guidance on the infonet.[26]

Health and Safety at Work Act 1974

Health and safety offences are usually prosecuted by the Health and Safety Executive the local authority or other enforcing authority. The CPS may also prosecute health and safety offences, but usually does so only when prosecuting other serious offences, such as manslaughter arising out of the same circumstances. For further information, see Legal Guidance and *The Work-Related Deaths: A Protocol for liaison*.[27]

Care Standards Act 2000

A registered person or company may be cautioned or prosecuted by the Commission for Social Care and Inspection (CSCI) for an offence under Part II of the Care Standards Act or associated Regulations.

Sections 24 and 25 concern the offences of failing to comply with conditions and contravention of Regulations, the penalties for which are (currently) a fine not exceeding levels 5 and 4 respectively. Section 20 provides that where there is a serious risk to life, health or well-being, an order may be obtained by the CSCI for the immediate closure of the home or service.

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25 Hansard Col GC361, January 2004
26 http://www.cps.gov.uk/legal/section5/chapter_a.html
27 http://www.cps.gov.uk/publications/agencies/wrdprotocol.html

Proceedings for offences under this Part of the Act or Regulations made under it cannot, without the written consent of the Attorney General, be taken by any person other than (a) the Commission or, in relation to any functions of the Commission which the Secretary of State is by virtue of section 113 for the time being discharging, the Secretary of State; or (b) the Assembly.

Proceedings for an offence under this Part or Regulations made under it may be brought within a period of six months from the date on which evidence sufficient in the opinion of the prosecutor to warrant the proceedings came to his knowledge; but no such proceedings can be brought more than three years after the commission of the offence.

For example, if sufficiency of knowledge occurred 2 years and 11 months after the offence had been committed, the prosecutor would have to bring proceedings within the next month, that is, within the 3 year limit.

See Annex C in this Guidance for the investigatory and prosecutorial powers of the CSCI.

Safeguarding Vulnerable Groups Act 2006

This Act created the Independent Safeguarding Authority (ISA) and introduces a new vetting and barring scheme for those who work with children and vulnerable adults, which will replace the existing Protection of Vulnerable Adults (POVA) and Protection of Children Act (POCA) schemes.[28] From 12 October 2009, those who are judged to pose a risk to children or vulnerable adults will be prevented from obtaining access to them via paid or unpaid work. Penalties for those employers who fail in their responsibility to carry out the necessary checks or who recruit people who are not members of the scheme include fines of up to £5,000.

It will be a criminal offence for a barred individual to seek a job in regulated activity working in close contact with children or with vulnerable adults, for example those receiving health or social care services.

Public Interest Disclosure Act 1998

Since July 1999, whistleblowers have been protected by this Act. In particular, section 43B(d) provides for workers to report suspicions that the health or safety of any individual has been, or is being, or is likely to be endangered.

Six types of wrongdoing are covered by the Act: a criminal offence; the breach of a legal obligation; a miscarriage of justice; a danger to the health or safety of any individual; damage to the environment; or deliberate covering up of information tending to show any of the above five matters.

The worker must reasonably believe that the wrongdoing is happening currently, took place in the past, or is likely to happen in the future. The belief need not be correct but must be reasonably held.

The Act does not apply to work covered by the Official Secrets Act, or to members of the Armed Forces or Intelligence Services, the self employed or volunteers.

Further information is available on the Health and Safety Executive's website.[29]

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[28] See also at Annex C of this guidance under Independent Safeguarding Authority
[29] www.hse.gov.uk/workers/whistleblowing.htm

National Assistance Act 1948

Section 47 enables the local authority to remove a person from their home if suffering chronic disease or unsanitary conditions and not receiving proper care or attention.

Health and Social Care Bill

The Bill is currently making its way through Parliament. It seeks to enhance professional regulation and to create a new integrated regulator, the Care Quality Commission, to regulate health and adult social care and to replace the Commission for Social Care Inspection (CSCI), the Healthcare Commission and the Mental Health Act Commission. The Bill will also introduce greater penalties for breach of regulations offences, increasing fines and bringing in custodial sentences.

Following the House of Lords decision in June 2007 in YL v Birmingham City Council and others, the provision of publicly-arranged accommodation in a private care home is not considered a function of a public nature; the care home itself is therefore not subject to the Human Rights Act 1998 (although the local authority that has placed a person there still has duties under the Act).

The government's intention was that the Human Rights Act should apply to all publicly-arranged care, including that provided by the voluntary or private sector. Therefore the Government is seeking amendment to the Health and Social Care Bill to remedy this.

Annex F

SENTENCING DIGEST

Part compiled by Robert Banks author of Banks on Sentence 2008 and sourced from the book

Case examples

Burglary

- ***General where victim is elderly***

R v Whittaker 1998 1 Cr App R (S) 172 – 10 years imprisonment for a series of burglaries committed at the homes of elderly people. Defendant masked and wore dark clothing, but no deliberate violence offered. One set of offences committed on bail for earlier offences.

R v Guigno 1998 2 Cr App R (S) 217 – 3 years imprisonment for a burglary at night of a dwelling occupied by a couple aged 87 and 91. D had no previous convictions.

- ***Aggravated burglary***

Guideline remarks – Att-Gen's Ref. No 32-33 of 1995 1996 1 Cr App R (S) 376
Two defendants pleaded guilty to aggravated burglary (one also pleaded G to attempted robbery). The Court said: *"The general effect of the reported cases is that where an elderly victim, living alone, is attacked by intruders and is injured, the likely sentence will be in double figures. We wish to stress that attacks on elderly people in their homes are particularly despicable and will be regarded by the court as deserving severe punishment. Elderly victims living alone are vulnerable, not only because of their lack of assistance, but also because of their own weakness and isolation. Any attack on such a person is cowardly and can only be expected to be visited with a very severe punishment indeed."*

Further cases:
Att-Gen's Ref. No 35 of 2001 2002 1 Cr App R (S) 187 Plea. Carving knife pointed at victim aged 72. Property worth £2,000 stolen. 6 years after substantial discount for plea.

R v Harrison 2002 1 Cr App R (S) 470 Plea. Threatened 91 year old bedridden victim with a knife late in the evening. Because of early plea 5 years not 7.

Att-Gen's Ref No 104 of 2002 2003 2 Cr App R (S) 682 Convicted Hit 76 year old victim with a coal scuttle. Seven weeks later a rib was still fractured. Defendant aged 18 with 26 previous convictions.9 years detention would have been appropriate, (7 because it was a reference).

R v Hunter 2005 2 Cr App R (S) 217 Pleaded to three burglaries, one aggravated burglary and aggravated vehicle taking. Hammer used. Victims aged, 69, 81, 81 and 85. 10 ½ years substituted.

- ***Distraction burglaries***

Victims in such cases are invariably elderly.

R v O'Brien 2002 2 Cr App R (S) 124 – 8 years imprisonment for an offender with substantial previous convictions for similar offences for a "distraction" burglary where the victim was a lady of 81.

R v Cawley and Cawley 2008 1 Cr App R (S) 341 – Both convicted of burglary. Victim 91. Wallet stolen. Both had similar previous convictions. 8 and 7 years upheld.

R v Casey and Maloney 2008 1 Cr App R (S) 5 – Plea to conspiracy to burgle involving 38 burglaries mostly at the homes of the elderly. Normally one of them would pose as a policeman. One defendant had just been released from a sentence for a very large number of similar offences. 12 years upheld. 7 years for the other defendant also upheld.

Fraud

R v Duggan 1999 2 Cr App R (S) 65 – 9 years imprisonment upheld for defrauding an elderly person of £688,000. *"The court held (considering R v Clark 1998 2 Cr App R (S) 950 in this case the defalcations extended over a considerable period and involved a victim aged 85 when the offences began. This was a grave case of prolonged financial defalcation committed against a vulnerable aged person who had not received any repayment from the appellant. The sentence was entirely right."*

Manslaughter

R v Slater 2006 1 Cr App R (S) D was 20, of previous good character and was suffering from clinical depression at the time of the offence. He and his wife were live in carers for a 91 year old woman, V who suffered from dementia and required 24 hour care. They had no assistance, despite requests, by way of respite care. The attack occurred after the accused had consumed alcohol and the victim had shouted and screamed when D and his wife tried to put her to bed. D went to the victim 3 times and eventually the wife awoke having heard a noise and found V to be injured. She had swelling and bruising to the eyes, a bruised and bloodied mouth, a broken jaw, and a fracture of the floor of an eye socket. V died 5 days later of pneumonia and cardiac failure, the pneumonia being a complication of her head injuries.

Held: This was a brutal and sustained attack, not a single provoked and immediately regretted blow. He left the victim in a perilous state. Given his youth and inadequacy, his mental impairment and especially the abnormal stress he was placed under having to care for this old lady 24 hours a day a greater reduction than normal should be given in this case. He presents no risk. 3 – 4 ½ years imprisonment (reduced from 6).

R v Warwood 2006 2 Cr App R (S) 113 "single punch" manslaughter, death caused by a fall resulting from a fist blow to an elderly man in the course of a "road rage" incident. A sentence of 3½ years imprisonment reduced to 2 ½ years imprisonment.

Murder

R v Last Re E and J 2005 2 Cr App R (S) 381 at 399 – E & J were brothers who pleaded guilty to murder of a 70 year old man who was well known in the area for enjoying success at betting. They made a plan to rob and kill him for his money, which they did.
Held: The statutory starting point is now 30 years. This was a murder committed in the course of a robbery at the victim's home. He was vulnerable because of his age.

Robbery

Guideline remarks.

R v O'Driscoll 1986 8 Cr App R (S) 121 – *"There is a tendency for burglars to select as victims elderly or old people living on their own. It is plain why. First of all they are less likely to offer much resistance, and the chances are that they have got not inconsiderable sums of money concealed about their house. Where thugs, because that is what they are, select their victims as old folk and attack them in their own homes and then torture them – that is what happened here – in order to*

try to make them hand over their valuables in this most savage fashion, then this sentence (15 years) will be the sort of sentence they can expect. One hopes this court may have some effect in protecting these old folk from this sort of savage, sadistic, cruel and greedy attack."

Att-Gen's Ref. Nos 3233 of 1995 1996 1 Cr App R (S) 376 – see aggravated burglary (above).

R v Marcus 2004 1 Cr App R (S) 258 – *"Those who select elderly or otherwise vulnerable people as victims and then invade their homes will receive very severe sentences. Such vulnerable people have to be protected, and this court will do everything it can to provide that protection. Lengthy prison sentences will normally be absolutely inevitable."*

See also:

Att-Gen's Ref No 113 of 2001 2002 2 Cr App R (S) 269 – Life imprisonment. D pleaded guilty to five counts of robbery on the date set for trial. Victims were all elderly and attacked in their own homes. He had been masked and terrified his victims. One victim was tied up and another was caused to fall. Money and small items were taken. D had a bad record of serious violent offences.

R v McDonnell 2003 2 Cr App R (S) 117 – 12 years imprisonment for a series of offences including 3 robberies, 6 burglaries, 2 thefts and one attempt burglary. The burglaries targeted elderly victims. There were a number of aggravating factors.

Theft and dishonesty

R v Hale 2002 1 Cr App R (S) 205 – 2 years imprisonment not excessive in a case where D, owner of a care home, stole £13,000 of elderly residents' pensions (having been entrusted with their pension books).

R v Roach 2002 1 Cr App R (S) 44 – 18 months imprisonment where D pleaded guilty to 3 specimen counts of obtaining a money transfer by deception. She stole £2,875 over a period of 15 months from an 80 year old lady for whom she acted as carer. She asked the victim to sign blank cheques on the pretext that they were to pay bills.

R v McGee 2004 1 Cr App R (S) 399 – 4 years imprisonment where the defendants M & H pleaded guilty to 2 counts of theft. In each case, an elderly victim was distracted thus enabling the victim's wallet to be stolen from a pocket. Both were professional criminals with long criminal records and many offences of dishonesty.

R v Goatley 2006 1 Cr App R (S) 143 – 3½ years imprisonment for 3 counts of theft where D targeted elderly people with valuable antiques in their homes, posing as a dealer or restorer.

Held: they were despicable offences in which the defendant preyed on vulnerable elderly people. They required a sentence at the top end of the bracket for these types of offence. The aggravating feature was the way in which the items were stolen and the effect which the thefts had on the victims.

Ill treatment or neglect of mental patient

R v Spedding 2002 1 Cr App R (S) 509 – 12 months imprisonment (concurrent) on 2 counts and 9 months concurrent on the rest. D was convicted of 11 counts of ill treating patients. He was a registered mental nurse working in a home for elderly mental patients. The prosecution said that he was a lazy, heavy-handed, cruel nurse whose ill treatment was systematic, prolonged and distressing. It ran from February 1997 to May 1999. None of the patients was fit to give evidence.

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CPS Communications Branch
50 Ludgate Hill
London EC4M 7EX

Tel 020 7796 8442
Fax 020 7796 8030
Email publicity.branch@cps.gsi.gov.uk

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