

# No Duty of Care?

By Peter Bates

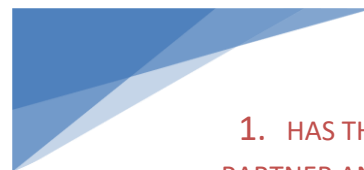
I came across an organisation recently that was offering advocacy services to people using health and social care services. They trumpeted their distinctive position as advocates by announcing that they had 'no duty of care' towards the person. I have been wondering what they meant.

## Formal obligations

**International law** is captured for the United Kingdom in the Human Rights Act 1998, which serves like a constitution, underpinning much of the legal edifice and specifically providing a framework within which safeguarding obligations and practices must be interpreted, so that 'safeguarding' is really just a shorthand for the work of 'safeguarding and upholding human rights'. Any definition of a duty of care should begin by setting out how it upholds the good life as set out in the Act, so taking this approach may help to resolve conflicts about appropriate actions. The Act recognises that some rights are absolute and cannot be restricted, while others must be balanced with competing rights.

In **UK law**<sup>1</sup>, duty of care has a very limited meaning and can only be applied where one person has a specific form of relationship with another which makes it fair, just and reasonable to impose a duty of care upon them and where they can be sued for loss or damage if they are negligent in the discharge of that duty. Thus, for example, a solicitor has a clearly defined relationship with a client that is played out through the twin routes of a contract and a duty of care - and so the lawyer can be sued if they fail in these duties. There are some similarities between the roles of solicitor and advocate, as both take instruction and seek to advance the case of their client, but the contract is agreed with the client in the case of the solicitor and with the commissioner in the case of advocacy. There have been circumstances in which compensation has been awarded to clients who have been poorly served by their solicitor<sup>2</sup>, but there is no such caselaw to demonstrate that advocates can be held to account in this way for their performance, or any suggestion that the courts would count it as fair, just and reasonable to do so.

Similarly, a manufacturer of electrical appliances, say, has a clear relationship as vendor to the purchaser and so must provide an appliance which is safe to use. While the government has asserted that health and social care agencies have a duty of care<sup>3</sup>, the courts have been very reluctant to burden individual staff with the possibility of being sued, and there have been no examples in caselaw to date. While the Mental Capacity Act 2005 made ill treatment and wilful neglect a crime,



1. HAS THE ADVOCACY PARTNER ANY REDRESS IF THEY DO NOT GET A GOOD SERVICE FROM THE ADVOCATE?

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<sup>1</sup> In England, (i) harm must be a reasonably foreseeable result of the defendant's conduct, (ii) the defendant must be in 'a relationship of proximity with the claimant, and (iii) it must be fair, just and reasonable to impose liability in the court. See *Caparo Industries plc v Dickman*.

<sup>2</sup> See <http://www.legalombudsman.org.uk/wp-content/uploads/2016/11/Annual-Report-2015-16-web-161108.pdf>

<sup>3</sup> Care and support statutory guidance issued under the Care Act 2014, paragraph 15.44 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/315993/Care-Act-Guidance.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf)

this was reinforced by the Criminal Justice and Courts Act 2015 which presupposes that there is an underpinning duty of care, thus strengthening the law's ability to prosecute care workers<sup>4</sup>.

The **Government** lays duties on the local authority and the NHS, who then commission a range of services to fulfil those duties, including the delivery of the Care Act 2014. This means that they must have regard for people's wellbeing, take preventative action to prevent problems from escalating, and support people's independence and membership of social support networks<sup>5</sup>. Perhaps these are components of what it means to exercise a duty of care.



## 2. IS THE ADVOCATE A HEALTH OR SOCIAL CARE WORKER?

All established health and social care professions in England<sup>6</sup> are regulated by the **Health and Care Professions Council**, which establishes the qualifications and conduct required, awards the relevant restricted title, maintains a register and removes unsuitable workers from it as necessary. Despite its statutory duties, advocacy does not fall within the remit of the HCPC in England, we are aware of no firm plans for it to be adopted, and a search for 'duty' on the HCPC website returns nothing<sup>7</sup>. So perhaps some Advocates would claim that they stand outside the family of health or social care providers and so are not care providers – they have no **duty to provide** care.

The **Social Care Institute of Excellence**, which is a charity promoting service improvement, defines duty of care as a legal obligation to act in the best interest of others and avoid causing harm, either intentionally or by acting beyond one's competence.



## 3. HOW IS IT DIFFERENT WHEN THE PERSON LACKS CAPACITY?

They say that health and social care staff owe this duty to their patients and clients, to colleagues, the employer, themselves and the public interest. Does SCIE consider advocates to fall within the meaning of their phrase 'health and social care staff'? Furthermore, they say - drawing on the Mental Capacity Act 2005 - acting in a person's best interests must be done with their consent unless the worker has evidence that the person lacks capacity to make that particular decision at the time it needs to be made<sup>8</sup>. So for SCIE, the duty of care lies largely within the sphere of consent, with only rare occasions when it spills over into the situations where the person lacks capacity. Of course, for health and social care staff working in mental health or dementia services, this generally unusual situation may apply to a high proportion of their clients or patients.

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<sup>4</sup> See sections 20 and 21 at [http://www.legislation.gov.uk/ukpga/2015/2/pdfs/ukpga\\_20150002\\_en.pdf](http://www.legislation.gov.uk/ukpga/2015/2/pdfs/ukpga_20150002_en.pdf).

<sup>5</sup> For example, the statutory guidance on the Care Act 2014 (see <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>) explicitly uses the phrase 'duty of care' at paragraph 6.28 in relation to carrying out assessments with people who may be unable to put their needs into words, and paragraph 15.42 says that both the NHS and local authorities owe a duty of care to the people within their care.

<sup>6</sup> In Wales, advocacy is to be regulated under the Regulation and Inspection of Social Care (Wales) Act 2016.

<sup>7</sup> The Health and Care Professions Council firmly stated that their members had a duty to care in the 2007 consultation document on Standards of Conduct, Performance and Ethics (<http://www.hpc-uk.org/assets/documents/10001b3cstandardsconductperformanceandethicsconsultationdocument.pdf>), but had removed the phrase entirely from its 2016 revision – see <http://www.hpc-uk.org/assets/documents/10004EDFstandardsconductperformanceandethics.pdf>.

<sup>8</sup> [http://www.scie.org.uk/workforce/induction/standards/cis05\\_dutyofcare.asp](http://www.scie.org.uk/workforce/induction/standards/cis05_dutyofcare.asp)

Such responsibilities might be summarised in lay terms as providing ‘care’. Since most advocacy organisations are commissioned by the **local authority** and the **Clinical Commissioning Group**, they owe a duty to their commissioner to support the implementation of this and other Acts of Parliament. We could say that this amounts to a duty of care.

From a different perspective, **professional bodies** sometimes expect someone with a restricted title to use their skills for the wider public’s wellbeing. To take an example from medicine, this extends the doctor’s role beyond their assigned patients to all citizens and beyond their working hours into their off-duty life<sup>9</sup>; but confines that duty to emergency situations only. Thus, when the cabin crew asks if there is a doctor on board, a medic who is on holiday and refuses to help in an emergency could be disciplined by their professional body for their failure to exercise this duty of care<sup>10</sup>.


### Moral and Ethical Considerations

Beyond this, there is an expectation that people who are employed in the caring professions, and perhaps others too, expend some emotional labour by caring about the general wellbeing of their patients or clients, rather than objectifying them and subjecting them to mechanical processes. This is seen most sharply in relation to safeguarding issues, where the usual duty of confidentiality is overridden by a duty of care when harm or a risk of harm has to be reported.


In **citizenship** terms, all members of society have moral duties within the social contract that glues society together through a pattern of mutual trust and obligation. We are all expected to respond to one other, and particularly to citizens who happen to be vulnerable or in crisis, such as by snatching a runaway toddler out of the path of moving traffic. While this sort of moral duty may be informal rather than grounds for disciplinary action by legal, professional or employment bodies, it neatly illustrates the range of interpretations that can be placed on the concept of ‘duty of care’.

### The role of Advocates

The role of statutory advocates is set out in the legislation that defined the function of the Independent Mental Health Act Advocate, Independent Mental Capacity Advocate, Independent Care Act Advocate, and Relevant Person’s Representative. Staff employed in these roles have a duty to act within the law, so that all legal processes relating to the person are undertaken at the right time with the right people present and to the highest standard. For Independent Mental Health Act



4. IS THERE A MORAL RESPONSIBILITY TO TREAT PEOPLE WELL THAT REACHES BEYOND THE JOB TITLE AND WORKING HOURS?



5. IS ADVOCACY WORK ‘TAKING CARE OF’ OR ‘CARING ABOUT’ PEOPLE?

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<sup>9</sup> The UNISON trade union emphasises that the duty of care only begins when a person is accepted as a client or patient by a health or social care worker. See <https://www.unison.org.uk/content/uploads/2013/06/Online-Catalogue197863.pdf>

<sup>10</sup> See [http://www.gmc-uk.org/static/documents/content/GMP\\_.pdf](http://www.gmc-uk.org/static/documents/content/GMP_.pdf) para 26 and medical ethicists such as Daniel Sokol at <http://www.bmj.com/content/345/bmj.e6804.full?ijkey=BaelgfZySySGXmb&keytype=ref>.

Advocates this includes participating in Tribunals, Hospital Managers Meetings and Care Programme Approach meetings.

Neither the advocacy Code of Practice<sup>11</sup> nor the Advocacy Charter<sup>12</sup> use the phrase 'duty of care', so there is no help here. The courts, employers and funding organisations expect advocates to do their job *carefully* and competently. Inspection bodies expect advocates to *take care* so that people do not come to harm through their actions or omissions. Best practice bodies assert that staff must try to align their actions with the person's wishes rather than routinely contravene them. Society expects advocates to act when vulnerable people are at risk – to do their *duty* as responsible citizens. One might even go so far as to suggest that certain branches of the media expect us all to take care of one another, and not restrict ourselves to those who are our friends or who are on our caseload. After all, in our modern communication age, judgement by news or social media is a powerful force driving behaviour. Finally, professional bodies expect people working in the health and care sector to *care about* people, and not just provide care to them.

In terms of competency, all statutory advocates must have a level of competence commensurate with their role and within one or two years hold the subject specific specialist unit, which allows them to practice; they have a duty to regularly update their knowledge and expertise by taking account of revisions to the Code of Practice, High Court Judgements and the like.

### The Distinctive Role of the Advocate

Overlaid on all this is the issue of consent and best interests. The distinctive role of the advocate is to represent the person's own view, in contrast to the Decision Maker, who must, where the person is known to lack capacity to make that particular decision, balance all the issues before acting in the best interests of the person. The advocate expresses what is *important to* the person, while the Decision Maker acts on what is *important for* the person<sup>13</sup>. However, it is noteworthy that recent caselaw has demonstrated a drift in which the person's Best Interests are viewed as more and more closely aligned to what the person is indicating they want, enshrining the principle of 'least restrictive practice' by ensuring that the person gets more of what they want in life<sup>14</sup>. Some advocates might claim that, if 'care' means no more than the precise action of identifying and acting on the person's best interests, then it is true that this is not the advocate's role, as it lies with the person themselves, their relative, or a social worker or Best Interests Assessor.

From this perspective, advocates capture and channel the wishes and preferences of the person without filtering those views through any kind of Best Interests lens – their reports conclude with 'Considerations' and never with 'Recommendations'. The duty to decide on the best kind of care in respect of a deprivation of liberty decision lies with the person themselves or the Best Interests

<sup>11</sup> See <http://www.qualityadvocacy.org.uk/wp-content/uploads/2014/03/Code-of-Practice.pdf>

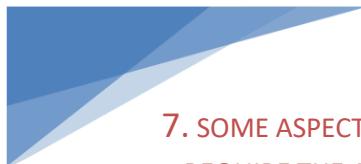
<sup>12</sup> See <http://www.qualityadvocacy.org.uk/wp-content/uploads/2016/09/New-Advocacy-Charter.pdf>

<sup>13</sup> This distinction has been drawn by Michael Smull – see <https://www.youtube.com/watch?v=VDqERixM4HM>

<sup>14</sup> Department of Health (2014) [Positive and Proactive Care](#).



6. ADVOCATES HAVE A DUTY TO DO THEIR WORK CAREFULLY AND COMPETENTLY



7. SOME ASPECTS OF THE JOB REQUIRE THE ADVOCATE TO IDENTIFY AND PROMOTE THE BEST INTERESTS OF THE ADVOCACY PARTNER

Assessor or Decision Maker. Consequently, Advocates have no **duty to decide** on what would be the best kind of care.

Advocates have a responsibility to challenge other agencies on behalf of the person and seek to uphold their rights, but they may feel that they have no formal authority to override the decisions of others. They can bring matters to the attention of the Decision Maker, the Court of Protection or others, but these bodies will then make their own determination about the best thing to do. A specific example occurs when advocates begin to see repeated patterns in the referrals they receive. Perhaps every resident they see in a particular care home is subject to degrading treatment, or every patient of a particular forensic psychiatrist is having significant problems obtaining leave to spend time in the community. In these situations, a wider duty of care towards other people receiving health or social care takes the advocate beyond the narrow confines of their immediate client into a systemic approach that seeks out these patterns and acts to influence and change services, commissioning behaviours and inter-agency collaborations. Perhaps some advocates feel that they have no formal powers to press for change at this strategic and preventative level, and so excuse themselves with the claim that they have no **duty to exercise their influence** in a caring manner.

But even this turns out to be imperfect as a description of the law, since advocates must surely do their work in a manner that is in the best interests of the person and the community, such as by respecting the individual's communication preferences, rather than using intimidating or coercive mechanisms in interview, and by offering evidence that will lead to improvements in health and social care provision rather than suppressing it. The Advocacy Outcomes Framework refers to these wider systemic changes as changes in the health and social care sector and changes in the wider community, which sit alongside changes in the individual and changes in the advocacy organisation<sup>15</sup>.

In the Relevant Person's Representative (RPR) function, the paid representative has a duty of care to ensure that the conditions of a deprivation of liberty are being adhered to, and in extreme cases they may even apply to the Court of Protection on behalf of the individual, therefore, if the person wishes to challenge their deprivation and if the RPR does not act on this they are failing in their duty of care to that individual, morally, ethically and legally.

For non-statutory advocacy, the terms of the service agreement in relation to the advocacy on offer will go some way to define their moral, ethical and professional duty of care. This is seen at the boundary of the duty of confidentiality, where an advocate would be failing in their duty of care if they did not report a safeguarding issue which resulted in harm.

## Denial of Responsibility

But what if the term 'duty of care' evokes a whole mix of themes in the minds of people who hear the phrase? Does asserting that advocates have no such duty suggest that they are not particularly interested in being competent, are reckless regarding harm, and have no compassion? Are they hoping that chanting this phrase might exonerate them from all responsibility if things go wrong?

Such attempts by professionals to self-define and limit their sphere of responsibility do not have an auspicious precedent. To give just one example, in the Climbie Inquiry, Lord Laming was scathing

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<sup>15</sup> See Mercer K & Petty G (2016) [Advocacy Outcomes Framework](#) Bath: NDTi.

about the local authority Chief Executive who said that child protection was not his job but rather had been delegated to his Director of Social Services<sup>16</sup>.

It may well be that the use of this phrase has no effect upon the attitudes or activities of the advocates themselves, as the associated demands for safeguarding, person-centred work and high performance standards may render void any potential harm that might otherwise be caused by adopting the 'no duty of care' motto. We can, however, be reasonably confident that including it in marketing delivered by the organisation to community groups is highly likely to have a negative impact on the external reputation of the advocacy organisation.



## 8. DENYING ONE'S DUTY OF CARE IS NO DEFENCE

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<sup>16</sup> See the Victoria Climbié Inquiry, chaired by Lord Laming, para 1.26, available at [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/273183/5730.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273183/5730.pdf)