

Identifying RISKS Sharing RESPONSIBILITIES

The Case for a Comprehensive Approach
to Safeguarding Vulnerable Adults

A Safeguarding Ireland
Discussion Paper

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/ Foreword

This report, *Identifying RISKS – Sharing RESPONSIBILITIES*, commissioned by Safeguarding Ireland, is the culmination of many months of research and consultation with experts in the area of adult abuse. It outlines the current situation in relation to the risks and challenges posed by adult abuse in Ireland and sketches the broad landscape within which adult abuse occurs. The sheer breadth of both the actual and potential adult abuse environment poses questions as to how best to tackle this major human rights issue in Ireland.

Over the last 20 years in Ireland, some attempts have been made to combat adult abuse, including the introduction of a dedicated HSE adult safeguarding service, regulation of some health and social care services, more robust mental health legislation and the soon to be enacted Assisted Decision-Making (Capacity) Act 2015. While these are all welcome safeguards, they primarily place adult safeguarding within the health and social care environment thus limiting the wider and more comprehensive response that is required. Furthermore, there are limitations in the health and social care policy areas in the roles of HIQA, the HSE and the Mental Health Commission in responding to instances of abuse, exploitation and/or neglect. Moreover, this report, in demonstrating the wider setting in which adult abuse occurs, makes clear that the lack of breadth and integration in the current safeguarding response means abuses such as have occurred in the past will continue.

It is obvious from this report that the potential for adult abuse occurs in any situation where one or more adults is dependent, or made dependent, on another person or persons. Adult abuse is not an abstract notion – where adult abuse occurs, it leads to considerable suffering and distress.

The continuation of adult abuse is facilitated somewhat by the absence of adult safeguarding legislation. There is an obligation on the state to protect all of its citizens, particularly those who cannot protect themselves. This includes the increasing numbers seeking protection or asylum in this country. The United Nations and Council of Europe Conventions have both focused attention on safeguarding as a human rights issue. The United Nations Convention on the Rights of People with

Disabilities, which Ireland ratified in 2018, among other safeguarding principles, specifically refers to the rights to freedom from exploitation, violence and abuse (Article 16). The continued absence of adult safeguarding legislation poses a risk, not only to those people suffering abuse, but also poses a significant risk to the State. Ireland relies heavily on voluntary, community and the private sector to deliver to citizens on its behalf and, though the state already imposes obligations regarding safeguarding, it is silent on the issue of necessary support and resources.

This report, in recognising the wide vista within which adult abuse occurs, points to a need for an integrated legislative and policy response. Adult abuse requires a cross-departmental and inter-agency approach, as well as a whole of society response, to address the embedded and unacceptable levels of abuse of vulnerable adults in Ireland. The report sets out the need for greater integration in relation to combatting adult abuse in the areas of finance, housing, homelessness, justice, health and social protection. It sets out the absolute need for a greater understanding in relation to the issue of information sharing between individuals and agencies in the context of safeguarding concerns. It puts forward a compelling case for the introduction of adult safeguarding legislation that is not confined to health and social care services, but rather cuts across all areas of society. It points to the need for the establishment of an independent National Adult Safeguarding Authority with overarching responsibility for safeguarding, to include the promotion of standards in the safety and quality of services; the provision of independent advocacy; to undertake investigations; to provide education, training, and public awareness; and to collect and collate accurate data on adult abuse.

Identifying RISKS – Sharing RESPONSIBILITIES, in its title and content, explicitly affirms that preventing and confronting adult abuse is a shared responsibility, requiring a legislative framework that underpins that shared responsibility. This shared responsibility can best be organised through a central agency linked to a government department with wide government and societal responsibilities.

Patricia Rickard-Clarke
Chair, Safeguarding Ireland.

/ Executive Summary

While all citizens have the right to be afforded equal protection from abuse by the State, its institutions and its laws, some people's basic human and legal rights to be protected from abuse are frequently and routinely disregarded in Ireland.

Chapter 1: Discussion Paper Context

This Discussion Paper sets out and analyses the multi-faceted contextual factors that are relevant to the safeguarding of adults who are at risk¹ from violence, abuse, neglect, exploitation, coercive control, or self-neglect, whether in the community generally or in health and social care settings.

United Nations and Council of Europe Conventions have focused attention on safeguarding as a human rights issue. In Ireland, the safeguarding of adults at risk has come to the fore as a matter of growing concern as a result of events associated with the Covid-19 pandemic, the significant risks and trauma to which nursing home residents were exposed and high-profile media reporting of cases of abuse in institutional and domestic settings. New legislative measures – the Assisted Decision-Making (Capacity) Act 2015 and the Domestic Violence Act 2018 – have also provided a stimulus for reflection and consideration.

What the Discussion Paper does

- The Paper aims to inform and contribute to the development of a safeguarding legislative and regulatory framework, and to complement the important work being carried out in this area by the Law Reform Commission.
- The effectiveness, appropriateness and adequacy of current safeguarding legislation, policy, practice and structures in providing protection and redress to adults at risk of abuse is explored and analysed.

¹ An 'adult at risk' is understood in this Paper as a person who is aged 18 years or over who needs help to protect themselves or their interests at a particular point in time, whether due to personal characteristics or circumstances. It is generally acknowledged that there are certain risk factors that may increase an adult's likelihood of being abused by another person, for example, dependency status, disability status, health status, domestic living arrangements, being in a congregated setting,

The Paper shows that the potential for adult abuse occurs in any situation where one or more adults is dependent, or made dependent, on another person or persons. Adult abuse is not an abstract notion – where adult abuse occurs, it leads to considerable suffering and distress.

- The cultural and societal factors that allow for the normalisation of persistent and insidious abuse and exploitation of adults at risk is described and the challenges related to developing appropriate responses are explored.
- Domestic abuse is situated in the broader context of abuse and exploitation of adults at risk. Issues specific to domestic abuse in intimate partner relationships are beyond the scope of this paper.
- The Paper does not make specific recommendations but rather outlines the broad landscape within which abuse of adults at risk occurs and identifies the general nature of the legislative and policy framework required to enable an adequate adult safeguarding infrastructure.

The Paper shows that the potential for adult abuse occurs in any situation where one or more adults is dependent, or made dependent, on another person or persons. Adult abuse is not an abstract notion – where adult abuse occurs, it leads to considerable suffering and distress.

While there has been significant progress in Ireland over recent years in recognising the rights of adults at risk, considerable challenges and shortcomings persist within and across the broad social, cultural, policy and legislative infrastructure. Much more work is required in order to guarantee adults at risk that they will be protected by the State and its institutions from abuse and exploitation.

Chapter 2: Current safeguarding regulatory framework

The quality and effectiveness of safeguarding provision in Ireland is heavily influenced by the regulatory framework that exists and which includes constitutional provisions, legislation, international conventions, criminal law, case law, civil law, regulations and standards. People's rights, obligations, responsibilities, powers to act and to seek legislative redress are all circumscribed and limited by that framework, as are the modus operandi of organisations and agencies with a safeguarding remit in respect of vulnerable adults.

In assessing the extent to which the current safeguarding framework for vulnerable adults is adequate and fit-for-purpose, it is necessary to consider not only how well it sets out the rights of persons at risk, but also how well it allocates responsibilities and powers to the people and agencies responsible for safeguarding.

A number of interlinked shortcomings arise as a result of a legislative void in terms of authority to act effectively in safeguarding situations. Safeguarding provision is heavily dependent on regulations and standards for health and social care services. Existing regulations fall short in respect of the settings to which they apply, the types of abuse that they can deal with and their legislative basis.

In assessing the extent to which the current safeguarding framework for vulnerable adults is adequate and fit-for-purpose, it is necessary to consider not only how well it sets out the rights of persons at risk, but also how well it allocates responsibilities and powers to the people and agencies responsible for safeguarding.

Many categories of abuse and exploitation relating to adults at risk, or the perpetrators of such abuse, or the settings in which abuse occurs are not adequately regulated.

Chapter 3:

The nature and extent of abuse of adults at risk

It is clear that, in many instances, abuse is multi-faceted and that there is considerable under-reporting.

The Annual Reports of the HSE's National Safeguarding Office provide considerable and valuable detail of the nature, extent and location of allegations of abuse and exploitation of adults at risk in Ireland. When considered in conjunction with other research, it is clear that considerable variations exist regarding the type of risk to which different groups of people are exposed, the identity of the alleged perpetrators of abuse, the settings in which abuse occurs and the extent to which concerns are reported.

Reporting of abuse may be hampered by various factors, including:

- Fear on the part of the person being abused of the consequences of disclosing abuse.
- A lack of awareness by people that what they are experiencing is abuse.
- A lack of clarity as to whom they should report abuse.
- Lack of capacity to understand and report abuse.
- Fear of an alleged abuser and/or ambivalence regarding a person who may be abusive.
- Limited verbal and other communication skills.
- Fear of upsetting relationships, shame and/or embarrassment.

There are strong indications that many forms of abuse are considered 'trivial', acceptable and somehow normal. These include instances of petty theft, exploitation of property and assets and actions based on false assumptions regarding the role and rights of 'next-of-kin'.

There are some types of abuse that deserve particular attention, e.g., financial abuse, not only because of the extent to which they appear to be under-reported and hidden but, also, as indicators of how abuse is multi-faceted and pervasive throughout Irish society.

- Specific forms of adult abuse, e.g., financial abuse and coercive control, are likely to have become normalised and tacitly accepted by society;
- Reporting of adult abuse in Ireland does not reflect the true nature and extent of such abuse and exploitation;
- There is a dearth of data (aggregated and disaggregated) in Ireland on the nature and extent of adult abuses;
- Abuse and exploitation of adults needs to become more central in public and policy discourse about the abuse and exploitation of adults at risk.

It is clear that, in many instances, abuse is multi-faceted and that there is considerable under-reporting.

Abuse and exploitation of adults needs to become more central in public and policy discourse about the abuse and exploitation of adults at risk.

Chapter 4:

Financial abuse

Financial abuse and exploitation of adults at risk is prevalent in society, both internationally and in Ireland. There is some uncertainty among the public about what constitutes financial abuse and a lack of knowledge of what to do when someone becomes aware of or suspects financial abuse.

Adults at risk can be financially exploited through the use of psychological manipulation or misrepresentation, coercion or undue influence. Such abuse can have serious impacts on people both financially and emotionally. The level of financial abuse reported to the HSE's National Safeguarding Office relating to people over 80 years of age gives rise to concern, particularly since there is a proportion of incidents where there is no meaningful follow-up.

It is almost certainly the case that many cases of financial abuse or exploitation go unreported and are not referred to a HSE Safeguarding and Protection Team, either because the person being exploited does not perceive what is happening as abuse and/or is relying on the perpetrator for care and support.

While legislation and regulation can help to safeguard people from financial abuse, this can only be effective when there is a cultural shift that names financial exploitation for what it is, namely a denial of people's right to control all of their assets and to have such assets used only for their benefit.

There are multiple aspects of financial abuse that require to be made a more central component of public and policy discourse.

- There is a need to challenge the widely held belief that the family members of persons at risk are entitled to manage and exploit the finances and assets of their kin, in the absence of proper authorisation.
- The risk factors for financial abuse are well known, and there is a critical need to engage people in early intervention or preventative strategies, for example, powers of attorney provision and planning ahead, in order to minimise the risks of being financially exploited in the event of a reduction in decision-making capacity.
- Financial service providers have a particularly important role to play in looking out for financial abuse of adults at risk, as has the Department of Social Protection and other agencies charged with the payment of state benefits, pensions and grants.
- It is critically important that people are advised to seek the assistance of an independent advocate where difficulties are perceived or identified in relation to the proper management of the assets of an adult whose decision-making capacity may be in question.

It is critically important that all of society – families, social networks and service providers – become more aware of and attuned to the issue of financial abuse and that people generally become more vigilant about recognising and reporting financial abuse.

The position of those adults who are most at risk, particularly those with reduced decision-making capacity and those who are subjected to coercive control by a family member, is a matter for serious public concern.

It is critically important that all of society – families, social networks and service providers – become more aware of and attuned to the issue of financial abuse and that people generally become more vigilant about recognising and reporting financial abuse.

Chapter 5: **Safeguarding people resident in nursing homes**

Safeguarding issues related to nursing home residents is a particular area of concern. While nursing homes should be places where residents feel safe, secure, cared for and protected, this may not always be the case.

Most nursing home residents are aged 85 years or over and have complex conditions, with dementia and related reduced decision-making capacity affecting some two-thirds of the over 30,000 people living in nursing homes in Ireland at any given time.

The reality is that, under current provision for long-term care, in many instances, a nursing home is the only option available. This is due to the absence of adequate community and home-based care, and the shortage of supported housing options to enable ‘ageing in place’.

The stark reality for nursing home residents came very much into focus with the onset of Covid-19. It is clear that the pandemic placed significant additional pressures on a long-term care system that was already under stress.

The right of nursing home residents not to be exposed to a higher level of risk than if they lived in the community was negated in many instances. This raises critical questions about how people at the high end of the vulnerability and risk spectrum are safeguarded.

There are aspects of nursing home care that give rise to significant safeguarding concerns: Many so-called voluntary residents in nursing homes are *de facto* detained and deprived of their liberty.

- There are clear safeguarding concerns associated with the prolonged isolation of people with high care needs in congregated settings with little connectedness with communities.
- The ‘closed’ nature of nursing homes makes it exceptionally challenging for either residents or staff to speak up and report abuse or inappropriate care.
- HIQA does not have the power to investigate specific issues relating to individual nursing home residents unless at the request of the Minister for Health.
- HSE Safeguarding and Protection Teams do not have right of access to private nursing homes.

The right of nursing home residents not to be exposed to a higher level of risk than if they lived in the community was negated in many instances. This raises critical questions about how people at the high end of the vulnerability and risk spectrum are safeguarded.

We need a system of long-term care and provision which ensures that people are not inappropriately and unnecessarily ‘placed’ in nursing homes against their wishes.

- There is no legislative provision for access by independent advocates to nursing homes (public or private).
- There continues to be a failure by nursing homes to comply with regulations as evidenced repeatedly in HIQA Inspection Reports.

Notwithstanding the urgent need to move quickly to an alternative community-based model of long-term care and support for older people who are frail, it is realistic to acknowledge that the current nursing home model will continue to operate in the short-to-medium term and that the private sector will continue to play a central role.

A central question to be addressed is whether or not residents in nursing home care can be adequately safeguarded under the current model of long-term care provision.

The appropriateness of congregated settings for older people requiring care and support needs to be fundamentally challenged from a safeguarding perspective.

There is a very strong argument from a safeguarding perspective, as well as a general human rights perspective, that the nursing home model as it currently exists in Ireland should become a thing of the past.

We need a system of long-term care and provision which ensures that people are not inappropriately and unnecessarily ‘placed’ in nursing homes against their wishes.

Chapter 6: **Coercive control of adults at risk**

Coercive control is used with intent to make a person dependent, to isolate them in order to exploit them, to deprive them of their independence and to exercise control over their behaviour and choices.

Coercive control is a pattern of behaviour which is designed to exert control over another person. It is a form of abuse that can be perpetrated in many settings and by different people involved in the life of an adult at risk. It can occur in people’s own homes, in residential care facilities and in other health and social care settings. Coercive control can be exercised by home care providers.

The Domestic Violence Act 2018 performs a very important task in criminalising coercive control which is now, in certain contexts, a criminal offence under the Act. However, there are significant shortcomings, limitations and difficulties attached to the application of the law in respect of providing protection against coercive control for many adults at risk. Protection under the 2018 Act is not available unless the perpetrator is or was an intimate partner. Neither does the Non-Fatal Offences Against the Person Act 1997 address this regulatory gap relating to coercive control.

Coercive control is used with intent to make a person dependent, to isolate them in order to exploit them, to deprive them of their independence and to exercise control over their behaviour and choices.

The definition of ‘relevant person’, in the Domestic Violence Act 2018, i.e., the perpetrator of coercive control, needs to be expanded to include all persons who inflict this form of abuse, irrespective of the relationship involved.

The narrow scope of the offence of coercive control under the 2018 Act does not adequately capture the nuanced coercive control often exercised over persons who are dependent on the perpetrator for their care.

The definition of ‘relevant person’, in the Domestic Violence Act 2018, i.e., the perpetrator of coercive control, needs to be expanded to include all persons who inflict this form of abuse, irrespective of the relationship involved.

Such an expansion of the definition would ensure that the general public can be made aware of this form of abuse of adults generally and of its unacceptability; and that all people experiencing coercive control have effective legal redress, irrespective of their relationship with the perpetrator.

There is a clear need for better protection for people in residential care facilities where staff and other residents perpetrate abuse in the form of coercive control. There is a similar need to provide legislative safeguards where coercive control is perpetrated by a home care provider.

Chapter 7:

Self-neglect by adults at risk

Self-neglect can have serious and sometimes life-threatening implications for the people concerned. It is widely regarded as a public health and human rights issue in that it may pose a significant threat to a person’s health, well-being and safety.

Self-neglect is often connected with, takes place in parallel with, or leads on to other forms of abuse perpetrated by other persons.

While self-neglect is most often associated with living alone and being socially isolated and disconnected from community, it is important to acknowledge the different factors that may contribute to self-neglect, including, in particular:

- A culture of self-neglect can have built up over a considerable period of time.
- Self-neglect in later life has been linked to traumatic personal life experiences, including experiences of suffering, loss, childhood abuse, and migration and traumatic life events in early years.
- Self-neglect has also been associated with high stress levels, economic vulnerability and mental health problems.
- The norms of the culture of self-neglect may be maintained and possibly enforced by a dominant personality in a household with weaker members of a household effectively being controlled and abused.

Responding to self-neglect poses many challenges. Health and social care professionals often find self-neglect cases to be enormously challenging and fraught with ethical and legal dilemmas, particularly when adults are judged to have decision-making capacity to refuse support.

Self-neglect is often connected with, takes place in parallel with, or leads on to other forms of abuse perpetrated by other persons.

Much of the policy discourse around self-neglect centres on the tensions between respect for autonomy on the one hand and the exercise of a protective duty of care on the other.

Much of the policy discourse around self-neglect centres on the tensions between respect for autonomy on the one hand and the exercise of a protective duty of care on the other.

The following factors are relevant in addressing the issue of self-neglect:

- There is clearly a need to ensure that personnel concerned with safeguarding of adults at risk are provided with the skills, policies and legislative framework that are necessary for dealing with cases of self-neglect.
- Any interventions must give due recognition to a person's right to autonomy, including the right to refuse supports, provided the individual has decision-making capacity.
- Professionals need to be able to operate in a context where appropriate provisions exist and where there is clarity regarding access, regarding sharing of information, regarding cooperation between agencies and regarding reporting mechanisms.
- There is a need for a broader and more integrated approach to the issue of self-neglect in an overall safeguarding context at national level which would include Gardaí, health and safety personnel, health and social care personnel as well as local communities.

There is a need to clearly separate out health and safety and environmental concerns associated with extreme self-neglect with the rights of the individual involved and the need to safeguard their health and well-being.

It is important that self-neglect (though often inter-connected with other forms of abuse) is considered as an issue in its own right, particularly given the specific challenges and characteristics involved.

Chapter 8:

Data sharing and safeguarding vulnerable adults

Effective information sharing is an integral aspect of the multi-agency and multi-disciplinary approach required to adequately safeguard adults at risk of abuse. The importance of sharing information and of relying on a legal basis to do so, is reflected in various guidelines relevant to the safeguarding of adults at risk. Data sharing is governed by the Data Protection Act 2018 and the Data Sharing and Governance Act 2019, which give effect to the EU General Data Protection Regulation (GDPR) and the Law Enforcement Directive.

There is a pressing need for effective information-sharing for safeguarding purposes between the various agencies that are typically involved.

Currently, there is a lack of clarity and guidance as to what data can be shared and under what conditions between individuals and organisations where concerns of abuse, neglect and exploitation of an adult at risk are being investigated.

There is a pressing need for effective information-sharing for safeguarding purposes between the various agencies that are typically involved.

In the absence of safeguarding legislation and of regulations under the Data Protection Act 2018, guidance from the Data Protection Commission specifically on data sharing in the context of adult safeguarding is urgently required to facilitate information sharing among the various organisations that encounter challenging and complex issues in the context of adult abuse.

- There is an absence of a positive obligation to share data where necessary to safeguard a person who is at risk of harm.
- The absence of regulations made under the Data Protection Act 2018 means that various legal bases cannot be relied upon to share information in a safeguarding context.
- There is no guidance from the Data Protection Commission as to how the legal bases for sharing information under the existing framework might be invoked in the context of safeguarding.
- Legal bases for data processing which could usefully be relied upon (in particular the public interest and substantial public interest bases) cannot be invoked due to a lack of ministerial regulations required by various provisions of the Data Protection Act 2018.
- The absence of ministerial regulations is a pressing issue and a significant barrier to the sharing of information between organisations involved with the safeguarding of adults at risk.
- The legal bases which can currently be relied upon (such as consent, contractual necessity, legal obligation, vital interests and legitimate interests) do not adequately cater for the range and complexity of situations encountered in the context of safeguarding.
- A significant challenge in practice is inconsistent approaches to data sharing within and across the different organisations involved in safeguarding.

To the extent that the existing legal bases can be relied upon under the current framework, clarity as to what information can be shared, by whom, to whom, and in what circumstances, would be beneficial.

In the absence of safeguarding legislation and of regulations under the Data Protection Act 2018, guidance from the Data Protection Commission specifically on data sharing in the context of adult safeguarding is urgently required to facilitate information sharing among the various organisations that encounter challenging and complex issues in the context of adult abuse.

There is a clear need for appropriate legislation, ministerial regulations and clarification around the sharing of data in the context of adult safeguarding.

Chapter 9:

Independent advocacy and safeguarding adults at risk

It is widely acknowledged that independent advocacy has a necessary and critical role to play in ensuring that adults at risk are protected and have their human and legal rights upheld.

Independent advocacy is particularly important where people are vulnerable because of place of residence or the non-availability of relatives or social networks characterised by trust, honour and integrity

There is a strong argument that new legal provision for an independent advocacy service is essential in order to enable the State to comply with the requirements of the UNCRPD and the Assisted Decision-Making (Capacity) Act.

While the provisions for supported decision-making included in the Assisted Decision-Making (Capacity) Act 2015 will address many of the issues around supporting people with reduced decision-making capacity to make decisions, there will be an ongoing need for independent advocacy in order to ensure that a person is provided with the appropriate level of decision support.

and, even more so, for people who have reduced decision-making capacity. However, there is no current effective mechanism to compel service providers to facilitate access to an independent advocate, which is a requirement under HIQA Standards.

The Assisted Decision-Making (Capacity) Act 2015 makes provision for the Director of the Decision Support Service (DSS) to develop a Code of Practice “*for the guidance of persons acting as advocates on behalf of relevant persons*”. The reference to the Code of Practice is the only reference to advocacy in the 2015 Act. A Code of Practice for Independent Advocates has been developed by the Decision Support Service.

There is a strong argument that new legal provision for an independent advocacy service is essential in order to enable the State to comply with the requirements of the UNCRPD and the Assisted Decision-Making (Capacity) Act.

An independent advocacy service with statutory rights and provision for more proactive investigative mechanisms is clearly necessary, particularly to ensure that people with reduced decision-making capacity residing in congregated care settings are informed of their legal rights and assisted in accessing them.

An independent advocacy service with statutory rights would also be important to underpin the practice of non-instructed advocacy where an advocate acts independently of the individual in situations where an individual's decision-making capacity may be significantly reduced and where they may be unable to give informed consent for an advocacy intervention.

Legislative underpinning for the practice of independent advocacy in Ireland is required in order to provide an additional safeguarding mechanism for adults at risk of abuse and exploitation.

- There is a need to embed, through legislation, the practice of and right of access to independent advocacy as a core component of safeguarding.
- There is a need for better coordination and oversight of existing advocacy services and agreed national quality standards for independent advocacy.
- People who are the victims of different forms of abuse and/or who are being subjected to coercive control clearly can benefit from the support of an independent advocate in order to ensure that they can deal with the abuse and receive appropriate protection.

While the provisions for supported decision-making included in the Assisted Decision-Making (Capacity) Act 2015 will address many of the issues around supporting people with reduced decision-making capacity to make decisions, there will be an ongoing need for independent advocacy in order to ensure that a person is provided with the appropriate level of decision support.

There is substantial scope for confusion, ignorance and misconceptions regarding what constitutes adult abuse both among the public generally and among adults themselves who are at risk.

Chapter 10:

Realising the potential of the social support infrastructure

There is substantial scope for confusion, ignorance and misconceptions regarding what constitutes adult abuse both among the public generally and among adults themselves who are at risk.

There is a relatively low level of awareness about how perceived abuse should be dealt with, how and to whom it should be reported and how adults at risk can be better safeguarded. The extremely low level of concerns noted in HSE National Safeguarding Office Reports as originating from the person experiencing the abuse clearly indicates that there are considerable barriers to self-referral.

Amongst professionals and agencies, there are also likely to be mixed perceptions, an under-recognition of responsibilities, confusion regarding lines of demarcation, roles and obligations, reporting pathways and, very importantly, the rights of adults at risk to control their own lives, to make their own decisions and to have their will and preferences respected.

While everybody has a role to play in safeguarding adults at risk, there are some categories of people and groups who can have a heightened role. These include both informal social support networks involving relatives, neighbours and social networks and formal supports in the sense that they are associated with service providers and professionals.

Groups with a potential role in safeguarding include health and social care services – Safeguarding and Protection Teams, public health nurses and GPs – as well as Department of Social Protection (DSP) staff, Gardaí, staff in financial institutions and post offices as well as other providers of essential goods and services, such as utilities.

There would be much merit in examining how each of the many potential actors can contribute to developing a culture and broad social support infrastructure within which the issue of abuse and exploitation of adults at risk can be better addressed and within which the concept of safeguarding can be more effectively embedded.

In an ideal world, each individual person would be aware of threats to their well-being, would be able to recognise abusive behaviour for what it is, would know how to seek support and protection, would not be afraid to seek help and would be encouraged and empowered to do so by families, social networks and professionals engaging with them. Clearly, for many adults at risk, this is not the case and there is only minimal attention to empowering people to safeguard themselves.

Much of the potential for abuse, neglect and exploitation of adults at risk, especially in subtle forms, is rooted in a culture that accepts and condones certain attitudes, practices and behaviours that deprive people of their basic human rights. Challenging and changing this culture, both within institutions and across society as a whole, is an integral part of safeguarding.

Much of the potential for abuse, neglect and exploitation of adults at risk, especially in subtle forms, is rooted in a culture that accepts and condones certain attitudes, practices and behaviours that deprive people of their basic human rights. Challenging and changing this culture, both within institutions and across society as a whole, is an integral part of safeguarding.

Tackling abuse and providing safeguarding to adults at risk, in addition to needing dedicated personnel and agencies with appropriate resources and legislative powers, will require the engagement and mobilisation of the general public, commercial entities, NGOs and others in breaking the present culture of acceptance of the abuse and exploitation of adults at risk.

Chapter 11:

Developing an integrated safeguarding policy response

There is a need to approach the issue of safeguarding on a broader and more integrated manner than has hitherto been the case. Such an approach must encompass the following key components:



There is a clear need for a new and overarching legislative and regulatory approach to adult safeguarding in order to adequately protect people's human and legal rights.

There is a clear need for a new and overarching legislative and regulatory approach to adult safeguarding in order to adequately protect people's human and legal rights.

There is currently no independent body in Ireland with overarching responsibility for regulating adult safeguarding in respect of:

- Receiving and investigating individual complaints.
- Overseeing the investigation of complaints where a person is not in receipt of any care services.

The fragmented nature of how safeguarding is provided for - and the gaps in provision - point to the need for a dedicated safeguarding regulatory body with the statutory powers necessary to ensure its ability and authority to implement a full range of essential safeguarding measures.

- Overseeing the investigation of complaints of various types of abuse, including financial and social welfare income abuse.
- Oversight of critical incidents including deaths and matters of abuse and neglect relating to adults at risk.
- Carrying out statutory inspections – existing provision is effectively limited to the health and social care domain, and even within that sector, is constrained and fragmented.

The fragmented nature of how safeguarding is provided for - and the gaps in provision - point to the need for a dedicated safeguarding regulatory body with the statutory powers necessary to ensure its ability and authority to implement a full range of essential safeguarding measures.

A National Adult Safeguarding Authority will need a range of powers, including the power to enter and inspect premises where there are concerns of abuse; and power to facilitate and oblige inter-agency collaboration and data-sharing.

The National Adult Safeguarding Authority should be within the remit of the Department of Justice as Lead Department, with a regulatory requirement for other agencies with a safeguarding remit to collaborate with the Authority.

An overall national safeguarding framework is also required in order to create a context within which the legislative basis, the development and the coordination of safeguarding initiatives can be effectively realised. Key participating agencies in this national framework will be:

- ➔ Department of Justice
- ➔ The HSE
- ➔ Department of Social Protection
- ➔ Department of Health
- ➔ Department of Finance
- ➔ Department of Children, Equality, Disability, Integration & Youth Affairs
- ➔ Decision Support Service
- ➔ Mental Health Commission
- ➔ HIQA
- ➔ Tusla
- ➔ Office of the Ombudsman
- ➔ An Garda Síochána
- ➔ Safeguarding Ireland
- ➔ Financial institutions
- ➔ Independent advocacy providers

The following factors will be central in the establishment of an overarching national safeguarding framework:

- Relevant statutory bodies (the Decision Support Service, HIQA, the Mental Health Commission) would have a statutory obligation to report to and interact with the National Adult Safeguarding Authority on safeguarding issues, as part of the interagency collaboration required in relation to safeguarding adults at risk.
- There is a logical argument for transfer of the role of the National Safeguarding Office to within the structure of a new National Adult Safeguarding Authority, thereby giving recognition to the reality of the extent of abuse of vulnerable adults across many aspects of society and across the remits of many agencies.
- There is a very strong argument that Safeguarding and Protection Teams (SPTs) should be independent of the HSE.
- Any new National Adult Safeguarding Authority must be empowered to adequately monitor and review the performance of the HSE S&PTs, oversee compliance with statutory duties and standards and ensure effective levels of inter-agency collaboration in the safeguarding arena.
- Consideration will need to be given to the design and implementation of the most effective and appropriate arrangements for communications and interaction between the HSE Safeguarding and Protection Teams and a new National Adult Safeguarding Authority.

The Assisted Decision-Making (Capacity) Act 2015 is an integral part of the safeguarding adults’ infrastructure. This would be significantly complemented by adult safeguarding legislation and the establishment of a National Adult Safeguarding Authority, the latter an independent agency within the remit of the Department of Justice as Lead Department.

Chapter 12
Synthesis of key points

Safeguarding means putting measures in place to uphold rights by supporting health and well-being and reducing the risk of harm. It involves families, services and professionals working together to prevent adult abuse, neglect or coercive control. It also involves neighbourhoods and local communities.

There is a clear need for multi-disciplinary and multi-agency approaches to safeguarding and for more effective and purposeful collaboration, information-sharing and linked-up actions (both within and between agencies).

The importance of establishing a high-level overarching authority that can enable, encourage, monitor, review and enforce the highest standards of cooperative practice cannot be overstated.

The Assisted Decision-Making (Capacity) Act 2015 is an integral part of the safeguarding adults’ infrastructure. This would be significantly complemented by adult safeguarding legislation and the establishment of a National Adult Safeguarding Authority, the latter an independent agency within the remit of the Department of Justice as Lead Department.

Safeguarding means putting measures in place to uphold rights by supporting health and well-being and reducing the risk of harm.

The fragmented nature of how safeguarding is provided for - and the gaps in provision - point to the need for a dedicated safeguarding regulatory body with the statutory powers necessary to ensure its ability and authority to implement a full range of essential safeguarding measures.

There is inadequate acknowledgement by society in general that safeguarding adults at risk is everybody's business.

The uncertainties that persist regarding access to and the sharing of data create barriers to effective safeguarding practice and contributes to levels of caution and reluctance regarding the taking of action, collaboration and safeguarding in general. Robust safeguarding legislation, clarification of other legislative provisions and the presence of an over-arching safeguarding framework and national authority is needed if these weaknesses are to be overcome.

There remains a lack of awareness amongst the general public, within institutions and agencies, and even within the ranks of health and social care professionals, as to what constitutes abuse of adults at risk. A culture that is dismissive of certain forms of abuse, that trivialises others and that plays down the human and legal rights of adults at risk, persists in Ireland. There is a need for an effective dismantling of this culture. The fragmented and specialised remits of various agencies limits their potential in this regard. There is a need for a national body that that can address the issue in a comprehensive and all-encompassing manner.

Looking to the future

In developing a regulatory framework for safeguarding adults at risk, it will be necessary to impose a statutory obligation on state bodies and organisations to prevent or reduce abuse in all its forms rather than to be focused on just the management of crises/acute responses as is currently the case.

Empowerment and safeguarding of adults at risk requires legislative, regulatory and policy provisions. The absence of adequate and appropriate legislative foundations weakens effective actions at the implementation levels, allows for confusion and over-caution in safeguarding response decisions and results in loopholes for people who wish to exploit others or who hope to avoid responsibility for their negligent approach to safeguarding.

In considering the matter of safeguarding adults at risk and upholding their basic human and legal rights, it needs to be acknowledged that the society we live in at present is deeply flawed in that it appears incapable of providing safe and humane care and support for all adults at risk. This is particularly the case in the manner in which we provide long-term care and support.

There is inadequate acknowledgement by society in general that safeguarding adults at risk is everybody's business.

Adult abuse requires a cross-departmental and inter-agency approach, as well as a whole of society response, to address the embedded and unacceptable levels of abuse of vulnerable adults in Ireland.

Appendix:
Indicative Case Scenarios

As part of the methodology involved in preparing the Discussion Paper, an analysis was carried out of case material provided to Safeguarding Ireland by a number of agencies and actors involved in areas relating to safeguarding adults at risk. These included health and social care, financial and income support agencies and institutions. The Appendix contains eleven indicative case scenarios relating to different forms of abuse and exploitation. These show the multi-faceted nature of adult abuse in Ireland.

In considering the matter of safeguarding adults at risk and upholding their basic human and legal rights not to be subjected to abuse and exploitation, it needs to be acknowledged that the society we live in at present is deeply flawed in that it does not provide safe and humane care and support for its most at risk and vulnerable members.

The full establishment and implementation of a safeguarding regulatory framework will be required to effect a move from aspiration to practice. This can best be achieved through a central agency under the remit of a Government department and to which other agencies with a safeguarding remit have clear regulatory links.

The critical question that must be addressed is what values underpin our policy choices and whether these values are commensurate with an integrated safeguarding approach which puts the human and legal rights of all citizens at the very centre of our discourse.

/ Chapter 1

Introduction and Context

Safeguarding Ireland promotes the safeguarding of adults at risk from all forms of abuse by persons, organisations and institutions. It seeks to enhance inter-sectoral collaboration, develop public and professional awareness and education, and undertakes research to inform policy, practice and legislation around safeguarding in the Republic of Ireland. It has also launched a consultation on a draft Safeguarding Charter² which will be shared with organisations across the health, social, justice and financial sectors for discussion and agreement. The Charter will then be put forward as a voluntary national code to which organisations, services and professions can sign up to.

² <https://www.safeguardingireland.org/wp-content/uploads/2021/11/Draft-Safeguarding-Charter-19.11.21.pdf>

This Discussion Paper sets out the multi-faceted contextual factors relevant to the safeguarding of adults in Ireland who are at risk from violence, abuse, exploitation, self-neglect or coercive control.

This Discussion Paper sets out the multi-faceted contextual factors relevant to the safeguarding of adults in Ireland who are at risk from violence, abuse, exploitation, self-neglect or coercive control. The Paper aims to inform the legislative and regulatory framework being developed at present and to complement the work being carried out by other bodies, including, in particular, the Law Reform Commission (LRC) and the Health Information Quality Authority (HIQA).

The research carried out for the Paper sought to:

1. Set out the different dimensions of and contexts for abuse and exploitation of adults at risk, including self-neglect.
2. Describe the nature and extent of abuse of adults at risk in Ireland.
3. Provide a synthesis of the current safeguarding and regulatory framework in Ireland and identify its main shortcomings.
4. Explore from a safeguarding perspective the impact of the current model of long-term care provision in Ireland with its inherent bias towards residential care.
5. Identify areas which present particular challenges in implementing an integrated safeguarding approach and suggest ways that these challenges might be overcome, including, in particular:
 - Data sharing between public services and other bodies for safeguarding purposes;
 - Separate roles of different agencies relating to safeguarding of adults at risk;
 - Lack of legal recognition for the practice of independent advocacy.

Equal rights for all:

A key premise of safeguarding adults at risk

The starting point for this research is the fact that we live in a society where the basic human and legal rights of at risk adults are frequently unrecognised and/or are disregarded. This matter came very much into focus during Covid-19 when many older at risk adults were subjected to abuse in various forms, for example -

- Deprivation of liberty;
- Unnecessary exposure to infections (by being in congregated settings);
- Inadequate health and social care supports;
- Isolated and dependent on family carers who were not supported;
- A disregarding of people's will and preferences;
- A disregarding of the principle of informed consent.

Issues and concerns relating to the safeguarding of adults at risk in all domains of living were explored and analysed in the context of people’s basic human right to be free from abuse, exploitation, violence and coercive control, including the challenges faced by people self-neglecting.

This present research is informed by the basic social contract principle whereby everybody is afforded equal protection by the State and its laws and an equal right as citizens to be safeguarded and protected from abuse in all its forms.

The research project sought to locate the issue of safeguarding adults at risk within the broad social and cultural infrastructure that contributes to policies that do not adequately address safeguarding concerns, for example, in relation to people’s right to control and manage their own finances and to be supported to do so. Issues and concerns relating to the safeguarding of adults at risk in all domains of living were explored and analysed in the context of people’s basic human right to be free from abuse, exploitation, violence and coercive control, including the challenges faced by people self-neglecting.

An underlying premise of the research is that safeguarding adults at risk is a matter that needs to be addressed at a much wider level than that of protecting people from abuse and exploitation in health and social care settings. While the latter is, of course, vitally important, there is a broader social context within which abuse and exploitation takes place and which needs to be fully acknowledged.

Methodology

The project consisted primarily of desk research which included the following components:

- A. Review of relevant international research to include an analysis and synthesis of relevant findings;
- B. Analysis of the Irish policy and regulatory landscape - in particular,
 - LRC Report 2019 Issues Paper³
 - National Safeguarding Office annual reports
 - Safeguarding Ireland research reports
 - HIQA Reports
 - Policy submissions relating to safeguarding adults at risk
 - Ongoing work and analysis by the Department of Health and the HSE
 - Oireachtas debates and committee discussions
 - GDPR and data sharing legislation;
- C. An analysis of case material provided to Safeguarding Ireland by a number of agencies⁴ involved in areas relating to safeguarding adults at risk;
- D. Consultation with selected key informants.

3 https://www.lawreform.ie/_fileupload/Issues%20Papers/LRC%20IP%2018-2019%20A%20Regulatory%20Framework%20For%20Adult%20Safegaurding.pdf

National Standards for Adult Safeguarding developed by HIQA and the Mental Health Commission in 2019 stated that “Safeguarding means putting measures in place to promote and protect people’s human rights and their health and wellbeing, and empowering people to protect themselves”.

Terminology and definitions

Questions relating to terminology and definitions related to safeguarding have been set out in considerable detail in the **LRC Issues Paper on A Regulatory Framework for Adult Safeguarding** under Issue 2: Defining Key Terms for Adult Safeguarding⁵ and will, no doubt, be considered in the forthcoming LRC report on the matter. This Discussion Paper does not, therefore, deal with questions of definition, other than in a summary manner. However, the LRC Paper’s concern regarding the danger involved in not clearly defining terms such as “abuse”, “harm”, “vulnerable” and “safeguarding”, and that the lack of such definitions contributes to a lack of clarity about roles and responsibilities⁶, is shared by this Report.

Safeguarding

National Standards for Adult Safeguarding developed by HIQA and the Mental Health Commission in 2019 stated that “*Safeguarding means putting measures in place to promote and protect people’s human rights and their health and wellbeing, and empowering people to protect themselves. It is fundamental to high quality health and social care*”.⁷ According to Safeguarding Ireland⁸, “*safeguarding means living safely, free from abuse or neglect. It means people’s choices are heard and respected*”. Safeguarding involves individuals, families, social networks, services and professionals all working together to prevent exploitation and abuse. Safeguarding also means empowering people to assert their rights and to plan ahead so that, in the event of facing challenges to their capacity, people’s own voice is heard and included and that there is clarity about their wishes and preferences. It also means that we plan ahead so that if, at a future date, we need help from others that there is clarity on our wishes – and that these will be respected.

Vulnerability

While acknowledging the vast spectrum of vulnerabilities that people may experience, vulnerability is understood in this document in accordance with the definition of a vulnerable person in the HSE Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures’ (2014).⁶

“*An Adult who may be restricted in capacity to guard himself/herself against harm or exploitation or to report such harm or exploitation. Restriction of capacity may arise as a result of physical or intellectual impairment. Vulnerability to abuse is influenced by both context and individual circumstances*” (p.3).

5 https://www.lawreform.ie/_fileupload/Issues%20Papers/LRC%20IP%2018-2019%20A%20Regulatory%20Framework%20For%20Adult%20Safegaurding.pdf
6 These agencies included health and social care, financial and income support.
7 <https://www.hiqa.ie/sites/default/files/2019-12/National-Standards-for-Adult-Safeguarding.pdf> p.8.
8 Safeguarding Ireland, <https://www.safeguardingireland.org/safeguarding/>

It is also noted that a vulnerable consumer is defined in the Central Bank of Ireland’s Consumer Protection Code⁹ as meaning a person who:

- Has the capacity to make his or her own decisions but who, because of individual circumstances, may require assistance to do so (for example people with hearing or visual difficulties); and/or
- Has limited capacity to make his or her own decisions and who requires assistance to do so (for example, persons with intellectual disabilities or mental health difficulties).

The Commission for Regulation of Utilities¹⁰ defines a ‘vulnerable customer’ as follows:

For energy customers you could be classified as a vulnerable customer if you meet the following criteria:

- *If you are critically dependent on electrically powered equipment. This includes (but is not limited to) life protecting devices, assistive technologies to support independent living and medical equipment, or*
- *If you are particularly vulnerable to disconnection during winter months for reasons of advanced age or physical, sensory, intellectual or mental health.*

For customers of Irish Water, you could be classified as a vulnerable customer if you meet the following criteria:

- *If you are critically dependant on water for their medical needs, or*
- *If for reasons that may include advanced age or physical, sensory, intellectual or mental health reasons, you require additional support communicating with, or receiving services from, Irish Water*

The inclusion of these definitions by financial services and utility providers shows that there is acceptance and related regulation outside of health /financial services that customers can be vulnerable and at risk of harm.¹¹

It is acknowledged that there are important issues associated with the quick onset of vulnerability arising from, for example, dementia or Acquired Brain Injury, which need to be further identified, analysed and addressed but which are beyond the scope of this Paper.

⁹ <https://www.centralbank.ie/docs/default-source/regulation/consumer-protection/other-codes-of-conduct/4-gns-4-2-7-cp-code-2012.pdf?sfvrsn=6>
¹⁰ <https://www.cru.ie/need-assistance/vulnerable-customers/#:~:text=For%20energy%20customers%20you%20could,living%20and%20medical%20equipment%2C%20or>
¹¹ In this regard, it should be noted that there are also references to the ‘vulnerable consumer’ in European Directives, for example, [https://www.europarl.europa.eu/RegData/etudes/BRIE/2021/690619/EPRS_BRI\(2021\)690619_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/BRIE/2021/690619/EPRS_BRI(2021)690619_EN.pdf)

The inclusion of these definitions by financial services and utility providers shows that there is acceptance and related regulation outside of health /financial services that customers can be vulnerable and at risk of harm.

National Standards for Adult Safeguarding developed by HIQA and the Mental Health Commission in 2019 stated that “Safeguarding means putting measures in place to promote and protect people’s human rights and their health and wellbeing, and empowering people to protect themselves”.

Abuse

The definition of abuse used in the **Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures**¹² is -

‘Any act, or failure to act, which results in a breach of a vulnerable person’s human rights, civil liberties, physical and mental integrity, dignity or general wellbeing, whether intended or through negligence, including sexual relationships or financial transactions to which the person does not or cannot validly consent, or which are deliberately exploitative. Abuse may take a variety of forms’.

Elder abuse has been defined¹³ as “a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person”.

A number of different types of abuse of adults at risk can be identified:

- **Physical abuse** - includes hitting, slapping, pushing, kicking and misuse of medication, restraint or inappropriate sanctions;
- **Sexual abuse** - includes rape and sexual assault, or sexual acts to which the vulnerable person has not consented, or could not consent, or into which he or she was compelled to consent;
- **Psychological abuse** - includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;
- **Financial or material abuse** - includes theft, fraud, exploitation, pressure in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;
- **Discriminatory abuse** - includes ageism, racism, sexism, and abuse based on a person’s disability, and other forms of harassment, slurs or similar treatment;
- **Neglect and acts of omission** - includes ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life such as medication, adequate nutrition and heating;
- **Institutional abuse** - may occur within residential care and acute hospital settings, including nursing homes and may involve poor standards of care, rigid routines and inadequate responses to care and support needs;
- **Coercive control** – a pattern of behaviour which is used to make a person dependent; to isolate them in order to exploit them; to deprive them of their independence; and to exercise control over their behaviour and choices.

¹² <https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf> p.8
¹³ <https://www.un.org/development/desa/ageing/world-elder-abuse-awareness-day.html>

It is generally acknowledged that there are certain risk factors that may increase an adult’s likelihood of being abused by another person, for example, dependency status, disability status, health status, domestic living arrangements and/or situational factors.

“It should be noted and strongly emphasised that the three criteria above make no reference to capacity. Capacity is not, and never should be, a consideration in the three-point test”.

Adult at risk

An adult at risk/vulnerable adult can be defined as a person who is aged 18 or over who needs help to protect themselves or their interests at a particular point in time, whether due to personal characteristics or circumstances, and is at risk of experiencing harm at the hands of another party. It is generally acknowledged that there are certain risk factors that may increase an adult’s likelihood of being abused by another person, for example, dependency status, disability status, health status, domestic living arrangements and/or situational factors.

A “vulnerable person” is defined in Section 1 of the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 as “a person...

(a) who—

- (i) is suffering from a disorder of the mind, whether as a result of mental illness or dementia, or
- (ii) has an intellectual disability, which is of such a nature or degree as to severely restrict the capacity of the person to guard himself or herself against serious exploitation or abuse, whether physical or sexual, by another person, or

(b) who is suffering from an enduring physical impairment or injury which is of such a nature or degree as to severely restrict the capacity of the person to guard himself or herself against serious exploitation or abuse, whether physical or sexual, by another person or to report such exploitation or abuse to the Garda Síochána or both.”¹⁴

The Adult Support and Protection (Scotland) Act 2007¹⁵(Section 3(1)) defines an ‘adult at risk’ as someone who meets all of the following three criteria - commonly known as the three-point test:

- That they are unable to safeguard their own well-being, property, rights, or other interests;
- That they are at risk of harm; and
- That because they are affected by disability, mental disorder, illness or physical or mental infirmity, they are more vulnerable to being harmed than adults who are not so affected;

Very importantly, the Act’s Code of Practice states that:

“It should be noted and strongly emphasised that the three criteria above make no reference to capacity. Capacity is not, and never should be, a consideration in the three-point test”.¹⁶

14 Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012, <https://www.irishstatutebook.ie/eli/2012/act/24/enacted/en/html>

15 <https://www.legislation.gov.uk/asp/2007/10/contents>

16 <https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2014/05/adult-support-and-protection-revised-code-of-practice/documents/00455465-pdf/00455465-pdf/govscot%3Adocument/00455465.pdf> p.13.

Adults can be at risk of harm in various settings, be it in their own homes or in the wider community. They also may be placed at risk through inappropriate arrangements for their care in a range of social or health care settings.

Risk of harm

Section 3(2) of the Adult Support and Protection (Scotland) Act 2007 defines an adult as being at risk of harm if:

- Another person’s conduct is causing (or is likely to cause) the adult harm; or
- The adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.

Adults can be at risk of harm in various settings, be it in their own homes or in the wider community. They also may be placed at risk through inappropriate arrangements for their care in a range of social or health care settings. Perpetrators of harm can include families and friends, informal and formal carers, fellow users of residential and day care services, fraudsters and members of the public.

Section 53 of the Adult Support and Protection (Scotland) Act 2007 states that “harm” includes all harmful conduct and gives the following examples:

- Conduct which causes physical harm;
- Conduct which causes psychological harm (for example by causing fear, alarm or distress);
- Unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft, fraud, embezzlement or extortion);
- Conduct which causes self-harm.

Consistency in definition and understanding

The question of definition of a vulnerable person was addressed in both the LRC Issues Paper and in the MAZAR’s Report¹⁷. The MAZAR’s Report noted that traditional terminology focused on using terms such as ‘vulnerable’ and ‘abuse’ and suggested that a number of jurisdictions are moving towards alternatives to these terms on the basis (among other reasons) of perceptions of stigma associated with the term “vulnerable” and of the concept of “abuse” lending itself to connotations that “abuse victims” have no choice or self-determination.

The MAZARS report noted that their research did not identify any published evidence to suggest certain terms work better than others and noted that each jurisdiction had developed the terminology to fit its needs. However, the research concluded that clarity on the selected terminology and the underlying definitions is crucial and that, if possible, terminology should be consistently used in legislation, policy, regulatory and practice discourses.

This Discussion Paper will use the term ‘adult at risk’ except in instances where other documents with alternative terminologies are being referenced.

17 Mazars, Phelan, A., O’Donnell, D. and Stokes, D. (2020) ‘Evidence review to inform development of a national policy on adult safeguarding in the health and social care sector: Department of Health.

While adult abuse has been recognised by many professionals, mainly in the healthcare area, as a significant concern for a number of years, there has been a wider recognition of the issue since the onset of Covid-19.

The low level of public awareness regarding adult safeguarding is compounded by the absence of any safeguarding legislation and by the limited role of HSE Safeguarding and Protection Teams.

Why a focus on safeguarding adults at risk is important and necessary

The safeguarding of vulnerable adults has come very much to the fore in recent years as an issue requiring attention at a number of levels – legislative, policy and public awareness. While adult abuse has been recognised by many professionals, mainly in the healthcare area, as a significant concern for a number of years, there has been a wider recognition of the issue since the onset of Covid-19. This is evidenced in the increase in allegations of domestic abuse, the significant risks to which nursing home residents were exposed and the issues associated with the withdrawal of social care supports and the general risks of lockdowns for adults at risk. A Red C National Poll carried out for Safeguarding Ireland¹⁸ found that approximately one-in-eight respondents had experienced abuse since the start of the Covid-19 pandemic. Earlier research showed that one in every ten Irish adults claimed to have witnessed the abuse of an adult they considered vulnerable in the previous 12 months and one-in-eight reported that they had taken no action in relation to the abuse experienced.

A November 2021 National Red C Poll carried out for Safeguarding Ireland¹⁹ found that two-thirds of people were aware of the term ‘safeguarding’ based on the definition ‘*safeguarding from adult abuse means putting measures in place to support people’s human rights and health and wellbeing, to reduce the risk of harm and to empower each person to protect themselves*’. However, only just over half of those polled said that they had understood what it meant prior to being offered the definition. Many respondents associated safeguarding with very functional roles, like providing security at care facilities, inspection and audit of health services and maintaining patient records and files, but not with its broader protection of rights aspects.

The low level of public awareness regarding adult safeguarding is compounded by the absence of any safeguarding legislation and by the limited role of HSE Safeguarding and Protection Teams.

It has been noted²⁰ that, internationally, policies addressing abuse of people with a disability tend to focus on more extreme forms of violence, sometimes at the expense of attending to the everyday indignities and insults experienced by the people concerned when receiving support. This latter point is important in that such lesser forms of abuse may actually be the ‘thin end of the wedge’ in the overall context of abuse of adults at risk and may contribute to a climate which allows for more extreme forms of abuse. Furthermore, so-called minor insults and indignities can have a cumulative effect, resulting in poor overall quality of life, anxiety and depression. This may also contribute to challenging behaviour in some instances.

18 <https://www.safeguardingireland.org/wp-content/uploads/2020/10/Incidence-of-Adult-Abuse-in-Ireland-during-COVID-19-5.10.20-FINAL.pdf>

19 <https://www.safeguardingireland.org/wp-content/uploads/2021/11/554421-Safeguarding-Ireland-Nov-2021-FINAL.pdf>

20 Recasting ‘harm’ in support: Misrecognition between people with intellectual disability and paid workers, <https://www.tandfonline.com/doi/full/10.1080/09687599.2022.2029357?scroll=top&needAccess=true>

Evolution of adult safeguarding systems

Historically, safeguarding was a concept that primarily focused on vulnerable children, older people and people with disabilities, but the concept of adult safeguarding has received a wider and increased focus in recent years.²¹ Approaches to adult safeguarding have differed in and between jurisdictions, which, in this research team’s opinion, appears to originate from the ad-hoc fashion in which safeguarding practices have developed and been designed in order to fit into each jurisdiction’s current systems, rather than being purposefully designed from the outset as a complete adult safeguarding system.

The MAZARS²² research found that gaps in adult safeguarding practice and policy can trigger scandals where harm is caused to an adult at risk. The MAZARS report noted that, where safeguarding scandals occur, they frequently act as a catalyst for new safeguarding developments or reforms to correct the issues which led to the scandal. In Ireland, scandals such as Leas Cross, Áras Attracta and, more recently, the ‘Grace’ case and the recent ‘Brandon’ case resulted in a high media profile and some political discussion. However, it remains to be seen how much and how quickly these cases result in fundamental changes to legislation, policy and practice. It should be noted that the Leas Cross case did result in the development of the HSE elder abuse service and hastened the independent inspections of all nursing homes – public and private; and that the Áras Attracta case resulted in the introduction of the HSE Policy on Safeguarding Vulnerable Persons at Risk of Abuse.

All people at risk have a right to be protected against abuse and to have any concerns regarding abusive experiences addressed. They have a right to be treated with respect and to feel safe, regardless of the setting in which they live. All adults have the right to be safe and to live a life free from abuse. All persons are entitled to this right, regardless of their circumstances.

*“It is the responsibility of all service providers, statutory and non-statutory, to ensure that service users are treated with respect and dignity, have their welfare promoted and receive support in an environment in which every effort is made to promote welfare and to prevent abuse”.*²³

The **Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures**,²⁴ which applies to all HSE and HSE funded services, outlines a number of principles to promote the welfare of vulnerable people and safeguard them from abuse. These include a requirement that all services must have a publicly declared “No Tolerance” approach to any form of abuse and must promote a culture which supports that ethos.

21 Mazars, Phelan, A., O’Donnell, D. and Stokes, D. (2020) ‘Evidence review to inform development of a national policy on adult safeguarding in the health and social care sector’: Department of Health.

22 Ibid.

23 Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures <https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf> ps.5-6.

24 Ibid. p.6.

Some of the stated principles underpinning the policy include²⁵:

- Respect for human rights
- A person-centred approach to care and services
- Promotion of advocacy
- Respect for confidentiality
- Empowerment of individuals
- A collaborative approach.

Provisions of the Assisted Decision-Making (Capacity) Act 2015

It is almost certain that the full commencement of the Assisted Decision-Making (Capacity) Act 2015 will have significant implications for the safeguarding of adults at risk in that the Act takes the presumption of capacity to another level by making provision for supported decision-making. The legal requirement to engage in supported decision-making mechanisms and related provisions envisaged in the ADMC Act 2015 provides necessary impetus and a more robust system for ensuring that people are enabled to take control of their affairs to the greatest extent possible. Guiding Principles to safeguard the autonomy and dignity of the person with reduced decision-making capacity are set out in the Act (Section 8) which states that:

- There is a presumption of decision-making capacity unless the contrary is shown
- No intervention will take place unless it is necessary
- Any act done or decision made under the Act must be done or made in a way which is least restrictive of a person's rights and freedoms
- Any act done or decision made under the Act in support or on behalf of a person with reduced decision-making capacity must give effect to the person's will and preferences.

The full commencement of the Act will, it is hoped, bring added and clearer emphasis to the public, institutional and legal awareness of the rights of adults at risk, the range of behaviours that constitute abuse the need for stronger safeguarding measures and access to independent advocacy.

The legal requirement to engage in supported decision-making mechanisms and related provisions envisaged in the ADMC Act 2015 provides necessary impetus and a more robust system for ensuring that people are enabled to take control of their affairs to the greatest extent possible.

²⁵ Ibid. ps.13-14

In 2019 the Law Reform Commission (LRC) published an Issues Paper, A Regulatory Framework for Adult Safeguarding which was the subject of public consultation. The Commission is currently preparing a report on the topic which is due to be published in 2022.

Safeguarding and Protection Teams have an important role to play in addressing all concerns of abuse in circumstances where a service, professional or family members believes there are concerns about bad practice, and act as a mechanism for reporting any such concerns.

Safeguarding adults at risk: Work of the Law Reform Commission

In 2019 the Law Reform Commission (LRC) published an Issues Paper, **A Regulatory Framework for Adult Safeguarding** which was the subject of public consultation. The Commission is currently preparing a report on the topic which is due to be published in 2022. The LRC previously completed work in this general area, including its 2006 report on vulnerable adults and the law²⁶, which recommended the replacement of the adult wardship system with legislation on adult capacity based on a functional test of capacity. These recommendations are largely reflected in the Assisted Decision-Making (Capacity) Act 2015.

The work of the LRC in this area involves exploring the many intersecting aspects and areas of law and includes identifying regulatory gaps and recommending that additional regulatory powers may need to be conferred on an existing body or bodies, or that a new body may need to be established, as well as possible recommendations regarding regulatory oversight functions, such as whether a body should have the power to deal with individual complaints as opposed to regulating systems.

The LRC is also considering possible recommendations on criminal offences where gaps in the law are identified, as well as specific measures relating to financial abuse, safeguarding powers and duties, and reporting models where suspected and indeed, actual abuse or neglect are encountered. Independent advocacy, inter-agency collaboration and information-sharing have all been identified by the Commission as relevant factors in order to ensure that assessment of the law in this area is comprehensive and that the recommendations made are solutions-focused, practical and workable, and provide adults at risk of abuse and neglect with the best possible legal protections within a comprehensive regulatory framework.²⁷

HSE Safeguarding and Protection Teams

HSE Safeguarding and Protection Teams are in place all over the country and work with services, families and community organisations to stop abuse and to ensure that people are safeguarded. These teams can be contacted through local HSE Community Healthcare Organisation Areas (CHO).

Safeguarding and Protection Teams have an important role to play in addressing all concerns of abuse in circumstances where a service, professional or family members believes there are concerns about bad practice, and act as a mechanism for reporting any such concerns.

²⁶ https://www.lawreform.ie/_fileupload/Reports/Report%20Vulnerable%20Adults.pdf

²⁷ LRC Presentation to the Oireachtas Joint Committee on Health, 16 February 2021, https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2021-02-16/2/

The underlying rationale for the Safeguarding Teams is that all adults have the right to be safe and to live a life free from abuse regardless of their circumstances. They have a right to be treated with respect and to feel safe, regardless of the setting in which they live.

The research underlying this Paper has identified areas in which workers involved with safeguarding have reported concerns and uncertainty regarding their authority and legislative basis for undertaking various safeguarding actions.

The underlying rationale for the Safeguarding Teams is that all adults have the right to be safe and to live a life free from abuse regardless of their circumstances. They have a right to be treated with respect and to feel safe, regardless of the setting in which they live.

The **Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures**, which applies to all HSE and HSE funded services, outlines a number of principles to promote the welfare of vulnerable people and safeguard them from abuse, including, in particular, respect for human rights and empowerment of individuals. All vulnerable people have a right to be protected against abuse and to have any concerns regarding abusive experiences addressed.

Safeguarding within a human-rights framework

In recent years, there has been a concerted effort to position safeguarding within a human rights framework which complies with both the UN Universal Declaration on Human Rights, the UN Convention on the Rights of Persons with Disabilities and the Istanbul Convention on preventing and combating violence against women and domestic violence.²⁸ The UN and Council of Europe Conventions promote, protect and ensure the full and equal enjoyment of all human rights and provisions detailed within specific human rights or anti-discrimination legislation. In Ireland, HIQA and the Mental Health Commission have stated that “*safeguarding means putting measures in place to promote and protect people’s human rights and their health and wellbeing, and empowering people to protect themselves*”²⁹ and have emphasised the need for a person-centred perspective in developing adult safeguarding standards.

Balance between right to autonomy and protection

The increasing and welcome human rights approach noted above has important implications for the development of legislation that will act as a framework for the design and practice of safeguarding of adults at risk in Ireland. It also draws attention to some of the tensions that will need to be resolved in reaching a balance between potentially competing human rights.

The research underlying this Paper has identified areas in which workers involved with safeguarding have reported concerns and uncertainty regarding their authority and legislative basis for undertaking various safeguarding actions. These concerns include issues such as the balance between autonomy and intervention in cases of self-neglect, limits of access to private properties and institutions, and how capacity can be determined where access to adults at risk is denied.

These issues are explored further throughout the Paper.

²⁸ <https://rm.coe.int/168008482e>

²⁹ National Standards for Adult Safeguarding, <https://www.mhcirl.ie/sites/default/files/2021-01/NATIONAL%20STANDARDS%20for%20adult%20safeguarding.pdf> p.8

Barriers to adults at risk disclosing abuse

The **Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures**³⁰ notes that barriers to disclosure of abuse may occur due to some of the following:

- Fear on the part of the service user of having to leave their home or service as a result of disclosing abuse.
- A lack of awareness that what they are experiencing is abuse.
- A lack of clarity as to whom they should talk.
- Lack of capacity to understand and report the incident.
- Fear of an alleged abuser.
- Ambivalence regarding a person who may be abusive.
- Limited verbal and other communication skills.
- Fear of upsetting relationships.
- Shame and/or embarrassment.

It is evident that the prevalence of abuse is highly likely to be underestimated, or at least under-reported, as a result of these barriers to disclosure. There is also the probability that a restricted and blinkered understanding across society of what constitutes abusive behaviour also results in under-reporting and in a continued infringement of the human rights, quality of life and personal dignity of many adults at risk. These issues are explored further throughout the Paper.

Overview

This introductory chapter has described the objectives and context of the research and the methodology used in carrying out the work. It has set out the overall context within which the matter of safeguarding adults at risk needs to be considered. Some of the questions relating to terminology and definitions have been discussed.

This Paper identifies the multi-faceted nature of abuse and exploitation of adults at risk in Ireland and the infrastructural, legislative and policy changes needed to address the issue.

It argues for a significantly enhanced role for the State in reducing the risk of harm and highlights the need for more robust regulation and meaningful inter-agency working.

The next chapter will discuss the current safeguarding regulatory system in Ireland.

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It argues for a significantly enhanced role for the State in reducing the risk of harm and highlights the need for more robust regulation and meaningful inter-agency working.

³⁰ <https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf>, P.20

/ Chapter Two³¹

Current Safeguarding and Regulatory Framework in Ireland: Existing Provisions and Main Shortcomings

The purpose of this chapter is to provide a synthesis of the current safeguarding and regulatory framework in Ireland and to identify its main shortcomings and regulatory gaps. First, the chapter provides an overview of existing legislation and regulations. Second, it examines the existing regulatory framework from the perspective of safeguarding adults at risk and identifies the main shortcomings of that framework.

³¹ This Chapter was authored by Niamh Ní Leathlobhair BL.

The quality and effectiveness of safeguarding provision in Ireland is heavily influenced by the regulatory framework that exists at present.

The quality and effectiveness of safeguarding provision in Ireland is heavily influenced by the regulatory framework that exists at present. The regulatory framework defines, authorises and limits the rights and obligations of people, organisations and agencies involved in safeguarding adults at risk. In particular, the regulatory framework provides a basis for those rights and obligations, and also defines and limits the availability of redress in law and the powers of people, organisations and agencies to act with a view to safeguarding adults at risk.

The rights and protections provided for adults at risk include those that are specifically aimed at persons who are at risk of abuse and exploitation, and those that are applicable to all citizens. Organisations and individuals tasked with safeguarding retain powers and are subject to limitations that apply generally and are not specifically tailored for use in the context of safeguarding.

The safeguarding regulatory framework includes constitutional provisions, international instruments, legislation and case law, as well as “soft law” in the form of standards, guidance and codes. It encompasses elements of both civil and criminal law. Bills of the Oireachtas are not strictly part of the regulatory framework but are listed in this chapter because they provide context for, and are relevant to, the process of law reform in the area of safeguarding. To assess the extent to which the framework is adequate and fit-for-purpose, it is necessary to consider how well it sets out the rights of persons at risk and allocates responsibilities and powers to the people and agencies responsible for undertaking safeguarding measures.

Current framework

Constitution – Bunreacht na hÉireann

- Article 40.1 “All citizens shall as human persons be held equal before the law. This shall not be held to mean that State shall not in its enactments, have **due regard to differences of capacity, physical and moral, and of social function.**” (emphasis added).
- Article 40.3.2° “The state shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and **property rights** of every citizen.” (emphasis added).
- Article 40.4.1° “No citizen shall be deprived of his personal liberty save in accordance with law.”
- Article 40.5 “The dwelling of every citizen is inviolable and shall not be forcibly entered save in accordance with law.”

International Instruments

- UN Convention on Rights of Persons with Disabilities, ratified by Ireland in 2018.
- European Convention on Human Rights (ECHR).

Legislation relating to health and decision – making capacity

- Assisted Decision Making (Capacity) Act 2015 (not fully commenced).
 - The Decision Support Service was established in October 2016 and is due to be operational in mid-2022.
 - Section 7(2) and Part 6 (sections 53 – 57), which repeal the Lunacy Regulation (Ireland) Act 1871 and provide for phasing out of the wardship system and its replacement, are not yet commenced.
- Lunacy Regulation (Ireland) Act 1871.
- Powers of Attorney Act 1996.
- Mental Health Act 2001.
- Health Acts 1947 – 2020.
 - In particular, the Health Act 2007, and the regulations made thereunder, including the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (S.I. No. 415 of 2013).
- Citizens Information Act 2007.
 - Section 5 provides for personal advocates but has not been commenced.

*Legislation relating to different types of abuse***Physical and psychological abuse**

- Domestic Violence Act 2018.
- Non-Fatal Offences Against the Person Act 1997.
- Prohibition of Incitement to Hatred Act 1989.

Sexual abuse

- Criminal Law (Rape) Act 1981.
- Criminal law (Rape) (Amendment) Act 1990.
- Criminal Justice (Sexual Offences) Act 2017, Part 3.
- Harassment, Harmful Communications and Related Offences Act 2020.

Financial abuse

- Criminal Law (Theft and Fraud Offences) Act 2001.
- The Central Bank and the Competition and Consumer Protection Commission (CCPC) provide regulatory and legislative protection for customers pursuant to the following statutory provisions:
 - Central Bank Acts 1942 – 2018;
 - Investment Intermediaries Act 1995;
 - The European Communities (Unfair Terms in Consumer Contracts) Regulations 1995;
 - Competition and Consumer Protection Act 2014.
- Financial Services and Pensions Ombudsman Act 2017.

Discrimination

- European Convention on Human Rights Act 2003.
- Equal Status Acts 2000 – 2018.
- Prohibition of Incitement to Hatred Act 1989.

Powers of entry and inspection

- Criminal Law Act 1997, section 6.
- Mental Health Act 2001.
- Domestic Violence Act 2018.
- Criminal Justice (Miscellaneous Provisions Act) 1997, as amended by the Criminal Justice Act 2006.
- Common law powers of entry and inspection: Entick v Carrington (1765) 16 State Trials, 2 Wills 275; DPP v Delaney [1997] 3 IR 453.

Mandatory reporting

- Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012.
- Criminal Justice Act 2011, section 19.

Information sharing

- Data Protection Act 1988.
- Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012.
- Criminal Justice Act 2011, section 19.
- General Data Protection Regulation (EU) 2016/679.
- Data Protection Act 2018.
- Law Enforcement Directive (EU) 2016/680.
- Data Sharing and Governance Act 2019.
- National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Case law/Precedent

- AC and Others v Cork University Hospital [2019] IESC 73.
 - Important guidance for HSE and medical professionals on the application of principles concerning decision – making capacity. Specifically, guidance as to the appropriate steps to take when determining whether a patient should remain or be discharged from hospital.
- Re a Ward of Court (No. 2) [1995] IESC 1.
 - Authority for the principle that loss of an individual's decision-making capacity does not result in a diminution of the personal rights recognised by the Constitution in Article 40.3.

General Civil law

- Tort law.
 - Liability in negligence can result in an award of damages against a person, for example, a family member or professional home carer who is guilty of neglect or acts of omission. Such an award may be made only if it is established that the person owed a duty of care to an adult at risk, that the duty was breached and that the breach resulted in harm to the adult at risk. This is merely a remedy and does not assist in detecting or preventing harm.
- Contract law.
 - Liability for breach of contract can result in an award of damages against a person, where that person was under a contractual duty to care for an adult at risk and the person breaches that contractual duty. This is merely a remedy and does not assist in detecting or preventing harm.

Regulatory bodies with relevant responsibilities

- Department of Health.
- Health Information and Quality Authority (HIQA).
- Mental Health Commission (MHC).
- Health Service Executive (HSE).
- Director of Decision Support Service (due to be operational in mid-2022).
- Central Bank of Ireland.
- Department of Social Protection.

Guidelines and Standards (Soft Law)

- HSE, **Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures, 2014.**
- HIQA and Safeguarding Ireland, **Guidance on a Human Rights – based Approach in Health and Social Care Services, 2019.**
- HIQA and Mental Health Commission, **National Standards for Adult Safeguarding, 2019.**
- HIQA, **National Standards for Residential Care Settings in Ireland, 2016.**
- Central Bank of Ireland, **Consumer Protection Code, 2012.**

Bills of the Oireachtas

- Assisted Decision-Making (Capacity) (Amendment) Bill 2021 (General Scheme of Bill approved by cabinet).
- Adult Safeguarding Bill 2017 (Seanad Third Stage – restoration to order paper in Seanad on 5 March 2021).
- Health (Amendment) (Professional Home Care) Bill 2020 (Dáil Second Stage completed on 21 July 2020).

- Disability (Miscellaneous Provisions) Bill 2016 (lapsed with dissolution of Dáil and Seanad on 14 January 2020).

Main shortcomings of the existing framework

The following shortcomings are interlinked because they arise due to a legislative void in terms of authority to act effectively in safeguarding situations.

1. No uniform framework for regulating safeguarding across all settings or contexts.

The regulatory landscape in this jurisdiction emphasises the physical place where care happens, rather than the type of care provided, or the needs of the people receiving the care. This makes it difficult to achieve a consistent approach to safeguarding across all settings. Some settings, such as formal homecare and day services, are completely unregulated.³² The lack of regulation creates a difficulty establishing a culture of safeguarding in those settings at all. Other settings, such as nursing homes and other residential care facilities, benefit from some protection afforded by regulation, but are not subject to robust safeguarding procedures.

The HSE *National Policy & Procedures* are limited in scope to HSE-owned or run services and are mainly limited to services for older people and people with disabilities. HIQA's remit is also limited to health and social care settings. Even within those settings, HIQA's remit relates only to the facility itself, rather than individual safeguarding concerns that arise within the facility. Chapter 5 of this Paper considers the general issues involved in relation to safeguarding in residential settings Chapter 10 of the Paper explores the potential of the social support infrastructure in safeguarding adults at risk. That chapter identifies the key actors involved in the life of an adult at risk. The categories of key actors span a wide spectrum of entry points to an at risk adult's life. The range of settings and contexts in which it may be possible to identify, detect and safeguard against a risk posed to an adult at risk are outlined in that chapter. The wide range of settings and relationships considered in that chapter underlines the importance of establishing and facilitating a culture of safeguarding across all relevant settings or contexts.

The lack of a framework for regulating safeguarding across all settings is an obstacle to identifying, preventing, investigating and stopping abuse or neglect in home care settings, in residential care facilities and in situations where an adult at risk is not in receipt of care services. Relatedly, there is currently no statutory provision for a care plan where adults at risk are in receipt of safeguarding services in the community.

³² HIQA, The Need for Regulatory Reform, A summary of HIQA reports and publications examining the case for reforming the regulatory framework for social care services, February 2021, <https://www.hiqa.ie/sites/default/files/2021-02/The-Need-for-Regulatory-Reform.pdf> at page 19.

2. Limited form of protection afforded by current regulation of nursing homes.

A main shortcoming of the current regulatory and safeguarding framework is the limited form of protection afforded to adults at risk of abuse or neglect in nursing homes. The nursing home sector is regulated by HIQA, whose regulatory powers relate to information and quality standards generally, rather than being focused on the specific issue of safeguarding vulnerable adults at risk in residential care facilities.

Section 8(1)(b) of the Health Act 2007 provides for HIQA's function to set standards in relation to the services provided by the HSE, the Child and Family Agency and certain service providers,³³ including nursing homes. HIQA also has a function in monitoring compliance with such standards³⁴ and undertaking investigations as to the safety, quality and standards of the services within its remit.³⁵ HIQA engages with registered service providers and inspects nursing homes to ensure compliance with standards and also conducts ongoing monitoring of information (both solicited and unsolicited). Where there is a failure to comply with standards, HIQA's focus is on how service providers respond to inspection findings and what actions can be taken to bring the provider into compliance.

HIQA published its **National Standards for Residential Care Settings for Older People in Ireland** in 2016. The *Standards* are designed to focus on outcomes which enhance the ability of people to participate in, and contribute to, daily life and this includes safeguarding and protecting people from abuse.³⁶ HIQA's role in safeguarding adults at risk from abuse is limited to doing so through ensuring compliance with quality standards more generally. To the extent that HIQA has a role in safeguarding adults at risk in nursing homes, this role is secondary to its primary purpose of ensuring the nursing home complies with quality standards.

Importantly, HIQA has no investigative powers over individual cases in the way the Child and Family Agency (TUSLA) has in the context of child protection, for example. HIQA is unable to investigate individual complaints about a health or social care service under the Health Act 2007.³⁷ Section 9(1) of the Health Act provides that HIQA may undertake an investigation as to the safety, quality and standards of the services in relation to which it sets standards pursuant to section 8(1)(b). The Health Act 2007 permits HIQA to investigate the service itself, but does not provide a legal mechanism for HIQA to investigate individual complaints. Section 9(2) provides that the Minister may require HIQA to undertake an investigation where he or she believes on reasonable grounds that: (1) there is a serious risk to the health or welfare of a person in receipt

33 HIQA may set standards in relation to services provided by service providers in accordance with: (1) the Health Acts 1947 to 2011, except for services under the Mental Health Acts 1945 to 2009 that, under the Health Act 2004, are provided by the HSE; (2) the Child Care Acts 1991 to 2013; (3) the Children Act 2001, and (3) services provided by a nursing home as defined in section 2 of the Health (Nursing Homes) Act 1990.

34 Section 8(1)(c) of the Health Act 2007.

35 Section 9(1) of the Health Act 2007.

36 HIQA, *National Standards for Residential Care Settings in Ireland*, 2016, page 8.

Standard 3.1 relates to safeguarding adults at risk, and is set out at pages 14 and 47.

37 Section 9 of the Health Act 2007.

of health care services in a nursing home,³⁸ and; (2) the risk is as a result of any act, failure or negligence by the HSE,³⁹ a HSE funded service provider,⁴⁰ a provider of a designated centre of a certain type,⁴¹ or the person in charge of such a designated centre.⁴²

A main shortcoming of the current regulatory and safeguarding framework is the absence of any statutory provision providing a procedure for the investigation of individual safeguarding complaints in residential care facilities. There is no statutory provision for HIQA, the HSE or independent advocates to investigate individual safeguarding complaints in nursing homes. Where HIQA receives unsolicited complaints, it uses that information to establish whether there is a risk to the safety, effectiveness and management of a particular service, but does not use information to investigate individual complaints of abuse or neglect. Relatedly, HSE Safeguarding and Protection Teams do not have a right of access to private nursing homes. Standard 1.6 of HIQA's **National Standards for Residential Care Settings for Older People in Ireland** requires that each resident has access to an advocate. However, the reference to advocate is limited to those provided for in the Assisted Decision-Making (Capacity) Act 2015⁴³ and does not appear to extend to advocates operating outside that scheme. Moreover, there is no legislative provision for access by independent advocates to nursing homes.

The Department of Health's **Covid-19 Nursing Homes Expert Panel Report** (August 2020) outlines that the Expert Panel received submissions which identified a need to: (1) provide an integrated system of support for older persons' care needs regardless of location, under a single source of funding, and; (2) integrate private nursing homes into the wider framework of public health and social care.⁴⁴

38 This provision applies to a person in receipt of services within the meaning of section 8(1)(b) of the Health Act 2007. It includes services provided by the HSE, by the Child and Family Agency and by certain service providers who provide services in accordance with: (1) the Health Acts 1947 to 2011, except for services under the Mental Health Acts 1945 to 2009 that, under the Health Act 2004, are provided by the HSE; (2) the Child Care Acts 1991 to 2013; (3) the Children Act 2001, and (3) services provided by a nursing home as defined in section 2 of the Health (Nursing Homes) Act 1990.

39 Section 9(1)(b)(i).

40 Section 9(1)(b)(iii). The Minister may require an investigation where he or she has reasonable grounds to believe that the risk arises due to any act, failure or negligence on the part of a service provider within the meaning of paragraphs (a) and (b) of the definition in section 2(1). This includes a service provider providing services on behalf of the HSE pursuant to an arrangement under section 38 of the Health Act 2004, or a service provider in receipt of assistance under section 39 of the Health Act 2004.

41 Section 9(1)(b)(v). The Minister may require an investigation where he or she has reasonable grounds to believe that the risk arises due to any act, failure or negligence on the part of a registered provider of designated centre to which paragraphs (a)(ii), (iii) or (c) of the definition of designated centre in section 2 applies. The definition of a designated centre at paragraph (a) includes "an institution at which residential services are provided by the HSE, the Child and Family Agency, a service provider under the Health Act 2007 or a person that is not a service provider but who receives assistance under section 39 of the Health Act 2004, to: (ii) persons with disabilities, in relation to their disabilities, or; (iii) other dependent persons, in relation to their dependencies." The definition of a designated centre at paragraph (c) includes nursing homes.

42 Section 9(1)(b)(vii).

43 HIQA, *National Standards for Residential Care Settings in Ireland*, 2016, page 26.

44 Department of Health, *Covid 19 Nursing Homes Expert Panels Report* (August 2020), at page 81.

The Report points out that the current model of private residential care for older persons has no formal clinical governance links to the wider HSE and that more formalised links would facilitate better national oversight of the care delivered to frail older people.⁴⁵ The report further outlines that the COVID-19 pandemic has highlighted challenges in relation to nursing home governance and the roles and responsibilities of the major stakeholders, including the Department of Health, HSE (especially the Health Protection Surveillance Centre and public health), HIQA and private nursing home providers.⁴⁶ It was also reported that a number of key stakeholders interviewed sought clarity on who was in charge of the wider private nursing homes system.⁴⁷

3. Absence of regulation of home care services.

A main shortcoming of the current regulatory and safeguarding framework is the complete absence of regulation of the home care sector.⁴⁸ The Law Reform Commission's **Report on the Legal Aspects of Professional Home Care**,⁴⁹ and HIQA's *Research Report and Position Paper* on the regulation of home care,⁵⁰ emphasised the pressing need to regulate the provision of professional home care services in this jurisdiction. In contrast to its role in setting standards and monitoring compliance in nursing homes, residential care facilities and other health and social care settings, HIQA has no involvement in regulating the home care sector, even where home care is funded by the HSE.

The absence of regulation raises three particular difficulties: (1) there is no harmonisation of safeguarding policies and standards across different home care service providers; (2) there is no statutory basis for monitoring compliance with safeguarding standards in home care settings; and (3) relatedly, there is no statutory framework for detecting and investigating risks of abuse or neglect in home care settings, or for implementing a care plan to safeguard adults from such risks.

Home care services for people with disabilities and older people are delivered through a range of providers, including the HSE, voluntary not-for-profit organisations and private for-profit services. The HSE funds home care by providing it directly, or through service providers that are commissioned or assisted by the HSE. Where home care is provided directly by the HSE, the HSE **Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures**, apply directly.⁵¹ Where home care is provided by a service provider commissioned by the HSE, the service arrangement will require that providers adhere to HSE policies

45 Department of Health, Covid 19 Nursing Homes Expert Panels Report (August 2020) at page 81.

46 Department of Health, Covid 19 Nursing Homes Expert Panels Report (August 2020), at page 81.

47 Department of Health, Covid 19 Nursing Homes Expert Panels Report (August 2020), at page 86.

48 The lack of regulation of professional home care services was emphasised by the Law Reform Commission in its 2011 Report.

49 Law Reform Commission, Report on the Legal Aspects of Professional Home Care, LRC 105 – 2011, https://www.lawreform.ie/_fileupload/Reports/r105.htm

50 HIQA, Regulation of Home Care: A Position Paper, and Regulation of Home Care: Research Report, December 2021.

51 The HSE, Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures, 2014, at page 6 sets out the scope of the Policy and sets out that it applies to public funded service providers, across all service settings, including domestic settings.

and procedures, and define the requirement for safeguarding and protection.⁵²

The current system for oversight of professional home care provision is inadequate, in part because the HSE is both the provider and commissioner of services.⁵³ For home care provided directly by the HSE, compliance with standards is monitored by the HSE itself. This monitoring occurs through engagement directly with service users and a complaints process directed to the HSE.⁵⁴ For home care services commissioned by the HSE, monitoring occurs through engagement with the service provider, who supplies the HSE with data relating to its compliance with the standards required by the service arrangement.⁵⁵ In its *Position Paper*, HIQA reported a perception among homecare providers and advocates that the HSE is proxy regulator through its agreements with homecare providers and that the HSE's own homecare provision is not subject to the same level of scrutiny as non-public homecare organisations.⁵⁶

In addition to HSE home care and HSE commissioned home care, there are many private entities providing home care without any regulation whatsoever. This includes private entities that provide services for profit and not-for-profit voluntary organisations that rely on donations. There is no regulatory barrier to entering the home care sector in Ireland.⁵⁷ Where organisations provide homecare without HSE funding, there is no requirement to comply with HSE standards or policies and procedures. In theory, organisations can provide any type of homecare.⁵⁸ Many private home care providers are members of Home and Community Care Ireland (HCCI). The HCCI is an umbrella organisation that represents a number of private homecare providers in Ireland. The HCCI *Home Care Standards* includes provisions directed at protecting recipients of homecare from abuse and exploitation,⁵⁹ but the *Standards* apply only to members of the HCCI who are not subject to any independent oversight or regulation. It is also possible for people without any relevant training or qualification to advertise home care services on an individual "cash for care" or "black market" basis, without going through any organisation.⁶⁰ Such individual arrangements would not be subject to even the limited form of protection afforded to adults at risk by the policies and standards in place when receiving home care from HSE funded services or HCCI members.

In addition to home care provided by HSE funded entities, voluntary organisations and private services providers, home care can also be provided on an informal basis by family, friends, neighbours and acquaintances of an adult at risk. It is possible for such home care to be provided for free on a voluntary basis, for payment (sometimes in cash), or in the expectation of obtaining an advantage or favour in return for

52 HIQA, Regulation of Homecare: Research Report, December 2021, pages 33 – 34.

53 HIQA, Regulation of Home Care: A Position Paper, December 2021, at page 5.

54 HIQA, Regulation of Homecare: Research Report, December 2021, pages 32 – 33.

55 HIQA, Regulation of Homecare: Research Report, December 2021, pages 33 – 34.

56 HIQA, Regulation of Home Care: A Position Paper, December 2021, at page 5.

57 HIQA, Regulation of Homecare: Research Report, December 2021, page 35.

58 HIQA, Regulation of Homecare: Research Report, December 2021, page 35.

59 HCCI, National Standards for the Provision of Home Care Support Services, Standard

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60 HIQA, Regulation of Homecare: Research Report, December 2021, page 39.

providing such care. Home care services can also be provided by the HSE, voluntary organisations, private providers and private individuals concurrently, in a hybrid manner. This gives rise to challenges in information sharing between the various individuals and organisations involved with the care of an adult at risk, which, in turn, can create difficulties identifying and resolving safeguarding concerns.

The absence of any oversight and independent assurance as to the quality and standards of home care provision⁶¹ exposes adults at risk in receipt of home care services to the risks of abuse, neglect and harm. The lack of regulation also has implications for identifying risks posed to vulnerable adults in home care settings and devising and implementing care plans to safeguard against those risks. There is no provision for independent inspection of home care service providers, or investigation of complaints relating to safeguarding concerns. There are no statutory provisions or policy standards regarding the need for a care plan for adults in receipt of home care services. Relatedly, there are no powers of entry and inspection of private dwellings where it is suspected that an adult is at risk of harm.

4. No regulatory body with responsibility for receiving complaints of all types of abuse (physical, psychological, emotional, or financial abuse and neglect).

The absence of a dedicated regulatory safeguarding body results in a lack of clarity as to who, exactly, a particular safeguarding concern should be reported to. It risks a silo approach to safeguarding, whereby each agency potentially addresses the safeguarding concern that falls within its own remit in isolation, without regard to the possibility that there may be other safeguarding concerns arising from the same circumstances. There is also a risk that a safeguarding concern might not be reported to or reach the appropriate agency. For example, safeguarding concerns might be reported to An Garda Síochána by a concerned person, even though a social work approach might be more appropriate than law enforcement. The absence of an overarching regulatory body to receive complaints also creates the risk that a safeguarding concern is reported to the incorrect agency initially and is not successfully passed on.

The regulatory agencies outlined above are limited by law as to the steps they can take to investigate and address a safeguarding complaint and would only be empowered to take steps relating to their own sphere of activity. There is also no legislative basis for individual agencies, such as the HSE, to rely on safeguarding as a justification to compel another agency to exercise powers within that agency's remit to take steps necessary for addressing safeguarding concerns. Safeguarding often involves multiple forms of abuse or welfare concerns. For example, financial abuse is often accompanied by physical abuse or psychological abuse in the form of coercion. The Department of Social Protection or the private financial institution concerned would be in a position to take steps relating to the person's finances but have no legal authority to act on foot of concerns regarding other forms of abuse, unless they suspect that certain offences have been committed against the adult at risk. Chapter Four of this report considers financial abuse.

61 HIQA, Regulation of Homecare: Research Report, December 2021, pages 25, 43 and 162.

The establishment of a dedicated safeguarding body to oversee and co-ordinate inter agency collaboration on safeguarding issues would facilitate a nuanced, multi-dimensional approach to safeguarding and clarify the pathway for making complaints.

5. No regulatory body with responsibility for, and powers to, investigate individual cases of abuse reported.

There is a lack of a dedicated safeguarding regulatory body and legislative tools to identify, investigate and address concerns that an adult is at risk. The regulatory bodies listed above have investigative powers only in relation to matters within their remit. For example, HIQA's investigative role is limited to inspecting quality and standards in residential facilities. It can act on foot of complaints to investigate the facility itself but has no power to investigate individual complaints or cases around safeguarding. The HSE Safeguarding and Protection Teams would be unable to effectively investigate financial abuse without co-operation from the financial institution concerned, or the Department of Social Protection. Information sharing between agencies is an important investigative tool, but there is inadequate provision for it in data protection law. Chapter 8 of this Paper addresses the legal bases that can be invoked under data protection law to share information relevant to safeguarding.

In terms of legislative tools, the Mental Health Act 2001 provides for a power of removal, detention in an approved centre and assessment by medical professionals in limited circumstances where An Garda Síochána have reasonable grounds to believe that a person is suffering from a mental disorder and that, because of the mental disorder, there is a serious likelihood of that person causing harm to himself, or herself, or others. There is no general legislative power to remove, detain or assess an adult in a safeguarding situation where the adult does not have a mental health issue. There is some debate as to the appropriateness of legislating for powers of entry and inspection to investigate and address neglect and abuse in home care settings.⁶² Sometimes, the more effective and sustainable way of resolving safeguarding concerns about an adult at risk in a home care setting is to gain access by consent. This can be difficult in situations where a family member of the adult at risk is blocking access to them, such that it is difficult to establish the extent to which the adult is at risk and / or has capacity. Access can sometimes be achieved by deploying social work skills to persuade the adult at risk and often their relative or care giver, to engage with the Safeguarding and Protection Team. Often the person suspected to be perpetrating the abuse is the person blocking access to the vulnerable person. In limited circumstances, this can potentially be addressed by an order barring the potential perpetrator from the home of the person at risk, to provide an opportunity for professionals to interview the person at risk in private.

Legislation in other jurisdictions provide for safeguarding investigative tools. In Scotland, the Adult Support & Protection (Scotland) Act 2007 imposes duty on a local council to make inquiries as to an at risk

62 Law Reform Commission, Issues Paper: A Regulatory Framework for Adult Safeguarding, at page 107.

person's well-being, property or financial affairs where it knows or believe the person is an adult at risk and that it might need to intervene to protect the person's well-being (section 4). Section 8 provides a power of interview and section 9 provides for power to conduct a medical examination. Assessment orders under section 11 allow the local council to take a specified person from a place being visited in order to allow for an interview with the person or to conduct a medical exam of the person in private. There are similar provisions in England and Wales.⁶³

6. No framework to facilitate inter-agency co-operation and collaboration.

Inter-agency collaboration in relation to safeguarding is possible under the current regulatory framework, but it is not facilitated. One particular obstacle is information sharing between agencies. There is a perception that the General Data Protection Regulation is a barrier to inter agency information sharing in relation to safeguarding concerns. Section 3 of the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012 provides that a person is guilty of an offence if they: (a) know or believe that an offence of false imprisonment, rape, sexual assault or assault causing harm, has been committed by another person against a vulnerable person, and; (b) have information, which they know or believe might be of material assistance in securing apprehension, prosecution or conviction of the other person for that offence, and fails without reasonable cause to disclose that information as soon as practicable to a member of the Garda Síochána. An important shortcoming of this provision is that it doesn't compel the sharing of information to or between agencies relating to various acts of abuse, omission or neglect, psychological abuse and financial abuse. Chapter 8 below explores further the issues surrounding data sharing.

7. No dedicated statutory provision for safeguarding.

The absence of targeted safeguarding legislation is a main shortcoming in the current regulatory regime and raises a number of difficulties. Safeguarding measures require a legislative basis to ensure that they are fully implemented. It is difficult to enforce the current standards in the absence of any legislative basis for doing so. The HSE *National Policy & Procedures*, HIQA and MHC *National Standards*, and HIQA and Safeguarding Ireland *Guidance* are regarded as soft law and are perceived as having little teeth.⁶⁴ The absence of a legislative basis causes concern among stakeholders that there are limits to the measures they can take to ensure adequate safeguarding.⁶⁵ There is consensus among stakeholders that dedicated safeguarding legislation is vital to achieve an adequate standard of safeguarding.⁶⁶ The Oireachtas Joint Committee on Health recommended that there be no unnecessary delay in implementing legislation on adult safeguarding.⁶⁷

⁶³ Care Act 2014, section 42 and Social Services and Well-being (Wales) Act 2014, section 127.

⁶⁴ Áras Attracta Swinford Review Group, Time for Action – priority actions arising from national consultation, July 2016, at page 4.

⁶⁵ Joint Oireachtas Committee on Health, Report on Adult Safeguarding (2017), at page 9.

⁶⁶ The Department of Health, SAGE, Inclusion Ireland and other entities concerned with safeguarding have acknowledged the need for legislation.

⁶⁷ Joint Oireachtas Committee on Health, Report on Adult Safeguarding (2017), at page 7.

There is an absence of legislative provision for the detection, investigation and prevention of abuse, other than by way of reporting criminal offences and pursuing prosecution. A further difficulty is that the legislative provisions outlined above are of general application and do not necessarily capture all the circumstances in which safeguarding concerns arise. For example, the scope of protected characteristics under the Prohibition on Incitement to Hatred Act 1989 is relatively limited and doesn't cover incitement of hatred on the basis of age, disability or reduced capacity. Provisions of general application can be a blunt tool. They do not necessarily facilitate the nuance required in complex safeguarding situations, where there are often issues as to decision – making capacity and possible tension between the preferences of an adult at risk and the measures that would most effectively protect them from harm. For example, existing legislation addresses various forms of abuse through criminal law. While this punishes abuse where there is a conviction and might also provide a deterrent effect, it does not provide for the detection and prevention of abuse. Moreover, prosecution for a criminal offence is not the appropriate approach in situations where the adult at risk wishes to maintain a good relationship with the perpetrator of the abuse.

The absence of dedicated legislation also means there is a lack of consistent legal definitions for terms relevant to the safeguarding context (for example terms such as “financial abuse”, “harm”, “vulnerable”, “at risk”).

Ideally, there should be a global, rather than silo, approach to the introduction of dedicated safeguarding legislation. It should address all aspects of safeguarding across all settings and contexts, to include all forms of abuse and neglect provide for information sharing and co-operation among the individuals and agencies involved with safeguarding, and multi-agency collaboration between public and private entities.

8. No statutory provision for independent advocacy services.

Access to independent advocacy is crucial for empowering an adult at risk to participate in decisions relating to their own safeguarding and care. Independent advocacy is discussed in detail in Chapter 9 of this report. Provision for non-directed or non-instructed advocacy is vital in a safeguarding context because a person might have reduced capacity. Many adults face challenges in asserting their rights and in having their preferences heard and taken into account when decisions about their care are being made by professionals or family members. It is, therefore, important that they have an advocate who is structurally, financially and psychologically independent of the health / social care provider and the family and whose sole interest is to assist the adult at risk in having their own views heard. The role of an advocate is distinct from the relatively paternalistic role of a Committee in wardship proceedings, because it is the advocate's role to assist the person in having their own views and desires heard rather than to act in the person's “best interests”. Independent advocates who check in regularly with adults at risk might also be in a position to identify abuse or neglect in residential facilities or homecare settings that might otherwise go undetected. Independent advocacy could be an alternative to mandatory reporting which better respects the dignity and autonomy of the person at risk.

There is currently no legislative basis for independent advocacy, including no legislative right of access to an advocate. Section 5 of the Citizen Information Act 2007 provides for the establishment of a Personal Advocacy Service by the Citizens Information Board but has not been commenced. The Citizens Information Board has established the National Advocacy Service for People with Disabilities (NAS) on a non-statutory basis. Sage Advocacy was established in 2014 and is also a non-statutory body and registered charity which advocates with and for adults who may be vulnerable in some situations, to support decision-making and people's capacity to make decisions about their own lives. There is also reference to the need for people to have access to independent advocates in **HIQA, National Standards for Residential Care Settings in Ireland, 2016** and in **HIQA National Standards for Residential Services for Children and Adults with Disabilities, 2013**. The Mental Health Act 2001, section 16(2)(b) essentially provides for legal advocacy in the review process of involuntary detention. The Assisted Decision – Making (Capacity) Act 2015 provides for the establishment of a Decision Support Service, which will have a role, pursuant to section 103(2)(c)(x), in issuing codes of practice for the guidance of persons acting as advocates on behalf of relevant persons.

There is legislative provision for independent advocacy in other jurisdictions. In England, sections 67 and 68 of the Care Act 2014 impose a duty on the local authority to arrange access to an independent advocate if certain conditions are met. The provisions require that the advocate be independent of the care provider but seem to permit a family member to be an advocate. Access to an 'independent mental capacity advocate' is also provided for in sections 35 – 41 of the Mental Capacity Act 2005. In Wales, section 181 of the Social Services and Well-being (Wales) Act 2014 similarly provides for independent advocacy. In Scotland, section 6 of the Adult Support and Protection (Scotland) Act 2007 imposes a duty on local authorities to consider the provision of advocacy. Section 259 of the Mental Health (Care & Treatment) (Scotland) Act 2003 appears to provide for non-instructed advocacy. The Mental Health (Care & Treatment) (Scotland) Act 2003 Code of Practice provides for advocacy where the person has a degree of incapacity, on the basis that *"the right of access to independent advocacy is for each patient and is not limited only to those who are best able to articulate their needs."* In Northern Ireland, the final policy proposals for the Adult Protection Bill include a provision for independent advocates who can assist adults at risk to be involved in and influence decisions taken about their care.⁶⁸

9. Restrictive scope of the Domestic Violence Act 2018.

A main shortcoming of the current system is the restrictive scope of the Domestic Violence Act 2018. The first difficulty is the narrow scope of the offence of coercive control under section 39. Section 39 provides that person commits an offence where he or she knowingly and persistently engages in behaviour that: (a) is controlling or coercive, (b) has a serious effect on a relevant person, and (c) a reasonable person would consider likely to have a serious effect on a relevant person. A person's behaviour

has a serious effect on a relevant person if the behaviour causes the relevant person to (a) fear that violence will be used against him or her, or (b) serious alarm or distress that has a substantial adverse impact on his or her usual day-to-day activities. Section 39(4) restricts the application of the offence to intimate relationships. It defines that a person is "relevant person" in respect of another person if he or she (a) is the spouse or civil partner of that other person, or (b) is not the spouse or civil partner of that other person and is not related to that other person within a prohibited degree of relationship but is or was in an intimate relationship with that other person. Section 39(4) specifically excludes the possibility of prosecuting a sibling, adult child, or other relative, or carer of an adult at risk for the offence of coercive control. This is entirely unsatisfactory, because psychological abuse in the form of coercive control can arise in a safeguarding context in non-intimate relationships. Coercive control often happens in conjunction with other forms of abuse, such as emotional, financial, physical or sexual abuse. Some of the people who are most at risk of being subjected to coercive control are older people who are frail, or vulnerable people living with a long term mental, intellectual or physical disability.⁶⁹

The offence of coercion under section 9 the Non- Fatal Offences Against the Persons Act 1997 does not address this regulatory gap, because the elements of that offence are entirely different to the offence under section 39 of the 2018 Act and are more difficult to establish. First, the mental element of section 9 requires that the perpetrator engage in behaviour *"with a view to compel another to abstain from doing or to do any act which that other has a lawful right to do or to abstain from doing"*. This is a higher threshold to meet than the mental element under section 39, which only requires an intention going to the behaviour that amounts to coercive control, rather than a specific intention as to the impact of the conduct on the victim. The act element of section 9 requires the use of violence or intimidation, or damage to property, or that the perpetrator persistently follows the victim (stalking), or watches and besets the premises in which the victim lives, works or carries on business. This is an exhaustive and prescriptive list which does not necessarily cater for the nuance and subtleties involved with psychological abuse and coercive control. By contrast, the act element of section 39 is far broader in its scope because it pertains to behaviour that is controlling and coercive and the 2018 Act does not define what sort of conduct is controlling and coercive.

This shortcoming could be addressed by an amendment to section 39 of the Domestic Violence Act 2018 to ensure the offence of coercive control applies outside of intimate relationships. Specifically, section 39(4) could be deleted and substituted for the following: *"in this section, a person is a 'relevant person' in respect of another person if he or she is subject to the behaviour as set out in subsection (1)."* The reality is that coercive control can include behaviours such as detaining a person at home, restricting their movements, constantly monitoring their whereabouts, preventing contact with family or friends, excessively contacting the person via technology, keeping a person's phone from them, controlling

68 Northern Ireland Department of Health, Adult Protection Bill – Draft Final Policy Proposals for Ministerial Consideration (July 2021), Head 7.

69 Safeguarding Ireland, Information Leaflet on Coercive Control, May 2021, Available at <https://www.safeguardingireland.org/wp-content/uploads/2021/05/6299-SI-A5-booklet-Web-2.pdf> >

money or medical care, imposing and making decisions on someone's behalf, ongoing undermining of a person's independence and, in serious cases, assault and violence.⁷⁰ The definition of coercive control should be expanded to capture these behaviours and reflect the reality of coercive control and how it can arise in a safeguarding context.

A further shortcoming relating to the Domestic Violence Act 2018 is that the limitation on who is eligible to apply for barring orders, safety orders and protection orders. Under section 11 of the 2018 Act the Child and Family Agency has power to apply for certain orders for the purpose of child protection. The HSE, or a dedicated safeguarding regulatory body, should similarly have power to apply for protective orders for the purpose of safeguarding vulnerable adults. A further issue in relation to the Domestic Violence Act 2018 is that the categories of persons against whom a protective order can be sought is restricted by reference to their relationship with the victim. Coercive control is further examined in Chapter 7 of this report.

10. No statutory provision for identifying and responding to self-neglect

There is no statutory provision specifically directed at identifying, investigating and addressing cases of neglect or self-neglect under Irish law, other than potentially in situations where a person lacks decision-making capacity or is suffering from a Mental Disorder under the Mental Health Act 2001. Neglect by another person can be addressed by way of tort law currently, but only where a duty of care, breach of that duty and resultant harm can be established. Such a duty might be more readily established in cases of neglect by professional carers. There is no statutory duty on adult children to care for their parents or other adult relatives. Neglect can also be addressed by the law on professional negligence, or by way of contract law where there is a breach of a contract to provide professional care services to an adequate standard. Self-neglect is a difficult area to legislate for because an empowerment approach to safeguarding might be regarded as a barrier to intervening in situations where a person who is engaged in self-neglect has full decision-making capacity. However, it is important that the perception that a person with full capacity is entitled to self-neglect is not relied upon to avoid intervention in situations where it would be appropriate to engage with a person in relation to their self-neglect, in order to reduce the risk to which they are exposed. Where self-neglect by a person results in environmental risks to people living nearby, for example fire hazards or neglected farm animals, the environmental risks may provide a basis for intervening in the situation of self-neglect and engaging with the individual in question to address the issue. (The issue of self-neglect by adults at risk is discussed further in Chapter 8).

⁷⁰ Safeguarding Ireland, Information Leaflet on Coercive Control, May 2021, Available at <https://www.safeguardingireland.org/wp-content/uploads/2021/05/6299-SI-A5-booklet-Web-2.pdf>

Overview and Conclusion

This chapter has examined in some detail the nature of the existing regulatory framework for safeguarding in Ireland and outlined the importance of its various components. In addition, it has discussed how legislative provisions that are not specifically targeted at safeguarding adults at risk enable and limit the delivery of effective safeguarding responses.

It is evident that safeguarding provision is heavily dependent on regulations and standards, overseen in the main by HIQA and the HSE. The existing provisions are particularly limited with regard to the settings in which they apply, the types of abuse that they can address, and the legislative base on which they are founded. Consequently, the current regulatory framework does not adequately provide for many adults at risk, categories of risk, potential risk settings or categories of perpetrators of abuse.

Persons and agencies responsible for identifying, investigating, preventing and safeguarding adults from risk are restricted in the scope and effectiveness of their powers by the absence of a uniform regulating framework across all settings. The scope and effectiveness of their powers are also impacted by the limits of their role in many contexts – particularly regarding many nursing home settings and the home care sector. Their powers are further impacted by current provision, or lack of provision, for information sharing and accessing premises in order to investigate suspicions or allegations of abuse.

The restrictive scope of the Domestic Violence Act 2018 is indicative of the inadequacy of the existing framework in dealing with the particular challenges involved in providing adults at risk with effective safeguarding supports. The absence of any legislation that is specifically targeted at dealing with cases of self-neglect and the absence of a legislative basis for independent advocacy are further indications of that inadequacy.

The shortcomings of some aspects of legislative and regulatory provision outlined above points to a need for specific amendments to existing legislation. However, there is also a clear need for a new overarching legislative approach to safeguarding.

The fragmented nature of safeguarding provision, and the resulting regulatory gaps, demonstrate the need for a dedicated safeguarding regulatory body with the statutory powers necessary to ensure its ability and authority to implement the full range of essential safeguarding measures discussed throughout this Paper.

The shortcomings of some aspects of legislative and regulatory provision outlined above points to a need for specific amendments to existing legislation. However, there is also a clear need for a new overarching legislative approach to safeguarding.

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/ Chapter Three

Nature and extent of abuse and exploitation of adults at risk in Ireland

Chapter One described the various types of abuse that can occur – physical, sexual, psychological, financial, discriminatory, neglect (including self-neglect) and institutional. This chapter describes and examines the nature and extent of abuse of adults at risk in Ireland as gleaned from research, data from the HSE’s National Safeguarding Office Annual Reports and case material provided to Safeguarding Ireland by a number of agencies.

Nature of abuse of adults at risk

While the average person may well be at risk of exploitation and abuse at different times and in various contexts, it is clear that certain groups of adults are at particular risk as a result of their age, health, social position, disability or living situation. These adults are often vulnerable as a result of their limited ability to state their wishes and/or to assert their rights. This may be due to their high levels of dependency on others and/or on institutions. The abuse that they endure can range from the seemingly minor to the most extremely serious.

While the media stories that attract public attention in this regard often involve cases that are criminal, extreme and distressing, the reality is that adults at risk are liable to experience forms of abuse and exploitation that many people may not see as such. However, a 2019 Red C poll⁷¹ conducted for Safeguarding Ireland highlighted the fact that half of all Irish adults say they have experienced the abuse of adults at risk either through being abused themselves or having seen somebody close to them abused. Two in five people think that adults at risk are badly treated and one in three believes that abuse of adults at risk to be widespread.

A more recent Red C Poll carried out for Safeguarding Ireland⁷² in October 2020 on the Incidence of adult abuse⁷³ in Ireland found that:

- Around one-in-eight have experienced abuse since the start of the Covid-19 pandemic.
- Women (especially younger women) are more likely to have ever experienced abuse than men.
- There is a higher incidence of abuse among lower social class groups, the unemployed and those that are widowed/divorced/separated.
- Women are more likely to have experienced emotional and sexual abuse, while younger people are more likely to have experienced sexual and cyber abuse.
- One in four feel more vulnerable to abuse due to Covid-19 restrictions.
- Of those that have ever experienced abuse, one quarter have experienced emotional abuse since the onset of the Covid-19 pandemic.
- Both younger men, younger women and single people are more likely to feel vulnerable to suffering abuse as a result of the Covid-19 lockdown and restrictions.

⁷¹ <https://www.safeguardingireland.org/wp-content/uploads/2021/04/Safeguarding-Ireland-Red-C-Research-2019.pdf>

⁷² <https://www.safeguardingireland.org/wp-content/uploads/2020/10/Incidence-of-Adult-Abuse-in-Ireland-during-COVID-19-5.10.20-FINAL.pdf>

⁷³ The following was the question asked in the Poll: Abuse can take the form of cyber, emotional, financial, physical, psychological, or sexual maltreatment by another person or institution, or neglect by another person or institution. Have you ever experienced any form of abuse?

Scale and context of reported abuse in Ireland

The HSE has nine Safeguarding and Protection Teams (SPTs) - one in each Community Healthcare Organisation (CHO) - responsible for coordinating consistent responses to concerns of abuse and neglect. SPTs have right of access to all HSE and HSE funded services, while access to private facilities is at the discretion of the service provider.

The HSE National Safeguarding Office (NSO) oversees the implementation, monitoring, review and ongoing evaluation of the HSE's Safeguarding Policy as well as coordinating the development and roll-out of safeguarding training. NSO Annual Reports⁷⁴ identify a significant level of reported concerns regarding the physical, sexual, psychological and financial abuse of adults at risk in Ireland, with over 10,000 concerns being recorded per annum since 2017. In 2020, the most frequent type of abuse alleged was psychological followed by physical. This was the position across all age groups. Adults under 65 had the highest proportion of psychological and physical abuse alleged. Financial abuse and neglect were alleged to a greater extent in adults over 80 years. Reports from preceding years indicate a similar pattern of concerns.

Table 1. Reported Abuse Types by age of adult at risk of abuse, 2020

Abuse Types Alleged	18-64 Years		65+		Over 80 (Subset of 65+)		Total	
	No.	%	No.	%	No.	%	No.	%
Physical	2950	38%	490	25%	322	21%	3861	33%
Sexual	333	4%	54	3%	53	3%	444	4%
Psychological	3261	42%	732	38%	497	32%	4688	40%
Financial	439	6%	303	16%	348	23%	1198	10%
Neglect	440	6%	220	11%	288	19%	1045	9%
Discriminatory	17	0%	5	0%	5	0%	28	0%
Institutional	157	2%	20	1%	16	1%	197	2%
Self-Neglect	104	1%	125	6%	2	0%	386	3%
Total	7701	100%	1949	100%	1531	100%	11847	100%

Source: NSO Annual Report 2020

The reporting rate per 1,000 population varied depending on age and gender. The reporting rate for adults aged 65 years or over at 5.34% was more than double that for adults in the 18-64 years' category (2.3) and was even higher for females aged 65 or over (6.13).

74 HSE National Safeguarding Office. Annual Report 2020, <https://www.hse.ie/eng/about/who/socialcare/safeguardingvulnerableadults/nationalsafeguardingofficereport2020.pdf>

Table 2. Reporting rate per 1,000 of adult population by age group and gender. 2020.

Age group	Male	Female	Total
18-64 Years	2.41	2.19	2.30
65+ Years	4.45	6.13	5.35
All Adults 18+	2.75	2.93	2.84

Source: NSO Annual Report 2020

Each Community Healthcare Organisation (CHO) operates in its own particular demographic environment, with differing proportions of the population in various age categories. CHOs may also differ in how they deliver and manage services. Table 3 shows the number of concerns raised in each CHO per 1,000 of the population by age group, thereby taking into account any differences caused by demographic factors.

The rate of concerns raised varies significantly across CHOs. It is unclear whether the variation can be attributed to differing rates of abuse, differences in rates of reporting, or differences in management and administration arrangements. The NSO 2019 Annual Report⁷⁵ suggests that, for example, the very low rate in CHO2 - particularly for 18-64 year olds - is due to the application of "an oversight meeting framework with their funded agencies". (It is not entirely clear what this means). There would be an obvious value in having a greater clarity regarding the underlying reasons for the variations between CHOs.

Table 3. Reporting rate per 1,000 of adult population by age group and Community Health Organisation (CHO) 2020

CHO Area	Rate/1000 Pop. 18-64 Years	Rate/1000 Pop. 65+ Years	Rate/1000 Pop. 18+ Years
1	2.87	2.65	2.82
2	0.84	6.01	1.88
3	1.98	4.17	2.40
4	2.06	4.72	2.57
5	2.75	7.25	3.63
6	2.43	6.51	3.20
7	2.10	5.53	2.60
8	3.23	4.71	3.47
9	2.34	6.35	2.94
Total	2.30	5.35	2.84

Source: NSO Annual Report 2020

75 HSE National Safeguarding Office. Annual Report 2019, <https://www.hse.ie/eng/about/who/socialcare/safeguardingvulnerableadults/national-safeguarding-office-annual-report-2019.pdf> p.20

Table 4 shows that, in 2020, over half of all reported concerns were attributed to abuse perpetrated by another service user/peer. For those under 65, the person allegedly causing concern was most likely (63%) to be another service user. In contrast, for those over 65, the person allegedly causing concern was likely (50%) to be an immediate family member.

Table 4. Person causing alleged abuse by age of adult at risk of abuse. 2020

Person allegedly causing concern	18-64	65+	Total
Other Service User/Peer	%	%	%
Immediate Family Member	66%	23%	53%
Staff	10%	50%	22%
Neighbour/Friend	17%	15%	17%
Other Relative	2%	5%	3%
Stranger	1%	5%	3%
Total	2%	2%	2%

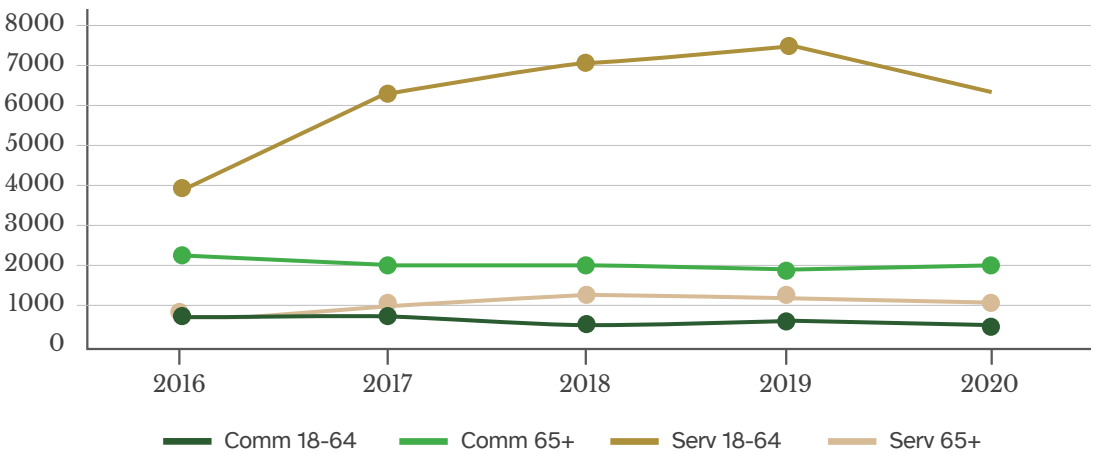
Source; NSO Annual Report 2020

Concerns were categorised as arising within either a community or a service setting. Figure 1 shows that variations in the pattern of community/service setting concerns were evident. For adults at risk age 65+ concerns within community settings were almost twice as prevalent. For adults at risk age 18-64 concerns within service settings were over ten times as prevalent.

The fact that concerns within a community setting are proportionately high amongst older people coincides with the much higher level of concern connected with older people where the alleged perpetrator is an immediate family member. However, it is also possible that older people are less likely to complain regarding their treatment in service settings.

The proportionately higher level of concerns within a service setting relating to the younger age group is more difficult to explain in the absence of more detailed data. (This matter will be discussed later in the chapter).

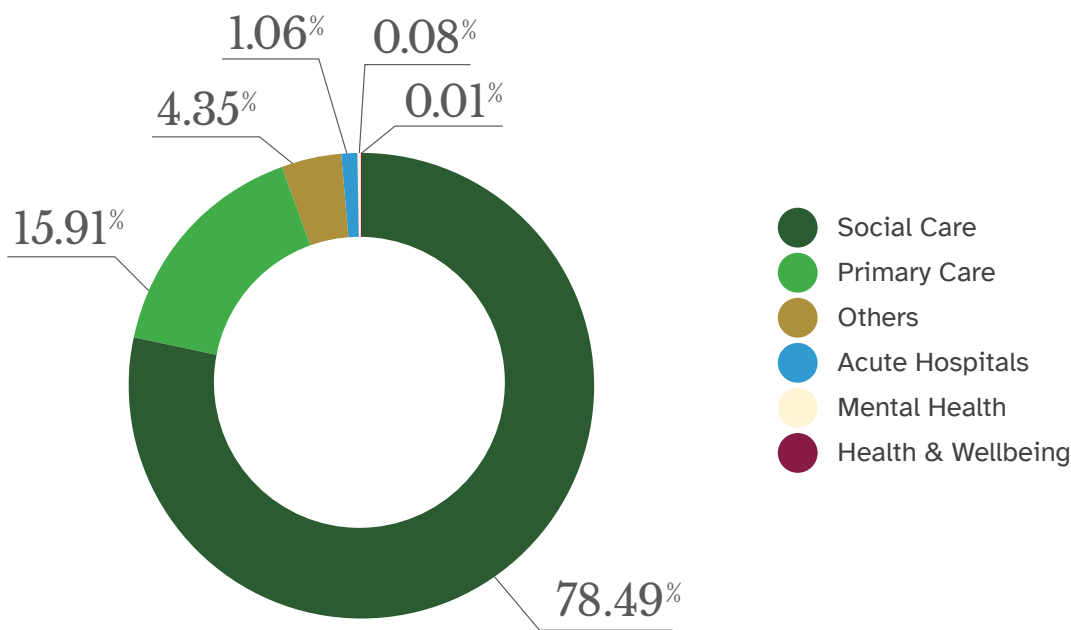
Figure 1. Profile of safeguarding concerns by setting and age. 2016-2020.



Source; NSO Annual Report 2020

The breakdown of alleged abuse across different sectors (Figure 2) shows that 78% of concerns arise within the social care⁷⁶ sector. This raises critical and urgent questions relating to whether or not there is a pervasive culture of abuse within such settings and related personal safety implications or whether the high rate of reporting is related to the fact that HSE policy and data collection on abuse is primarily being applied in the social care sector.

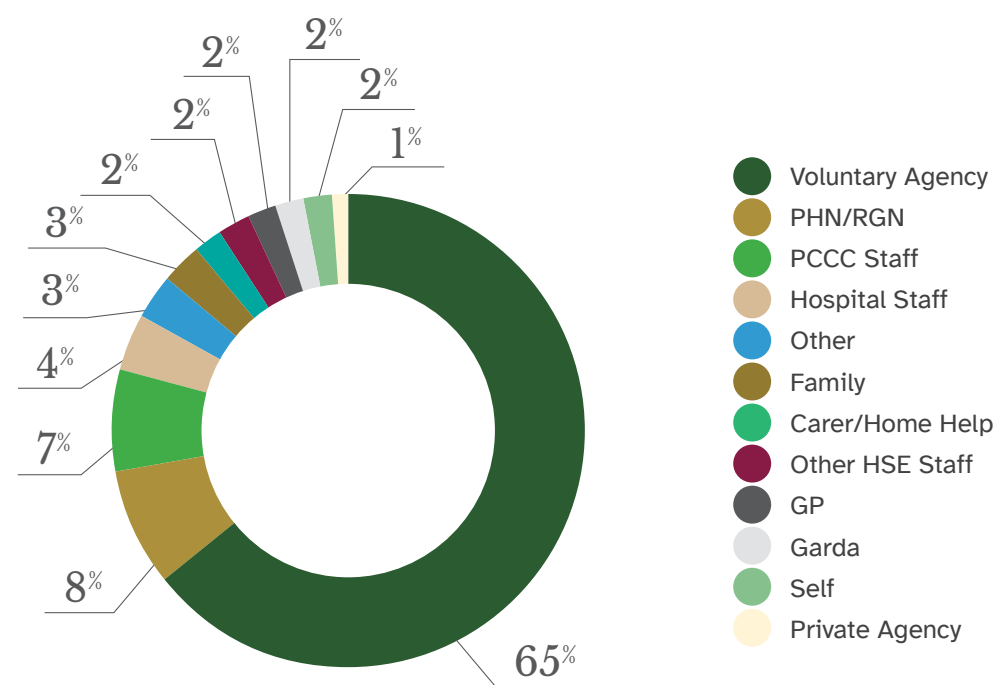
Figure 2: Concerns by referring care group 2020



Source; NSO Annual Report 2020

Voluntary agencies remain the largest single source of referrals, followed by Public Health Nurse (PHN)/Registered General Nurse (RGN). The low level of self-referral by the person alleging the abuse (self-referral) is noteworthy.

76 The HSE Social Care Division supports ongoing service requirements of older people and people with disabilities to enable people to live at home or in their own community.

Figure 3: Referral source 2020

Source: NSO Annual Report 2020

Screening of reported concerns

Reported concerns are subjected to a preliminary screening. Preliminary screening assessment concludes with a determination of outcome. There are three possible outcomes:

- Reasonable grounds for concern.
- No grounds for concerns.
- Additional information required (a holding position until either of the two options above are reached).

Designated Officers conclude an outcome for each preliminary screening and this must then be agreed with the Safeguarding and Protection Team (SPT). In 2020, almost two-thirds (65%) of preliminary screenings were agreed as containing reasonable grounds for concern, with 9% warranting additional information. Just over one quarter (26%) were assessed as having no grounds for concern.

Synthesis of relevant points in NSO Annual Reports

In considering the nature and extent of alleged abuse during 2020, it is important to reference the fact that this was a period of significant exposure to risk, both in residential care settings and in domestic settings, as a result of Covid-19 lockdowns and of the spread of the illness, the latter particularly in nursing homes. The risk to already very vulnerable adults was significantly compounded. The data reported in the NSO Annual Report 2020 needs to be considered in that context.

The following are some of the main statistics in the 2020 Annual Report:

- There was a drop of 9% between 2019 and 2020 in the number of safeguarding concerns notified to the HSE Safeguarding Teams.
- There was a particular drop in notifications in the first half of 2020, coinciding with the onset of the Covid-19 pandemic and associated restrictions.
- There was a notable increase in safeguarding notifications in the latter part of 2020.
- The 10,216 concerns reported in 2020 covered 11,847 different alleged abuse types.
- The most frequent type of alleged abuse was psychological, followed by physical.
- The percentage of psychological abuse concerns reported was marginally higher for persons under 65 years than in the over 65s.
- Financial abuse and neglect were alleged to a greater extent in adults over 80 years than in younger age-groups.
- Over three-quarters (78%) of concerns arose within the social care division, down from 81% in 2019.
- The 'categories of relationship' between the adult at risk of abuse and the person allegedly causing concern in 2020 is consistent with previous years – over half related to another service user/peer.
- For those under 65, the person allegedly causing concern was most likely to be another service user.
- In contrast, for those over 65, the person allegedly causing abuse was likely to be an immediate family member.

Data provided to Safeguarding Ireland by the Department of Social Protection⁷⁷ (DSP) relating to reported concerns points, as one would expect, to a number of alleged cases of financial abuse. Of the 208 cases brought to the Department's attention in 2020, 154 involved financial abuse. In the majority of cases, the reports related to alleged abuse by a family member.

The relatively small number of allegations of financial abuse reported to the DSP in comparison with the much higher number reported to HSE Safeguarding Teams is worth noting. This almost certainly is indicative of financial abuse extending much wider than just the misappropriation of social welfare payments.

The 2020 National Safeguarding Office Annual Report notes that possible contributors to the reduction in reporting rates may have been staff re-deployments and reductions in occupancy in residential units.

⁷⁷ DSP Communication to Safeguarding Ireland November 2021.

It also suggests that the reductions in the availability of short stay beds, provision of disability services and of day services could have been factors.

While the Annual Report states that all of these factors would have resulted in “fewer opportunities to witness and/or disclose concerns”, it also notes that international studies have shown that restrictions in access to services and external support increase safeguarding risks.⁷⁸ This is a critically important consideration.

The reduction of 9% in the number of concerns reported in 2020 was identified as a concern by the Irish Association of Social Workers (IASW)⁷⁹, especially in the context of Covid-19, where there was almost certainly an increased risk of abuse, especially of those who were already vulnerable and were confined to their homes for long periods during the early part of 2020. The high risk of abuse associated with Covid-19 is highlighted in the Safeguarding Ireland research referenced above.⁸⁰ The IASW has also noted that, in 2020, domestic violence referrals to An Garda Síochána increased by 17%, while child protection referrals to Tusla rose by 23%.⁸¹

Reported concerns for the 18-64 age-group

Variations regarding several aspects of reported concerns as between age-groups has been noted above. These variations deserve some attention.

The incidence of alleged abuse where the victim is aged 65+ years, and the characteristics of the alleged abuse – level, type, setting, referral sources, alleged perpetrator – have been relatively consistent over the years 2018 to 2020. The reporting rate per 1,000 of population for the 65+ group was 5.35 in 2020, as detailed in Table 3 above. In addition, the information relating to this older age group appears to correlate well with data from other jurisdictions and from international research studies.

The significant and notable difference between the situation regarding persons aged 65+ and the situation regarding adults aged 18-64 years relates to the *person allegedly causing concern* – the alleged perpetrator. The NSO annual reports (2018-2020) indicate that for persons aged 18-64 years, approximately two-thirds of *persons causing concern* were *other service users/peers*. For persons aged 65+, less than a quarter of allegations concerned *other service users/peers*. For that older age-group the alleged perpetrator was most likely (50%) to be an *immediate family member*.

The high proportion of concerns for the younger group of adults at risk where the alleged abuse is by another service user/peer deserves attention. In considering the situation of the 18-64 age group it may be useful to examine various aspects of the alleged concerns of abuse, in order to provide context.

⁷⁸ National Safeguarding Office Annual Report 2020, ps. 30-31

⁷⁹ See <https://www.rte.ie/news/health/2021/1028/1256538-hse-safeguarding-drop-reports/>

⁸⁰ <https://www.safeguardingireland.org/wp-content/uploads/2020/10/Incidence-of-Adult-Abuse-in-Ireland-during-COVID-19-5.10.20-FINAL.pdf>

⁸¹ https://www.iasw.ie/DropInSafeguarding_Concerns2020

For this age group, data drawn from NSO Annual Reports 2018-2020 reveal that:

- 45% of reported concerns related to physical abuse.
- 35% related to psychological abuse.
- 5% related to sexual abuse.
- 92% of concerns related to a service setting.
- 8% to a community setting.
- 78% of concerns related to designated centres for disabled adults as the reporting location.
- 7% related to day centre as the reporting location.
- 68% of concerns identified other service user/peer as the person allegedly causing concern.
- 14% identified staff as the person allegedly causing concern.
- 8% identified immediate family member as the person allegedly causing concern.
- Only 2% of concerns were classed as being reported by self.

As noted earlier, the detailed data presented in the NSO Annual Reports relates to *alleged concerns of abuse*; these allegations are then assessed and screened for *reasonable grounds*. Of all concerns reported, the percentage determined as having *reasonable grounds* was 65% in 2020. For most years, these percentages are provided only for the totality of all cases, regardless of age. However, the 2017 annual report offers a once-off insight in the proportion of reported concerns that were deemed to have *reasonable grounds* differentiated by age group. The information, while not comprehensive, suggests that a high proportion of allegations involving other service users in the areas of physical and psychological abuse, at 83% and 76% respectively – were deemed as having *reasonable grounds*.

It is worth noting that approximately one-third of reported concerns relating to financial abuse by another service user were found to have *reasonable grounds*.

Comparisons with other jurisdictions are difficult to make, due to variations in how data is collected and classified. However, comparisons with data from England⁸² offer some insights.

The reporting system in England differs from the system in Ireland in that concerns are notified; these are assessed and if meeting certain criteria are classed as enquiries; these are then assessed as to whether there is a need for safeguarding actions.

⁸² Health and Social Care Information Centre 2014. Abuse of Vulnerable Adults in England. 2012-13, Final Report, Experimental Statistics. <https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/2019-20> <https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/2020-21>

In general terms, around 40% of concerns translate into enquiries; 70% of enquiries lead to safeguarding actions. Every 100 concerns, therefore, lead to approximately 26 requiring safeguarding actions.

The number of safeguarding enquiries in England for the 18-64 age group is reported as 1.41 per 1,000 of the population. This compares with around 2.4 reported concerns per 1,000 in Ireland. This suggests a higher initial rate of reporting in England, but one that is screened to a higher degree than in Ireland.

The Irish data does not indicate whether a reported concern resulted in a need for safeguarding actions, only whether there were *reasonable grounds*.

A number of factors may, therefore, contribute to the high level of referred concerns in Ireland involving other service users/peers as the person allegedly causing concern.

- Given the location of the alleged abuse – residential and day centre settings – and the fact that only 2% are referred by self, it is likely that most concerns are referred by staff.
- It is possible that staff and/or institutions set a low ‘threshold’ for classing incidents as deserving of reporting action.
- It is probable that the referred concerns encompass a wide set of incidents and behaviours, ranging from ones that are extremely serious to ones that are substantially less so.
- It is also likely to be the case that staff may be more likely to refer concerns involving other service users as opposed to cases involving themselves, other staff members, or the institutions themselves.

Much of the internationally available data and research⁸³ tends to concentrate on abuse of older people and on sexual abuse of all age groups. Unfortunately, the material provides little clarity regarding the extent and nature of abuse as experienced by the younger age group – at least not in a manner that offers any real insight into the extent to which abuse – in the broad sense – is carried out by other service users, the range of actions warranting concern and/or the proportion of concerns that lead to safeguarding actions.

There is a risk, in considering the data relating to the younger age group in Ireland, that the focus and emphasis of concern will be directed predominantly toward situations involving other service users while ignoring those types of abuse involving institutional shortcomings, abuse by staff, neglect, financial abuse and infringements of basic rights, all of which may be less well acknowledged, identified, referred and/or acted on.

⁸³ See, for example, <https://disability.royalcommission.gov.au/publications/research-report-nature-and-extent-violence-abuse-neglect-and-exploitation-against-people-disability-australia>
See also Amelink Q, Roozen S, Leistikow I, Weenink J, Sexual abuse of people with intellectual disabilities in residential settings: a 3-year analysis of incidents reported to the Dutch Health and Youth Care Inspectorate. BMJ Open 2021 accessed at <https://bmjopen.bmj.com/content/11/12/e053317>

Multi-faceted abuse

Case evidence⁸⁴ provided to Safeguarding Ireland for this research shows that, in many abusive situations, the abuse is multi-faceted and that some people may, for example, be simultaneously subjected to coercive control, undue influence, financial abuse, neglect and other forms of exploitation.

There are cases reported where:

- Access by the adult at risk to services or to relatives is blocked or controlled and managed by someone acting as a gatekeeper;
- Third parties are excluded from the property of an adult at risk;
- An adult at risk is being blocked from accessing necessary medical or other assessments.

Financial abuse is a useful category for the purposes of considering the manner in which multi-faceted abuse can become normalised and acceptable. Clearly, financial abuse can involve substantial and serious financial exploitation of an adult at risk. However, financial abuse is broader than abuse relating simply to personal finances. Financial exploitation of adults at risk can often include the illegal or improper use of property, the misuse of the person’s home, theft of possessions and inappropriate use of resources such as utilities and food. Very importantly, financial abuse includes the inappropriate transfer of property and assets and coercion and intimidation to gain access to assets, including gift giving and creating a will. People can be financially exploited through the use of psychological manipulation or misrepresentation, coercion or undue influence. However, the exploitation can also involve petty theft and use of resources without permission, sometimes viewed by both perpetrator and victim as being tolerable, if not desirable.

Adults at risk can fall prey to both serious and ‘trivial’ exploitation by people and organisations that, for example, target them through aggressive fund-raising, through aggressive sales techniques, through manipulative on-line and other scams, through offers of dubious services and products and through exploitative ‘professional’ services. These abuses can originate from within both registered and unregulated charities, from unscrupulous trades people, from so-called ‘grassroots’ entities that offer support and advice to people who may be vulnerable⁸⁵, from entities promoting false/harmful or misleading health and legal information and from criminal fraudsters.

The fact that not all Irish charities receive HSE funding means that many fall outside the remit of its safeguarding policies and requirements.

⁸⁴ Indicative detailed case scenarios are contained in an Appendix

⁸⁵ See comments of Mr. Justice Barrett regarding “unregulated charlatans... who purport to ‘assist’ vulnerable people in debt. Such people are fraudsters who, like all fraudsters, prey on the vulnerable”. Available at <https://www.bailii.org/ie/cases/IEHC/2021/2021IEHC531.html>

While the Charities Regulatory Authority (CRA) does place obligations⁸⁶ on registered charities to have a Safeguarding Policy in place, there are organisations that are not registered charities offering ‘support’ and ‘advice’ to people who may be vulnerable which do not fall under the ambit of the CRA. (The issue of financial abuse is discussed in detail in Chapter Four below).

Limitations in data on abuse of adults at risk

The overall rate of elder abuse reporting (people aged 65+) indicates figures of approximately 2,000 community referrals per year which has remained broadly at the same level since 2018. National Centre for the Protection of Older People research has reported a twelve-month prevalence rate of 2.2% for elder abuse and neglect among community-dwelling older people⁸⁷. Applying this rate to the population aged over 65, the number of people who have experienced elder abuse in the community setting can be estimated at 14,026 per annum.

The under-reporting of elder abuse is acknowledged internationally as well as in Ireland.⁸⁸ It is suggested that this is a result of a combination of older people being reluctant or unable to inform on the perpetrators, not recognising the behaviour as abuse and the failure of services and professionals to detect abuse or neglect. It would be reasonable to anticipate that under-reporting of abuse of adults at risk (other than older people) is likewise significantly high.

While data relating to criminal assaults, sexual assaults and homicide in Ireland⁸⁹ indicates that older people, for example, are less likely to be victims than other age groups, the level of reported assaults is, nevertheless, of grave concern. International studies⁹⁰ relating to homicide in domestic settings have noted a paucity of research and, therefore, evidence, regarding the extent, nature and consequences of violence against older people. It is suggested that ageist assumptions often mask the true levels of violent abuse that exist, especially in domestic contexts.

A further factor can be viewed as contributing to a significant degree of under-reporting. This relates to the limitations and constraints that apply to the ability of the HSE Safeguarding Teams to carry out inspections with regard to the management and assessment of concerns within private health care settings not covered by individual HSE contracts. This is seen as most relevant within the private nursing home sector. Whilst the majority of private sector providers are reported as voluntarily co-operating with HSE safeguarding services, there is no satisfactory method

86 <https://www.charitiesregulator.ie/media/1866/safeguarding-guidance-for-charitable-organisations-adults-final.pdf>
87 Naughton, C., Drennan, J., Treacy, M.P., Lafferty, A., Lyons, I., Phelan, A., Quin, S., O’Loughlin, A., Delaney, L. (2010) Abuse and Neglect of Older People in Ireland: Report on the National Study of Elder Abuse and Neglect, Dublin: University College Dublin, available at : <https://www.safeguardingireland.org/wp-content/uploads/2020/02/National-Prevalence-Study-FullReport2010.pdf> [accessed 15 Nov 2021].
88 See for example <https://journals.sagepub.com/doi/full/10.1177/21582440211053256>
89 CSO, Recorded Crime Victims 2019 and Suspected Offenders 2018, <https://www.cso.ie/en/releasesandpublications/ep/p-rcvo/recordedcrimevictims2019andsuspectedoffenders2018/>
90 See for example <https://academic.oup.com/bjsw/article/49/5/1234/5211414?login=true>

to ascertain how well such services internally assess and investigate abuse concerns. It is likely, therefore, that this lack of effective oversight may hide a level of abuse that is not being reflected in NSO report data.

A similar situation exists with regard to the provision of home care support. Home support services in Ireland are provided by a mixture of the HSE, voluntary organisations and for-profit organisations. Over half (58%) of home support is provided by for-profit organisations. Approximately 33% of total home support in 2019 was provided by HSE staff and 9% was provided by the voluntary sector.⁹¹ A centrally important point here is that HIQA currently does not have any regulatory oversight in relation the home care sector.

In addition to low rates of reporting, it appears likely that other factors contribute to hiding the true level of abuse. While matters such as the capacity of the abused person to make a complaint, reluctance or fear on their part, lack of knowledge regarding who to inform and how to do so, concern for future security, or high levels of dependency on perpetrators of abuse, it is also likely that many forms of abusive behaviour are not recognised or acknowledged as being abusive by either the victim, the perpetrator or by witnesses. Abuse that can be classed as trivial, normal and/or somehow socially acceptable can be easily dismissed and ignored. Vulnerable service users and people who are highly dependent on others, including those in institutional settings, may feel that there is no value in resisting or in demanding redress in relation to ‘petty’ forms of abuse, however persistent and upsetting they may be, and may be fearful that complaining may make their situation worse. A recent (November 2021) Red C Poll carried out for Safeguarding Ireland⁹² shows that, while two-thirds of people were aware of the term ‘safeguarding’, only just over half of those polled said they already understood what it meant. An earlier poll⁹³ found that doubt surrounding the impetus to report mistreatment exists for two-in-three of the population, with the same proportion being uncertain about the appropriate point of contact for such reporting.

There is a dearth of current data relating to abuse of older people in residential care settings. Research,⁹⁴ carried out in 2012, pointed to a strong prevalence of neglect and abuse of residents by staff. While practice may have changed in the intervening years, the findings have ongoing relevance in that there is strong anecdotal and case evidence of abuse and neglect in residential care facilities on an ongoing basis.

The 2012 research found that more than half (57.6%) of staff reported that they had observed one or more neglectful behaviours by other members of staff in the preceding 12 months. The most frequent neglectful behaviours that were observed included a member of staff

91 Walsh, B., Lyons, S. (2021) Demand for the Statutory Home Support Scheme, Dublin: ESRI.
92 <https://www.safeguardingireland.org/wp-content/uploads/2021/11/554421-Safeguarding-Ireland-Nov-2021-FINAL.pdf>
93 <https://www.safeguardingireland.org/wp-content/uploads/2018/10/Red-C-Survey-Vulnerable-Adults-in-Irish-Society-060417.pdf>
94 Drennan, J., Lafferty, A., Treacy, M.P., Fealy, G., Phelan, A., Lyons, I. Hall, P. (2012) Older People in Residential Care Settings: Results of a National Survey of Staff-Resident Interactions and Conflicts. NCPop, University College Dublin, https://www.safeguardingireland.org/wp-content/uploads/2020/02/Older-People-in-Residential-Care-Settings_Final-Proof_28Nov2012.pdf

ignoring a resident when they called and a member of staff not bringing a resident to the toilet when they asked. Approximately 11% of respondents had observed, on one or more occasion, a member of staff refusing to help a resident with their hygiene needs, with 10% reporting that they observed a member of staff neglect to move or turn a resident to help prevent pressure sores. Over a quarter (26.9%) of staff had observed at least one psychologically abusive act directed towards a resident in the previous twelve months by another member of staff. The most frequently observed type of psychological abuse was shouting at a resident in anger. Approximately 10% of respondents also reported that they had observed a member of staff insult or swear at a resident on at least one occasion. Another reported abuse was that of staff isolating a resident beyond what was required. A small minority of respondents also reported staff punishing a resident through the denial of food or privileges and restraining a resident beyond what was needed at the time.

Information regarding cases of abuse of adults at risk does, on occasions, emerge from the actions of whistle-blowers. However, data relating to the Irish situation, as published by Transparency International Ireland⁹⁵ indicates relatively low levels of reporting of abuse. It appears likely that attitudes, ignorance and a failure to recognise abuse, as well as fear or unwillingness to reveal cases or patterns of abuse, all contribute to masking and hiding the real situation.

Factors conducive to the abuse of vulnerable adults

Research carried out in 2019⁹⁶ identified a number of factors relevant to identifying the population of adults at risk of abuse in Ireland, including, in particular:

- There are limited interventions or protective actions available to address situations where an adult at risk is regarded as not having decision-making capacity and is not a Ward of Court, but is subject to an enacted Enduring Power of Attorney where a family member is the attorney;
- There are situations where a next-of-kin 'takes control' of the life of an adult at risk but who does have capacity; there are few avenues of intervention to protect the autonomy and right to self-determination of such people;
- Coercive control and undue influence are sometimes exercised over adults at risk by family members with whom they reside or by 'friends'/acquaintances living in their locality;
- There are situations where a family member acts as a gatekeeper or exerts undue influence over a relative by intimidation and threatening behaviour and thereby prevents them receiving services which they need and want;

⁹⁵ <https://transparency.ie/resources/whistleblowing/speak-report-2020>

⁹⁶ Donnelly, S and O'Brien, M (2019). Falling Through the Cracks: The case for change. Key developments and next steps for Adult Safeguarding in Ireland. Dublin: University College Dublin, https://researchrepository.ucd.ie/bitstream/10197/11242/1/Falling%20Through%20the%20Cracks_Full%20Report_Donnelly%20and%20O%27Brien_2019.pdf

- There is evidence of men in a locality befriending women who are vulnerable due to an intellectual disability and/or mental health challenges in order to access their resources, including savings and accommodation, as well as sexual favours;
- There is a lack of availability of community supports commensurate with need and limited access to housing or supported accommodation, for example, for people experiencing domestic violence;
- The HSE may not always provide home care supports regarded as essential to safeguarding, particularly in situations of unintentional neglect;
- There are situations where a person's will and preference are to remain living at home, but where their care needs are such that their family no longer has the capacity or financial resources to meet their care needs; this places these adults at significant risk;
- People with an acquired brain injury or mental health difficulties were identified as having distinctive needs and tended to fall through the cracks of service provision.

The research reported mental health social workers as describing ethical challenges relating to their safeguarding role and the difficulty in practice of balancing 'care and control' of their service users in safeguarding investigations, particularly where their service user is the alleged perpetrator.

Carrying out safeguarding work in an environment of reduced staffing levels was identified as extremely challenging. This issue was deemed to be particularly critical for Primary Care and Mental Health social workers with participants reporting that service users can wait 6 to 8 weeks to access a Primary Care social worker in some areas.

The lack of services to support the specific needs of people with dementia and their family carers was noted as a recurring theme identified by research participants. Particular challenges related to the absence of support for carers of people with dementia. For example, in situations where the person with dementia's behaviour cannot be managed or is posing a threat to themselves or others, the only form of support available to a family carer may be to ring the Gardaí or emergency services.

Unsolicited information received by HIQA

A total of 4,651 pieces of unsolicited information were received by the HIQA during the period January 2019 to November 2021. This is indicative of a high level of public concern about the way care is provided to adults at risk.

Unsolicited information is classified by HIQA under four pillars – nursing homes, residential centres for people with a disability, Healthcare (acute and community hospitals) and children's social services.

The information is further classified under two domains:

- 1. Quality and safety
- 2. Capacity and capability

Table 5 shows that, during the period January-September 2021, of the 2,156 concerns classified under the *Quality and safety* domain, 581 related to *safeguarding*. This accounted for over a quarter (26.9%) of the concerns identified under this domain.

Table 5: Issues identified in unsolicited information of concern provided to HIQA under the *Quality and safety* domain January-September 2021

Person allegedly causing concern	Number	%
Quality of care	618	28.7
Safeguarding	581	26.9
Rights	455	21.1
Infection prevention and control	249	11.5
Other	253	11.7
Total	2,156	100

Source: Data provided to Safeguarding Ireland by HIQA

Safeguarding accounted for the highest proportion of concerns classified under the *Quality and safety* domain in both nursing homes and residential centres for people with a disability. A total of 390 concerns regarding *safeguarding* related to nursing homes. More than two-thirds (67%) of all *safeguarding* concerns identified across all settings related to nursing homes and almost 15 per cent related to residential services for people with a disability.

When the number of concerns relating to *quality of care* and *rights* across all services (618 and 455 respectively) is taken into account, a picture emerges of a very significant level of concerns being expressed in relation to the protection and *safeguarding* of adults at risk.

Domestic abuse

The issue of domestic violence and its various ramifications is an important issue in Irish society and has a clear and obvious adult *safeguarding* dimension. While it is beyond the scope of this Discussion Paper to consider the issue of domestic violence in detail, it is acknowledged that domestic abuse is a key issue and one that has been widely referenced in the context of the restrictions instigated as a result of the Covid-19 pandemic. There is some anecdotal evidence

There is clear evidence that there is widespread abuse and exploitation of adults at risk in Ireland which is additional to the high levels of domestic violence prevalent in Irish society.

that this may have led to a decrease in the reporting and detection of domestic and intimate partner abuse. However, as noted earlier, a Red C Poll carried out for Safeguarding Ireland found that both younger men, younger women and single people are more likely to feel vulnerable to abuse as a result of the Covid-19 lockdown and restrictions. Domestic violence and abuse is often associated with coercive control which is discussed in detail in Chapter Six below.

Overview and Conclusion

There is clear evidence that there is widespread abuse and exploitation of adults at risk in Ireland which is additional to the high levels of domestic violence prevalent in Irish society. Reporting of abuse may not reflect the true nature and extent of abuse and exploitation for a variety of reasons, including; fear on the part of the person being abused of the consequences of disclosing abuse; a lack of awareness that what they are experiencing is abuse; a lack of clarity as to whom they should report abuse; lack of capacity to understand and report abuse; fear of an alleged abuser; ambivalence toward a person who may be abusive; limited verbal and other communication skills; fear of upsetting relationships; shame and/or embarrassment.

Abuse that occurs within a person’s own home presents particular difficulties in terms of investigation and assessment, and *safeguarding* staff have pointed to the challenges that they face in tackling this issue.

The various legal *safeguarding* mechanisms that are available – such as barring orders – are inadequate in many cases. This is particularly true where the alleged abuser is not an intimate or close family member.

Much of the potential for abuse, neglect and exploitation of adults at risk, especially in their subtler forms, is rooted in a culture that accepts and condones certain attitudes, practices and behaviours that deprive people at risk of their basic human rights.

Challenging and changing those cultures, both within institutions and across society as a whole, needs to be an integral part of the work of progressing toward a safe and equitable life for adults at risk. There is a need for vigilance in ensuring that people in residential care facilities are not subjected to abuse or neglect in any form.

The next chapter will explore the issue of financial abuse of adults at risk.

/ Chapter Four

Financial Abuse

This chapter explores the issue of financial abuse and its many dimensions. It references various research findings which highlight the nature and extent of financial abuse in Ireland and internationally. It also discusses factors that are likely to contribute to financial abuse and the need to ensure that people with reduced decision-making capacity are supported to control and manage their finances to the greatest extent possible. It is suggested that financial abuse is a useful category to illustrate the manner in which abuse of adults at risk can become normalised and socially and culturally acceptable.

Defining 'financial abuse'

There are various definitions of financial abuse. Section 42 (3) of the Care Act (2014) in England⁹⁷ states that 'financial abuse' includes: (a) having money or other property stolen; (b) being defrauded; (c) being put under pressure in relation to money or other property; and (d) having money or other property misused.

Additional forms or alternative categories of financial abuse found in the literature include exerting undue influence to give away assets or gifts and putting undue pressure on persons requiring care and support to accept lower-cost/lower-quality services in order to preserve more financial resources to be passed to beneficiaries on death.⁹⁸

A Red C Poll for Safeguarding Ireland and Banking and Payments Federation Ireland (BPFI)⁹⁹ defined financial abuse as including theft, fraud, exploitation; pressure in connection with wills, property, inheritance or financial transactions; or the misuse or misappropriation of property, possessions or benefits. The nature and extent of financial abuse can be illustrated by reference to the questions asked in the Poll about which of the following applied to the respondents:

- Someone has accessed or used my property or possessions without my permission.
- Someone has made or makes decisions about my money without consulting me.
- Money has been taken or used by someone I have a joint bank account with, for uses which I have not agreed to.
- Someone has put pressure on me or has forced me to change, or sign an important document such as a Will, an investment, a property deed, or Enduring Power of Attorney.
- Someone has threatened to withdraw care or support from me, unless money or property is available.
- Someone has threatened that I will not see family members, unless money or property is available.
- Someone has promised care or support for me if money or access to property is available and not followed through on the promise.
- An independent adult makes significant use of household utilities such as heating, water, electricity, or phone and refuses to contribute to the costs.

⁹⁷ <https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

⁹⁸ See Browne, M., (2020), Funding Long Term Support and Care for Older People – A Safeguarding Perspective, <https://www.safeguardingireland.org/wp-content/uploads/2020/10/Web-Version-Funding-Long-Term-Support-and-Care-for-Older-people.pdf>

⁹⁹ <https://www.safeguardingireland.org/wp-content/uploads/2019/11/BPFI-Safeguarding-Ireland-Financial-Abuse-Nov-2019.pdf>

Why safeguarding people from financial abuse is important

There is a clear obligation to ensure that the financial rights and freedoms of adults who may be at risk are promoted and protected. Many people face challenges to their financial independence due to one or more of multiple factors:

- a. Reduced decision-making capacity arising from having an intellectual disability, dementia, an acquired brain injury;
- b. Mental health difficulties;
- c. An inability to communicate effectively;
- d. Lack of family and community supports;
- e. Inability to access financial services that meet their needs;
- f. Frailty associated with the ageing process.

For some people, this vulnerability is due to a lifelong condition, while for others their ability to manage their financial affairs effectively deteriorates slowly as a condition such as dementia develops over time, or as financial products change. The increasing use of digital banking has created barriers to financial independence for many people.¹⁰⁰

The nature of current financial services – the emphasis on on-line banking, the closure of local bank branches, the withdrawal of the Ulster Bank and KBC from the Irish market and the gradual move towards a cashless economy – creates additional vulnerabilities for adults at risk, particularly for some older people in controlling and managing their own finances. For example, there appears to be no obligation on Banks (in the context of withdrawal from the Irish market) to assist existing customers, many of whom are long-standing.¹⁰¹ It is noted that the Central Bank has issued a letter to CEOs of financial entities.¹⁰² This states that specific consideration should be given to the impact of decisions on vulnerable customers and that the assistance necessary to reasonably mitigate those impacts and enable people to retain access to basic financial services should be provided. The entities should also have “specific and effective processes and communication plans to support vulnerable customers during this time of increased uncertainty” (Paragraph 3 of Letter).

The closure and the related challenge for UB and the remaining banks in identifying and supporting the ‘vulnerable’ customer base shines a light on how underdeveloped systems and processes to support customers with additional or atypical support needs may be.

¹⁰⁰ <https://www.irishtimes.com/business/work/i-m-old-not-an-idiot-older-customers-are-ill-served-by-online-strategies-1.4817480>
¹⁰¹ It should be noted that Ulster Bank have been engaging with Safeguarding Ireland and other groups in order to help to ensure a smooth transition for customers at risk.
¹⁰² Consumer Protection expectations in a changing retail banking landscape 2021 <https://www.centralbank.ie/docs/default-source/regulation/consumer-protection/other-codes-of-conduct/consumer-protection-expectations-in-a-changing-retail-banking-landscape-2021.pdf?sfvrsn=4>

It is noted that the Department of Finance is currently carrying out a broad-ranging review of the retail banking sector in Ireland¹⁰³ and that one of its Terms of Reference is to consider the potential consequences for consumer protection (including for existing and future customers and for vulnerable customers).

It is acknowledged that there are important issues associated with the quick onset of vulnerability arising from, for example, dementia or an acquired brain injury which need to be identified, analysed and addressed but which are beyond the scope of the current Paper.

While it is likely that the majority of people who support adults at risk to manage their finances (e.g., those acting as Agents for social welfare payments for people unable to do so themselves) act out of a genuine caring disposition and in good faith, there is an increasing awareness and evidence of the financial abuse of adults at risk which has been documented in research. This is a critically important issue in that financial abuse in all its forms can have a profound effect on individuals and also undermines their basic right to control and manage their own affairs.

The Law Reform Commission (LRC), in its Issues Paper, **A Regulatory Framework for Adult Safeguarding**, has comprehensively highlighted (4.3) the issues that contribute to financial abuse – a lack of understanding of financial decisions among vulnerable or at risk adults; inadequate provision of training and professional development for banking staff; inadequate supports for banking staff; the absence of mandatory reporting of financial abuse; and an absence of inter-sectoral collaboration. Inadequate legislation and policy is also identified by the LRC as a key issue. The LRC Paper also refers to many additional issues, including: a lack of public awareness of the abuse of adults at risk; financial abuse related to joint accounts; financial abuse related to social welfare payments; and increasing rates of financial abuse linked to advancements in technology.

Extent of financial abuse

Financial abuse is widely regarded as a significant issue for older populations and was identified as the most common form of maltreatment in a 2010 Irish prevalence study.¹⁰⁴ National Centre for the Protection of Older People (NCPOP) research¹⁰⁵ has shown that financial abuse is the most common type of abuse reported in relation to older persons. The number of financial abuse alleged incidents reported to the HSE National Safeguarding Office (NSO) in 2020¹⁰⁶ was 1,198 (10% of all concerns reported). Financial abuse alleged incidents were reported to a greater extent in adults over 80 years. Reports from preceding years indicate a similar pattern of concerns.

¹⁰³ <https://www.gov.ie/en/press-release/d9ba7-minister-donohoe-publishes-term-of-reference-for-retail-banking-review/>
¹⁰⁴ Naughton, C; Drennan, J; Treacy, M.P (2010), Abuse and Neglect of Older People in Ireland, <https://www.lenus.ie/bitstream/handle/10147/115375/Prevalence%20study%20summary%20report.pdf?sequence=1&isAllowed=y>
¹⁰⁵ Fealy, G., Donnelly, N., Bergin, A., Treacy, M.P., Phelan, A. (2012) Financial Abuse of Older People: A Review, NCPOP, University College Dublin, <https://www.lenus.ie/bitstream/handle/10147/300701/599NCPOP.pdf?sequence=1&isAllowed=y>
¹⁰⁶ HSE National Safeguarding Office. Annual Report. 2020

Data relating to safeguarding provided by the Department of Social Protection¹⁰⁷ indicates, as might be expected, a number of alleged cases of financial abuse. Of 208 cases brought to the Department's attention in 2020, 154 involved financial abuse. In the majority of cases, the reports related to alleged abuse by a family member.

It is worth noting, however, the relatively small number of allegations of financial abuse reported to the DSP in comparison with the much higher number reported to the HSE. This may reasonably be taken to reflect the fact that financial abuse extends much deeper than just the misappropriation of social welfare payments.

Among the key findings of a 2019 Red C poll¹⁰⁸ conducted for the BPFI and Safeguarding Ireland were:

- One-in-five (20%) adults aged 18+ in Ireland either were currently experiencing or have in the past experienced financial abuse.
- The most common types of financial abuse reported included accessing or using someone's property or possession without permission, and people living with others that are not paying their way to cover the household costs and bills.
- A considerable proportion of the population (43%) are also concerned about experiencing financial abuse at some point in the future.
- A similar proportion (43%) have not experienced any financial abuse and are not concerned about experiencing it in the future.
- While a friend or family member is the most likely person to whom people will turn to in the event that they are experiencing financial abuse, almost one-in-ten (9%) said that they would probably not consult anyone if they experienced financial abuse.

According to a further Red C Poll commissioned by Safeguarding Ireland and BPFI in October 2020¹⁰⁹, two-thirds of people who needed help from others to manage their money during the Covid-19 lockdown (11% of those polled) had not taken back control of their own finances. The Poll also showed that:

- One in twenty people (5%) stated that they experienced financial abuse during lockdown with 19% having experienced financial abuse at some time in their lives;
- 13% were concerned about someone taking advantage of them financially;
- 12% experienced less control of their finances since the pandemic began.

¹⁰⁷ DSP – Safeguarding Ireland communication. 2021.

¹⁰⁸ <https://www.safeguardingireland.org/wp-content/uploads/2019/11/BPFI-Safeguarding-Ireland-Financial-Abuse-Nov-2019.pdf>

¹⁰⁹ <https://bpfi.ie/insights/safeguarding-your-money/>

Sage Advocacy has reported¹¹⁰ a connection – in cases where adults at risk had experienced financial abuse – between having to depend on family or carers for help with spending or managing their money. This became a particular issue with the onset of Covid-19 as many adults at risk had to rely on others for help in accessing their funds and social welfare payments. It was noted that over half of financial abuse referrals made to Sage Advocacy during 2020 were related to people being dependent on help from others to manage their finances.

In practice, there is very limited or little oversight by the DSP in respect of agents¹¹¹ for social welfare payments. While the Department does take action when complaints are made, there is no proactive or systematic oversight of the system. While Type 2 Agents will probably cease with the commencement of the ADMC Act 2015, Type 1 agents will continue in existence and, thereby, allow for financial abuse, especially by a family member exercising coercive control over a claimant who is living at home and not in contact with any service. There is strong anecdotal evidence that a proportion of agents (either Type 1 or Type 2) receive state payments on behalf of claimants and simply keep it. This is evidently theft and needs to be acknowledged as such.

A related issue is that there is some evidence of people receiving the Carer's Allowance social welfare payment to provide care to people at home but who are not providing the care required or, indeed, any care.¹¹² From a safeguarding perspective, it should be noted that care recipients are often very vulnerable people who rely heavily on the carer for essential needs so that they do not have to move to long-term residential care. Therefore, their vulnerability leaves them reluctant to complain or report poor quality or non-existent care. The DSP and the HSE rely on the care recipient to complain if the care they are receiving is not adequate, but clearly not everybody has the ability to or wants to make a complaint due to reduced decision-making capacity, disability, a controlling carer or an abusive situation.

Safeguarding and Protection Teams have an important role to play in addressing concerns about financial abuse. However, there is also some anecdotal evidence of inconsistency between Teams in relation to how the matter of financial abuse is dealt with. It is possible that some Safeguarding Teams do not have the expertise required to deal with financial abuse matters and there may be instances where there are complex challenging issues around family finances which make a resolution difficult.

¹¹⁰ Breaking the Wall of Silence, <https://www.sageadvocacy.ie/media/2202/6376-sage-voc-report-fa-for-web.pdf>

¹¹¹ There are currently two types of social welfare agents. A Type 1 agent collects the payment on behalf of a person who is unable to do so due to illness or loss of mobility. Type 1 agency confers no authority on the agent to do anything other than collect the payment. A Type 2 agent applies where a person is deemed unable to manage their own financial affairs and an agent is appointed to collect the payment and act on behalf of the claimant. In all cases a medical practitioner must certify that the person is unable for the time being to manage their own financial affairs

¹¹² <https://www.sageadvocacy.ie/news/2020/august/shows-family-carers-going-above-and-beyond-the-call-of-duty>

International research¹¹³ has indicated that older people are more at risk of financial abuse if they have diminished capacity (either arising from reduced decision-making capacity or a physical/sensory disability). The growing body of literature in this field of financial abuse of older people has identified both a sense of entitlement on the part of family members and diminished capacity on the part of an older person as the key risk factors contributing to abuse. It has been noted¹¹⁴ that older people's assets can be a site of competing interests, in that families have an interest in protecting potential inheritances; the market has interests in promoting lifestyle, care, and accommodation options, as well as financial products, such as reverse mortgages; the State is concerned with self-provision and financial independence in older age; and service providers have an interest in preserving assets to pay user charges for health, care and accommodation in older age. (p. 156)

All of the above research indicates a worrying prevalence of financial abuse of adults at risk, some uncertainty about what constitutes financial abuse and a lack of knowledge of what to do when someone becomes aware of the financial abuse of adults at risk. It should, of course, be noted that adults without reduced decision-making capacity or who do not lack financial capacity can be financially exploited through the use of psychological manipulation or misrepresentation, coercion or undue influence. (See Appendix/Case Scenario 10)

Another form of financial abuse exists where there is a delay in applying for the Nursing Homes Support Scheme (NHSS) (often months may pass by during which a person does not get appropriate care) as family members manage finances to 'protect their inheritance'.¹¹⁵ Many families, particularly those which are asset-rich but cash-poor, are reluctant to sign up to the NHSS because doing so could see them lose a good chunk of their assets to the NHSS and pay more for their nursing home care than someone who has no assets whatsoever. Families can also be concerned that the depletion of assets by the NHSS would eat into the inheritance pot earmarked for loved ones.¹¹⁶

The 2020 Comptroller and Auditor General Special Report stated that their examination found no evidence on file - for the sample analysed - that third party sources had been used to verify the completeness and accuracy of income and assets included on the application form or to identify income and assets that may have been transferred by the individual in the prior five years.¹¹⁷ There would be a lot of merit in exploring how NHSS financial assessments could tap into this

113 https://web.archive.org/web/20190309064534id_/https://seniorsrights.org.au/wp-content/uploads/2014/03/Financial_abuse-of-older-people-by-family-members.pdf
https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/money-matters/financial_abuse_evidence_review-nov_2015.pdf

114 Wilson et al. cited in Age UK, Financial Abuse Evidence Review, https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/money-matters/financial_abuse_evidence_review-nov_2015.pdf

115 See Browne, M., Funding Long Term Support and Care for Older People – A Safeguarding Perspective, <https://www.safeguardingireland.org/wp-content/uploads/2020/10/Web-Version-Funding-Long-Term-Support-and-Care-for-Older-people.pdf>

116 Ibid.

117 <https://www.audit.gov.ie/en/find-report/publications/2020/special-report-110-the-nursing-homes-support-scheme-fair-deal-.pdf>

information, minimise duplication of work and reduce the HSE workload in that regard. Indeed, there is a strong argument to be made for the financial assessment to be carried out by the Revenue Commissioners rather than by the HSE.

Transfers of an applicant's cash assets in the five years prior to an application for support are taken into account in determining the required personal contribution. According to the HSE, local offices should request bank statements covering a period of at least six months prior to the application being made. However, the HSE noted that it had difficulty in obtaining bank statements for the five-year period prior to the application.

The 2020 Comptroller and Auditor General (CAG) Special Report noted that 93% of applicants in the sample cases examined had declared cash assets. The examination found in all cases that the documentary evidence provided to support declarations of cash assets was a statement from the relevant financial institution, with 93% of those being less than three months old at the date of submission. For around €1.3 million, or 47% of these cash assets, the applicants had only provided statements covering a one-month period.¹¹⁸ This was regarded by the CAG as not providing sufficient evidence to establish whether the individual had transferred financial assets in the five years prior to the application.

The experience of the HSE, as noted in the Comptroller and Auditor General report, is that when family members are trying to sort out a relative's affairs when making an application, in many cases they may not know what accounts their relatives have in financial institutions. The HSE further noted that family members also find it very challenging to get relevant information of account details from financial institutions, due to data protection issues, unless they have enduring power of attorney arrangements in place.

There are a number of specific issues relating to NHSS financial assessment which may result in people being enabled to 'hide' money and assets. On this point, there is a lot of scope for transferring cash prior to the NHSS financial assessment. While there is provision in the legislation for people to be convicted for non-declaration of assets, there has been no such conviction to date. This is not surprising given the inadequate evidence collected in many cases. Clearly, if the HSE does not specify what documentary evidence is required, and collect this evidence, they are not in a position to make any conviction for non-declaration of assets.

Nursing Home Contracts of Care

Typically, people who are engaging with the nursing home sector are in a vulnerable position, particularly when contracts are being negotiated. There is potential for financial abuse in such situations if all matters relating to finances and fees are not made fully transparent in contracts, without any ambivalence, or are not explained fully to the individual (with communication support if necessary).

118 Ibid. p.55

Issues relating to Contracts of Care in Long-term Residential Care Services for Older People were highlighted by Sage Advocacy in a 2018 Submission to the Competition and Consumer Protection Commission (CCPC).¹¹⁹ The CCPC has since published Guidelines for Contracts of Care in Nursing Homes.¹²⁰ The guidelines are aimed at ensuring that residents and their families have more certainty and clarity in what they, and the nursing home, are committing to. The Guidelines highlight examples of potentially unfair terms in contracts of care that were in operation in the sector.

People most likely to be at risk of financial abuse

There is a range of key risk factors that indicate those who are most likely to be victims of financial abuse. A synthesis of international research evidence on financial abuse carried out by Age UK¹²¹ shows that the risk increases with age, meaning that older people are more at risk than younger cohorts.¹²² Those who have reduced decision-making capacity are a specific subgroup of people who are most at risk of being victims of financial abuse compared to any other risk factor. Similarly, those who have poor health and have (or are at risk of) clinical depression and other illnesses have also been reported as being at a substantial risk of financial abuse.

Social risk factors associated with financial abuse identified in research include low levels of social support and needing help with Activities of Daily Living such as bathing, feeding, or showering; and needing help with Instrumental Activities of Daily Living, for example, managing money, shopping and housework. Other social risk factors identified include being dependent on the abuser.

Another context for financial abuse is where adults at risk are manipulated by people who position themselves as ‘friends’ and then use the ‘friendship’ to gain access to the person’s money or property. A decision in a recent court case by Judge John O’Connor in respect of a person who engaged in manipulative financial abuse of an adult at risk is significant.¹²³ The Judge found that the friendship of an innocent, vulnerable man had been abused by a person who eventually took control of his finances and tried to acquire his €275,000 home and contents through a disputed homemade will. This case is highly important for a number of reasons, including, in particular:

1. It is illustrative of the insidious and manipulative nature of financial abuse that takes place and the manner in which perpetrators attempt to ‘normalise’ such behaviour;

¹¹⁹ <https://www.sageadvocacy.ie/media/1431/nursing-home-contracts-sage-submission-to-ccpc-220218.pdf>

¹²⁰ <https://www.ccpc.ie/consumers/wp-content/uploads/sites/2/2019/10/2019.05.15-Care-Home-Guidelines-May-Updated-FINAL.pdf>

¹²¹ https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/money-matters/financial_abuse_evidence_review-nov_2015.pdf

¹²² https://www.eapu.com.au/uploads/research_resources/VIC-Financial_Elder_Abuse_Evidence_Review_JUN_209-Monash.pdf

¹²³ Conroy vs. O Ceallaigh -- see <https://www.thejournal.ie/taxi-driver-seamus-conroy-disputed-will-court-5636620-Dec2021/>

2. The Court Judgement referenced the activity of the perpetrator for what it was – the whole domination and control by one person over another.

Coerced debt

‘Coerced debt’ is debt incurred by an abuser, in the name of a victim of domestic violence, through threat, force, or fraud. It is a form of coercive control, identity theft, and economic abuse. (Surviving Economic Abuse, 2019). While there is no research in Ireland on this issue, it is noted that the Banking Federation have referenced it recently in the context of domestic violence. However, the practice of coercive debt is likely to exist outside intimate partner relationships, most obviously where an adult incurs debts (personal loans, credit card debt) under pressure/duress from a third party, or defaults on mortgage, utility or rent payments because a third party is misusing their money. It also likely to occur in situations where older parents acting as guarantors on an adult child’s mortgage are left to pay-off the debt when an adult child deliberately defaults, drug debts (where a parent pays-off the debt to protect themselves, other children and the adult child who ‘owes the debt’), and illegal money lending.

Impacts of financial abuse on adults at risk

Financial abuse can have serious impact on adults at risk, not just financially but also emotionally. Even a small amount of financial abuse can be catastrophic, especially to those who are on limited incomes. It has been noted that It is more difficult for older people to recover from financial abuse than younger people because they have less time and opportunity to remedy the injustice.¹²⁴

A range of emotional implications that stem from financial abuse have been identified in research¹²⁵, including:

- Feelings of betrayal.
- Distress and anxiety.
- Embarrassment, loss of self-esteem and confidence in one’s own judgement.
- Denial, fear and self-blame.
- The loss of confidence to live independently.

These emotional effects can also make adults at risk more vulnerable to further exploitation. Financial abuse has also been linked to negative health outcomes and a decline in mental health.¹²⁶

¹²⁴ https://www.eapu.com.au/uploads/research_resources/VIC-Financial_Elder_Abuse_Evidence_Review_JUN_209-Monash.pdf

¹²⁵ Age UK, Financial Abuse Evidence Review, https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/money-matters/financial_abuse_evidence_review-nov_2015.pdf

¹²⁶ Ibid. p.7.

Enabling people with reduced decision-making capacity to manage their own finances

There is a strong argument that the more people with reduced decision-making capacity are empowered and enabled to manage their own money, the less likely they will be vulnerable to financial exploitation. This applies, in particular, to people with a life-long intellectual disability. A question, however, arises as to how well current policy and practice supports and facilitates the development of people's decision-making capacity to the greatest extent possible in respect of understanding and using money, experiencing 'ordinary' social transactions in the community, knowing where their money comes from, why they receive it, how much money they get and where it goes.

In the continued absence of safeguarding legislation, there remains inadequate protection for people at risk because of an intellectual disability relating, *inter alia*, to protection from financial abuse. For example, there are no guidelines in existence for safeguarding the finances of a person who may be vulnerable to financial abuse who lives on their own in the community, or with a family member, or in a house with other people (apart from HSE funded community group homes).

Significant progress has been made in recent decades in relation to the way the finances of people in residential care facilities are managed taking into account the need to protect the rights of people with reduced decision-making capacity. Residential care service providers are generally engaged in a process of developing appropriate protocols in this regard. Many have set out in detail policies and procedures, including staff roles and responsibilities, in facilitating and supporting service users' choice. Protocols for accounting, record-keeping, opening and managing bank accounts have been developed and disciplinary action relating to any misuse of service users' accounts has been identified.

HIQA inspection reports over the years have referenced evidence in many residential care services of robust systems in place in relation to the management of residents' finances. However, a gap identified in HIQA Inspection Reports has referred to insufficient support being provided to residents to manage their own financial affairs, as well as some lack of transparency around the use of residents' money to cover certain staff expenses. For example, a 2019 Overview Report¹²⁷ on **Five Years of Regulation in Designated Centres for People with a Disability** noted that, in some services where it was deemed that the risk of financial abuse was too great, some residents were denied the right to manage (with support if required) their own financial affairs.

A 2019 HIQA Overview Report on Nursing Homes¹²⁸ found a relatively high rate of non-compliance with regulations relating to personal possessions in 2019, albeit lower than the rate in 2018.

127 <https://www.hiqa.ie/sites/default/files/2019-08/HIQA-DCD-5-Year-Regulation-Report-2019.pdf> p.46.

128 https://www.hiqa.ie/sites/default/files/2020-12/DCOP_Overview_Report_2019.pdf

Current Standards and Guidelines for the management of the finances of people living in residential care services may not be sufficiently detailed to cater for the specific support needs of a range of people with different decision-making capacity in relation to financial management. For example, a 2019 Sage Advocacy Discussion Document¹²⁹ referred to a 'one size fits all' approach in some services to the management of residents' personal finances with active engagement with individual residents around money matters remaining underdeveloped.

Decision-making capacity and financial capacity

The matter of the management by at risk adults of their personal finances is intrinsically linked to decision-making capacity. There is a common law assumption, now given statutory effect in the Assisted Decision-Making (Capacity) Act 2015, that all persons are presumed to have the capacity (or ability or competency) to make a specific decision or decisions until the contrary is indicated. A person is, therefore, only to be regarded as having reduced capacity to understand and manage their finances after all efforts have been made to support their decision making by facilitating them to understand the decision to be made.

Pending the full commencement of the Act, the presumption of capacity and a functional approach to capacity should prevail in all situations. Under current provisions, where there is no legal provision for the management of a person's personal finances on their behalf, e.g., an attorney or attorneys under a registered Enduring Power of Attorney, the only alternative available in order to safeguard an at risk adult's personal money is wardship. When the ADMC Act is fully commenced a number of decision support mechanisms will be available to people. Under the Act, where a person who has been assessed as lacking decision-making capacity for specific matters, the Circuit Court will appoint a Decision-Making Representative to act for that person.

Financial capacity has been found to be an advanced activity of daily life, conceptually distinct from household activities and basic activities of daily life. Research has shown that financial capacity is already significantly reduced for people with mild Alzheimer's disease, especially in the more complex domains of cheque book use and management, bank statement management, bill payment and financial judgement.¹³⁰ The decline in financial capacity can be rapid, for example, in Alzheimer's disease.

The development of a domain-based approach to financial capacity recognises that an individual may be competent to carry out some financial activities and not others. The following related domains have been identified¹³¹ - basic monetary skills, financial conceptual knowledge, cash transactions, cheque book management, bank statement management and financial management.

129 Best Practice in Supporting Adults Who May Be Vulnerable to Manage Their Own Finances, <https://www.sageadvocacy.ie/media/1906/support-1.pdf>

130 Marson, D.C. et al (2009), Clinical Interview Assessment of Financial Capacity in Older Adults with Mild Cognitive Impairment and Alzheimer's Disease, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2714907/>

131 Ibid.

For example, support with everyday transactions is clearly different to the more complex task of managing investments.

Ward of Court or Power of Attorney

In the case of a Ward of Court or an attorney appointed under an enduring power of attorney (EPOA), the DSP will make payments directly to the Committee of the Ward or to the attorney by nominating them as agent for the beneficiary. All such payments are made electronically to a nominated bank account. In EPOA cases, this must be a financial institution account of which the payment recipient is a registered party.

Institutional agents

SI 142/2007, as amended by S.I. No. 378 of 2009 202A(f),¹³² stipulates that after an institutional agent has collected a pension or benefit payment (normally by direct EFT transfer to the residential care centre account) and after the agent has undertaken any authorised financial transaction/offset on behalf of the recipient/patient, in line with the above provision, as long as all monies are used by the institution only for the benefit of the recipient (Provisions 202A (d) and (e)), ensure that the balance of any benefit is lodged to an interest bearing account for the benefit of the claimant or beneficiary (f), and that clear and accurate records are maintained (g) and (h)).¹³³

The DSP has indicated¹³⁴ that it is satisfied that the accounting obligation in paragraph (f) of the legislation can be met by a designated centre if it has in place a secure and reliable internal structure/system for individualised accounting and tracking of patients' finances. This means that once there is a detailed account of every transaction which is traceable to each individual resident then the entirety of the funds for all residents can be held in one dedicated client account. While the latter is acceptable practice, it may not be best practice.

The DSP is in the process of reviewing and revising the general use of Agents for receiving the State payments of adults who may be at risk in the context of ensuring best practice and in order to meet the requirements of the Assisted Decision-Making (Capacity) Act 2015 once this is commenced. It is most likely that Type 2 agents will be replaced by the supported decision-making structures provided for in the Act.

There is some anecdotal evidence that the level of control which may be exercised by family members over people's finances in some instances may be unnecessarily controlling, with particular reference to the Agency system for social welfare benefit payments. DSP requirements in respect of agency for social welfare payments (discussed above) provide some protection in that the Department will act promptly to investigate any case of alleged non-compliance by an agent with the obligations set out in its legislation (which the nominated person/agent undertakes to

¹³² <https://www.irishstatutebook.ie/eli/2009/si/378/made/en/print>

¹³³ These regulations are likely to be updated when the ADMC Act and related Codes of Practice are implemented.

¹³⁴ Sage Advocacy, Best Practice in Supporting Adults Who May Be Vulnerable to Manage Their Own Finances, <https://www.sageadvocacy.ie/media/1906/suppor-1.pdf>

adhere to at the outset, and which are again notified to the agent at the time of their appointment). While legislation provides for the payment recipient to request the discontinuation of an agent arrangement if at any time they are not satisfied with the arrangement, this presumes that the recipient has decision-making capacity.

Putting an account into a 'Joint Account'

It is often suggested to people who are experiencing difficulty in managing their finances that placing their bank or credit union account into the joint names of themselves and the other person who is prepared to support them is a way of achieving this. This, however, can present a significant problem which is very difficult to address if this "arrangement" is not set up with due diligence and absolute clarity as to the intentions of the account owner. The putting of an account with a financial institution which contains money belonging to one party only (for example accumulated Disability Allowance or savings from it or other income or allowances) into joint names with another party has serious legal (and potentially taxation) consequences because of the operation in law of the concepts known as "resulting trusts" and "presumption of advancement".¹³⁵ These legal concepts can operate to deprive the rightful owner of some or even all of their money and may make it impossible for them to access the funds without the approval and/or signature of the other party whose name is put on the account.

Role of HSE Safeguarding and Protection Teams

As outlined earlier in this report, HSE Safeguarding and Protection Teams are in place in all CHO areas¹³⁶ and work with services, families and community organisations to stop abuse and to ensure that people are safeguarded. In circumstances where a service, professional or family member believes that there are concerns about bad practice, Safeguarding and Protection Teams provide a mechanism for dealing with any such alleged incidents once they are brought to their attention. The underlying rationale for the Safeguarding Teams is that all adults have the right to be safe and to live a life free from abuse regardless of their circumstances. They have a right to be treated with respect and to feel safe, regardless of the setting in which they live.

The **"Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures"**, which applies to all HSE and HSE funded services, outlines a number of principles to promote the welfare of vulnerable people and safeguard them from abuse, including, in particular, respect for human rights and empowerment of individuals. All vulnerable people have a right to be protected against abuse and to have any concerns regarding abusive experiences addressed, including financial abuse or exploitation as described earlier in this chapter.

¹³⁵ These are relatively complex legal terms which highlight the potential consequences for a person of putting an account in the sole name of an individual into a 'joint account'.

¹³⁶ <https://www.hse.ie/eng/services/list/4/olderpeople/elderabuse/protect-yourself/safeguardpro-tectteams.html>

Next-of- kin

Financial abuse may sometimes occur because of a wrong understanding of the role of ‘next-of kin’. The findings of a Red C Public Opinion Survey carried out for Sage Advocacy in 2018 are informative. When asked if a family member has authority to make decisions for someone who is frail but still has decision-making capacity without their consent, 30% said that yes the family member does have this authority, 28% did not know, and just 40% recognised that the decision continues to lie fully with the person as long as they have decision-making capacity.

More than two-thirds (70%) of respondents answered, correctly, that ‘next of kin’ is “someone, such as a close relative or friend, who I would like contacted in an emergency”. However, in relation to financial matters, almost one-third (32%) believed that ‘next of kin’ was “someone who can access my bank accounts and assets if I’m unable to”.

In the context of ensuring that a person’s will and preference is to the fore in all decisions affecting their finances, it is vital that there is absolute clarity that ‘next-of-kin’ have no legal rights apart from being someone nominated to be contacted in an emergency. The correct understanding of the limited role of ‘next-of-kin’ is a crucial factor in ensuring that people’s assets are used properly and that people’s right to control their finances is fully protected and that their assets are not misused in any way.¹³⁷

Role of financial service providers in safeguarding the finances of an adult who may be vulnerable to financial abuse

Banking policy regarding at risk customers is informed by the Central Bank of Ireland’s Consumer Protection Code which sets out a duty of care approach for financial institutions in relation to at risk adults. It provides that, where a regulated entity has identified that a personal consumer is a vulnerable consumer, the regulated entity must ensure that the vulnerable consumer is provided with such reasonable arrangements and/or assistance that may be necessary to facilitate him or her in his or her dealings with the regulated entity (3.1).

A Financial Service Provider who is engaging with a person who is perceived by a staff member of that Financial Service Provider to be potentially vulnerable to financial abuse has a particular duty of care to that person on account of their vulnerability. This was established by a High Court judgement in October 2010.¹³⁸ The bank’s customer was a woman who had been in bad health for some years and was now living in a nursing home. She attended at the bank to withdraw all of the proceeds of an insurance policy, which had recently been lodged to her account and which was her only asset, in order to give the money to her

¹³⁷ See Browne, M., Funding Long Term Support and Care for Older People – A Safeguarding Perspective, <https://www.safeguardingireland.org/wp-content/uploads/2020/10/Web-Version-Funding-Long-Term-Support-and-Care-for-Older-people.pdf>

¹³⁸ Bourke v O’Donnell & Others [2010] IEHC 348 <https://ie.vlex.com/vid/bourke-v-donnell-governor-792956029>

neighbours. Mr Justice Hedigan considered that the customer was highly vulnerable, the transaction wholly improvident and its circumstances so bizarre that the bank ought to have enquired further to satisfy itself that their customer had the capacity to issue instructions free from undue influence and in not doing so had breached its duty of care and so was liable for the sum of money.¹³⁹

Research¹⁴⁰ which examined bank staff’s experiences of financial abuse of vulnerable adults found that almost 70 per cent of survey respondents had had a suspicion of financial abuse of a vulnerable adult. Bank managers and National Safeguarding staff highlighted particular issues in relation to capacity, family assumption of entitlements to a vulnerable adult’s finances and difficulty in relation to sharing PIN numbers. There was also some evidence of financial abuse being perpetrated on at risk adults who had power of attorney orders in place and where powers of attorney had been abused,

The ADMC Act 2015 (Section 103) provides for the development of a statutory Code of Practice for the guidance of, inter alia, independent advocates and other persons (including healthcare, social care, legal and financial professionals) acting on behalf of relevant persons. The Code for Financial Professionals is expected to confirm a duty of care and set out the steps that financial professionals must take in order to comply with that duty. Changes to the Power of Attorney arrangements to be introduced under Part 7 of the ADMC Act, as well as the decision-making support options, will be centrally relevant to financial institutions and will need to be reflected in their policies and codes of practice.

The Banking and Payments Federation of Ireland **Guide to Safeguarding your Money Now and in the Future**¹⁴¹ provides a valuable guide for this purpose. It provides guidance on, inter alia, asking your bank for help, managing everyday banking, getting another person involved in managing your money, setting up a joint bank account, setting up a third-party authority and setting up a power of attorney. It should be noted, however, that there is a very low take-up rate of the latter option. For example, a RED C Poll,¹⁴² carried out for Safeguarding Ireland, found that almost three-quarters of respondents had not (and had not considered) putting in place an Enduring Power of Attorney.

Pending the commencement of the ADMC Act, in order to eliminate financial abuse in the context of Bank transactions, financial service providers should assist adults who may be at risk in setting up and managing appropriate accounts. They should have a mechanism in place for periodic checking to ensure that the arrangements in place continue

¹³⁹ See also <https://www.lawsociety.ie/Solicitors/Practising/Practice-Notes/Transactions-involving-vulnerableolder-adults-to-include-requests-for-visits-to-residential-care-settings/#.XZ97SUZKg2w>

¹⁴⁰ Amanda Phelan, Deirdre O’Donnell and Sandra McCarthy (2021), Financial abuse of older people by third parties in banking institutions: a qualitative exploration, <https://www.cambridge.org/core/journals/ageing-and-society/article/financial-abuse-of-older-people-by-third-parties-in-banking-institutions-a-qualitative-exploration/8CB9EF-01B3A1DC261D0DE177A89E671B>

¹⁴¹ <https://www.bpfi.ie/wp-content/uploads/2018/06/BPFI-Guide-to-Safeguarding-Your-Money-Now-and-in-the-Future.pdf>

¹⁴² <https://www.safeguardingireland.org/wp-content/uploads/2020/05/Plan-Ahead-Future-Care-June-2020.pdf>

to meet the person's needs in a transparent and accessible manner. This is particularly important in the case of Joint Accounts (see above). It is crucially important that financial institutions have experienced staff trained in the legal and tax consequences of transferring financial accounts into joint names and be able to explain the issues to the customer. There is a clear role for independent advocacy in these processes.

Overview and Conclusion

Ireland currently does not have legislation giving a statutory right to protections for adults at risk. In 2017, the Government approved the development of a national policy on national safeguarding in the health and social care sector and underpinning legislation. However, this proposed legislation did not make any provision for safeguarding from financial abuse in society generally. Similarly, National Standards for Adult Safeguarding developed by HIQA and the Mental Health Commission (MHC)¹⁴³ did not include safeguarding against financial abuse and exploitation other than to require (2.2.6) that services build *“networks and relationships across a range of services and agencies so that they can respond effectively when a safeguarding concern arises, for example, with Gardaí and other statutory services, financial institutions, advocacy and support groups”*.

There are people who need 'physical' support in managing their financial affairs as, for example, their mobility deteriorates, but who still understand and can still give direction as to what they want done with their money and property. They may want support or assistance with paying bills or withdrawing funds for daily living but otherwise are fully capable of managing their finances. There are others who, because of reduced decision-making capacity, require additional supports and this group is particularly vulnerable to financial abuse and exploitation.

HSE Safeguarding Teams can play an important role in helping people to deal with financial abuse when a concern is reported. However, it is almost certainly the case that many cases of financial abuse or exploitation go unreported and are not referred to a Safeguarding Team, either because the person being exploited does not see what is happening as abuse and/or is relying on the perpetrator for care and support. There is also the issue of a relatively low level of public awareness about what constitutes financial abuse and where to report concerns about abuse generally.

Financial service providers have a particularly important role to play as has the Department of Social Protection in relation to the payment of state benefits. It is critically important that people are advised to seek the assistance of an independent advocate where difficulties are perceived or identified in relation to the proper management of the assets of an adult whose decision-making capacity may be in question.

¹⁴³ <https://www.hiqa.ie/sites/default/files/2019-12/National-Standards-for-Adult-Safeguarding.pdf>

Research evidence strongly suggests that financial abuse and exploitation of adults at risk is prevalent in society, both internationally as well as in Ireland. It is critically important that all of society – families, social networks and service providers – become more aware of and attuned to the issue of financial abuse and that people generally become more vigilant about recognising and reporting financial abuse. While legislation and regulation can help to safeguard people from financial abuse, this can only be effective when there is a cultural shift that names financial exploitation for what it is, namely a denial of people's right to control all of their assets and, in instances of reduced decision-making capacity, to have such assets used *only* for their benefit.

This chapter has raised multiple concerns about the matter of financial abuse that require to be made a more central component of public and policy discourse. The position of those adults who are most at risk, particularly those with reduced decision-making capacity and those who are subjected to coercive control by a family member, is a matter for public concern.

The current reality may well be that society in general and service providers may be ill-equipped to understand and address the issue of financial abuse. The risk factors for financial abuse are well known, particularly where people have reduced decision-making capacity. Since there is an obvious challenge in engaging people with reduced decision-making capacity in controlling and managing their finances, there is a critical need to engage people in early intervention or preventative strategies, for example, powers of attorney provision, in order to minimise the risks of being financially exploited.

While well-publicised cases of major, criminal financial abuse of adults at risk attract much public attention, there remains a culture which tolerates many forms of persistent financial abuse of adults who are at risk.

There is a need for greater public awareness and recognition of the fact that financial abuse, irrespective of magnitude, is a breach of people's rights and is unacceptable.

The level of financial abuse reported relating to people over 80 years gives rise to concern, particularly since there are some reported alleged incidents of financial abuse where there is no meaningful follow-up. This highlights a need for Safeguarding and Protection Teams to have multi-disciplinary skills, including finance and legal.

The next chapter will discuss the safeguarding of people in residential care settings.

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/ Chapter Five

Safeguarding People Resident in Nursing Homes

This chapter explores, from a safeguarding perspective, the impact of the current model of long-term care provision in Ireland, with a particular focus on nursing homes. While nursing homes should be places where residents feel safe, secure, cared for and protected, this may not always be the case. This chapter identifies issues arising from the impact of Covid-19 on nursing home residents. The implications for safeguarding adults at risk arising from the current model of long-term care in Ireland with its inherent bias towards nursing home care are examined.

The long-term residential care landscape in Ireland

Most nursing home residents are aged 85 years or over and have complex conditions, with dementia and related reduced decision-making capacity affecting some two-thirds of the over 30,000 people living in nursing homes in Ireland at any given time. Some 80 per cent of nursing home beds nationally are managed by private entities.¹⁴⁴

The nursing home sector in Ireland has changed considerably in terms of the size of new centres and consolidation over the past 10 years. The average number of beds per centre nationally continues to increase and new centres that apply to be registered are larger. Moreover, these new centres are largely concentrated in the east of the country, particularly in Dublin. At the same time, smaller centres are closing across the country, presenting a challenge to rural communities. There is also evidence of consolidation in the sector, with a small number of owners providing a growing number of nursing homes.

Private providers account for some three-quarters of nursing home places; about one-fifth are directly run by the HSE.¹⁴⁵ With regard to size of nursing homes: 10% are 100 rooms/beds or more; 41% are between 50–100; and 49% are less than 50. There are 10 nursing homes (of all types) with 150 or more residents and the largest has capacity for 184 residents. According to the HSE National Service Plan 2021, the number of people supported through the NHSS was expected to reduce by 237 through repurposing existing or developing additional intermediate, rehabilitation, re-ablement and outreach services and by significantly increasing home support hours.¹⁴⁶

The closed organisational culture in some nursing homes makes it exceptionally challenging for either residents or staff to speak up and report abuse or inappropriate care. There may also be a reticence on the part of residents or families to make complaints because of their heavy reliance on a nursing home for their care. In addition, the complaints process in private nursing homes could be viewed as being less than impartial and can be cumbersome.

There are clear safeguarding concerns associated with the prolonged isolation of people with high care needs in nursing home settings. The significant shift in recent years towards the privatisation of nursing home care, coupled with the failure of society to prioritise community-based care to enable people to age in place, has resulted in a situation where the human rights of adults at risk have been undermined with people being unnecessarily put at further risk by virtue of having to live in a congregated setting. There is also the fact that the people who are, in many cases, being 'obliged' to live together may have little in common and their interests and personalities may not be in any way compatible. There is repeated media reporting of poor standards of care in nursing homes as well as anecdotal evidence of neglect and abuse of residents.

¹⁴⁴ HIQA (2020) The impact of COVID-19 on nursing homes in Ireland https://www.hiqa.ie/sites/default/files/2020-07/The-impact-of-COVID-19-on-nursing-homes-in-Ireland_0.pdf

¹⁴⁵ The remainder are provided by NGOs funded under Section 38 and Section 39 grants.

¹⁴⁶ HSE National Service Plan 2021, www.hse.ie/eng/2Feng%2Fservices%2Fpublications%2Fservice-plans%2Fnational-service-plan-2021.pdf

There is, of course, a related question from a safeguarding perspective as to whether people living at home with largely unsupervised (currently) home care supports or who are dependent for their care on family members may also be at risk. This matter was highlighted in a 2020 Sage Advocacy report¹⁴⁷.

Regulation of nursing homes

HIQA inspects nursing homes in order to establish compliance with regulations, but it does not have the power to investigate specific issues unless at the request of the Minister for Health. Very significantly, HSE Safeguarding and Protection Teams do not have right of access to private nursing homes and there is no legislative provision for access by independent advocates to nursing homes.

The regulation of nursing homes by HIQA is carried out through inspections, the ongoing monitoring of solicited and unsolicited information, and through engagement with registered providers. When non-compliance is found, the emphasis by HIQA is on how providers respond to inspection findings and what action they take to bring their nursing home into compliance.

The 2019 HIQA Overview Report on the regulation of designated centres for older persons¹⁴⁸ (which marked 10 years since the commencement of regulation in nursing homes) noted continuing increased compliance in the sector. Most nursing homes were regarded as providing a good service to residents, and compliance rates were observed to improve year-on-year in many key areas.

However, notwithstanding these compliance improvements, nursing homes continue to fail to comply with regulations as evidenced repeatedly in HIQA Inspection Reports. For example, of the 35 inspection reports published on 5th November 2021, inspectors found evidence of non-compliance in 29 inspections. Areas of non-compliance included governance and management, fire precautions, staffing, infection control, risk management, and notification of incidents. They also included concerns regarding personal possessions, residents' rights, individual assessment and care plans, and complaints procedures. In the previous nursing homes inspection reports (October 2021), evidence of non-compliance was found in 32 of the 49 reports. More than half of nursing homes inspected by HIQA in the first six months of 2021 were found not to be fully compliant with regulations.¹⁴⁹

HIQA provides guidance¹⁵⁰ on 'monitoring notifications' for designated centres for older persons and designated centres for adults and children with disabilities. . These are the notifications required under the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Care and Welfare of Residents in Designated

¹⁴⁷ Browne, M. (2020), Choice Matters, Sage Advocacy, <https://www.sageadvocacy.ie/media/2026/choicematters2020.pdf>

¹⁴⁸ https://www.hiqa.ie/sites/default/files/2020-12/DCOP_Overview_Report_2019.pdf

¹⁴⁹ See <https://www.rte.ie/news/ireland/2021/0823/1242371-hiqa-nursing-homes-inspections/>

¹⁵⁰ <https://www.hiqa.ie/sites/default/files/2017-01/Statutory-Notifications-Guidance.pdf>

Centres for Older People) Regulations 2013. HIQA provides details on the types of events to be notified and the timescales that apply to each and has developed a Registration Notifications Handbook which provides guidance on registration notifications.

HIQA has also developed an Adult Safeguarding Assessment and Decision Form to enable the Authority to properly process potential safeguarding concerns brought to its attention. The Assessment Form covers a range of factors to be considered and decided upon relating to:

- Whether the information provided amounts to 'an adult safeguarding concern'.
- Making a decision whether to share information relating to an 'Adult Safeguarding Concern' with a third party.
- Determining the scope of the information to be shared with a third party.
- Legal basis for sharing personal information.

While significant progress in a number of areas has been reported by HIQA, some nursing homes are still failing to meet basic requirements, such as protecting residents from the risk of fire and ensuring they are afforded adequate space, privacy and dignity.¹⁵¹

Importantly, under current legislation, HIQA does not have the legal power to investigate individual complaints but does review all information or concerns about services received and assesses them against the regulations and the standards. While HIQA is unable to investigate individual complaints about a health or social care service under the Health Act 2007, it does use feedback in a number of ways to establish if a service is safe, effective, caring and well managed. Where HIQA believes that those responsible for providing a service may not be compliant with the necessary regulations and or national standards, it can take a number of actions in response, including:

- Identifying any trends or patterns that indicate that something unacceptable may be happening;
- Carrying out a risk-based inspection;
- Issuing a notice of non-compliance;
- Closing the nursing home.

Notwithstanding the above, there continues to be persistent trends in terms of non-compliance in key regulations nationally. These are concentrated around problems with fire safety, governance and management, and the suitability of outdated buildings in terms of providing good quality, person-centred care. The extent to which providers met the deadline of 31 December 2021 for meeting the new requirements relating to physical premises¹⁵², e.g., bedroom space, accessible bathrooms, is, as yet, unknown.

¹⁵¹ <https://www.hiqa.ie/hiqa-news-updates/quality-care-improving-nursing-homes-lack-effective-safeguarding-measures-puts>

¹⁵² S.I. No. 293/2016 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016. <https://www.irishstatutebook.ie/eli/2016/si/293/made/en/print>

“Care homes are places where physical distancing is almost impossible. It’s like a perfect storm: a susceptible population, not being able to implement the measures and the staff are not well supported and trained enough. Many of the staff are care assistants with very little medical knowledge.”

Impact of Covid-19 on nursing home residents from a safeguarding perspective

The issue of safeguarding in nursing homes came very much to the fore with the onset of the Covid-19 pandemic. An International Long Term Care Policy Network study on international measures to prevent and manage Covid-19 infections in care homes¹⁵³ concluded that homes were ill-equipped to deal with the crisis because of chronic staffing shortages, lack of protective gear and the paucity of testing for the virus.

As noted by Adelina Comas-Herrera, of the London School of Economics (LSE) Care Policy and Evaluation Centre,

“Care homes are places where physical distancing is almost impossible. It’s like a perfect storm: a susceptible population, not being able to implement the measures and the staff are not well supported and trained enough. Many of the staff are care assistants with very little medical knowledge.”¹⁵⁴

The last set of statistics - released before the cyber-attack on the HSE curtailed the collection of data - showed that nursing homes accounted for more than 2,000 deaths or almost two-thirds of coronavirus outbreak deaths in Ireland. No other sector was as badly affected. Surveillance data regarding Covid-19 cases and related deaths among long-term care facility residents in the EU/EEA, as of 09 November 2021 show that 2,344 deaths were reported for Ireland¹⁵⁵. There were 5,652 Covid-19 related deaths in total reported in the period to November 26th 2021.¹⁵⁶

In April 2020, HIQA warned that, in the context of a Covid-19 outbreak, nursing homes with a “regulatory history of persistent noncompliance” would face challenges when it came to infection control and governance. Recent media coverage¹⁵⁷ refers to nursing homes where allegedly:

- Covid-positive and Covid-negative residents were being placed in the same wards.
- Covid-positive residents were being brought into a day room with other residents who had not tested Covid-positive.
- Residents not having their personal care needs met in a dignified manner.
- People being confined to their rooms for long periods.
- Poor dental care and oral hygiene care.
- Periods where there was no nurse on duty.

153 <https://ltccovid.org/wp-content/uploads/2020/05/International-measures-to-prevent-and-manage-COVID19-infections-in-care-homes-11-May-2.pdf>
154 <https://www.theguardian.com/world/2020/apr/13/half-of-coronavirus-deaths-happen-in-care-homes-data-from-eu-suggests>
155 <https://www.ecdc.europa.eu/en/all-topics-z/coronavirus/threats-and-outbreaks/covid-19/prevention-and-control/LTCF-data>
156 <https://www.cso.ie/en/releasesandpublications/br/b-cdc/covid-19deathsandcasesseries37/>
157 RTÉ Investigates, <https://www.rte.ie/news/investigations-unit/2021/0629/1231957-care-in-covid-nursing-homes-third-wave/>

It is reasonable to suggest that all of these are related to some extent to the shortage of resources, including adequate appropriately qualified nursing staff.

The initial warning signs regarding the Covid-19 pandemic were generally recognised by nursing homes. However, the lack of effective working relationships with the HSE and the general policy focus on an expected surge and resultant threat to the acute hospital system, resulted in the significant risk to nursing home residents not becoming centre-stage until after the systemic weaknesses of the private nursing home system became clear. This significant ‘blind spot’ at statutory level has major implications for the safeguarding of nursing home residents and is a matter that requires urgent and serious consideration from an overall safeguarding of adults at risk perspective.

There may also be an issue of relating how the role of nursing homes is currently understood. Historically, when most of the nursing homes were in public ownership, they tended to be regarded as ‘hospitals’ and typically had a Medical Officer who was responsible for the clinical care of residents. With the move to private ownership, regulation, the increasing emphasis on nursing homes being people’s homes and the drive to move away from the ‘medical model’, there may have been less of an emphasis on clinical matters. This may have contributed to nursing homes being poorly prepared for Covid-19. Another factor, which may often be overlooked, not just in terms of the Covid-19 crisis, is that of inadequate staffing levels and, especially, of appropriately qualified nursing staff. Nursing older people remains less attractive than nursing in the acute services, and nursing frail and dependent older persons requires competent and appropriately qualified nursing staff with expertise in nursing older people.¹⁵⁸

It is clear that Covid-19 placed significant additional pressures on a long-term care system that was already under stress. Private nursing homes were under-staffed, lacking in clear clinical governance and without adequate oversight. The implications for safeguarding people at the high end of vulnerability are stark.

Overall impact of reliance on nursing homes for long-term care provision

In many European countries, long-term care is understood in its broadest sense as the support and care that may be needed over a lifetime in the case of some people with a disability, or in later years of life in the case of some older people. In Ireland, long-term care has tended in public discourse and in policy statements to be synonymous with residential care in a congregated care setting such as a nursing home or other institution.

For older people in Ireland, long-term care is divided into a regulated statutory system (Nursing Homes Support Scheme) for ‘nursing homes’

158 See Sage Advocacy, Delivering Quality Medical Care in Irish Nursing Homes, <https://www.sageadvocacy.ie/media/1679/6078-report-medical-care-in-nursing-homes-web2.pdf>

for which co-payment is required; and an unregulated non-statutory Home Support Service system which is currently free of charge. Under proposed legislation, people receiving homecare support in the future will be expected to pay some of the costs themselves.¹⁵⁹ This would be in addition to the significant amount of direct caring provided by family members in many instances.

Nursing home care: Divestiture to the private sector

In recent decades, the State's approach to residential care of older adults has been one of divestiture to private providers. This has resulted in a wide range of models of care, from large traditional public congregated settings to small family-run businesses and including larger corporate-type operations.

The growing reliance on the 'for profit' sector for nursing home care has been highlighted by both politicians and the media during the Covid-19 pandemic. A centrally important aspect of private provision that has to be acknowledged is the pressure on private nursing home operators to cut costs, increase profits, pass on charges and employ a low-paid work force. At a more basic level, however, the current architecture for long-term care (with its high reliance on residential nursing home care) is basically flawed. The State, by outsourcing the service, can be said to have been practising 'sectoral distancing' and, until the onset of Covid-19, its links with private providers were mainly through HIQA.¹⁶⁰ It has been widely acknowledged that there are major gaps in clarity and responsibility in the oversight of private nursing homes and that this issue needs to be examined urgently. Up to the onset of Covid-19, the HSE did not normally have a direct relationship with private nursing homes. This in itself is rather extraordinary given the significant amount of public resources allocated to private nursing homes, e.g., over €1 Billion in 2020.

**Safeguarding nursing home residents:
Key considerations**

While people residing in nursing homes generally have more complex health care needs than the average older person, their experiences of health care services has been found to be of variable quality.¹⁶¹ In particular, the provision of primary care to nursing homes is too often reactive, with little proactive or anticipatory care and little in the way of continuity.¹⁶² As a result, residents sometimes have a poor experience, receive sub-optimal medication and have frequent

159 This legislation was expected to come before the Oireachtas in early 2020 but has not been progressed.
160 See https://data.oireachtas.ie/ie/oireachtas/debateRecord/special_committee_on_covid-19_response/2020-05-26/debate/mul@/main.pdf p.43 and p.55
161 Chris Sherlaw-Johnson, Helen Crump, Natasha Curry, Charlotte Paddison and Rob Meaker, Transforming health care in nursing homes, <https://www.nuffieldtrust.org.uk/files/2018-04/transforming-care-report-final-web.pdf>
162 Robbins I, Gordon A, Dyas J, Logan P and Gladman J (2013), Explaining the barriers to and tensions in delivering effective healthcare in UK care homes: a qualitative study, <https://bmjopen.bmj.com/content/3/7/e003178.full>

unplanned admissions to hospital.¹⁶³ Concerns have been expressed that nursing home residents receive less organised medical care than their community-dwelling counterparts, with poorer monitoring of chronic disease and higher rates of unnecessary prescribing.¹⁶⁴

A 2020 Sage Advocacy Discussion Document¹⁶⁵ noted that nursing home staff may not always have the exposure, experience and training available to their counterparts in acute hospitals and, also, that there is an important specialist element to nursing care in residential settings. Residential care nursing, by its very nature, involves complex and multi-faceted dimensions which need to be fully acknowledged. Research¹⁶⁶ has illuminated these complexities and called for a greater recognition of the value of expertise in nursing in the residential care of older people in Ireland. This is a very relevant consideration in the context of ensuring that nursing home residents are fully safeguarded.

People inappropriately 'placed' in nursing homes

The lack of statutory provision for home care, and its related under-resourcing, results in a significant number of people being 'placed' in nursing homes inappropriately, that is, they are being 'placed' in environments where their rights cannot be fully safeguarded. In particular, the fact that some younger people with disabilities are inappropriately placed in a nursing home contrary to their will and preference - often because they could not access the supports which would enable them to live in their own homes in the community - has been regularly highlighted and has been the subject of an Ombudsman's Report. That report estimated that the number of younger people in such circumstances was more than 1,300.¹⁶⁷ Some younger disabled people are in nursing homes because there was no alternative option available to them. Others are there because the congregated setting they used to call home was de-congregated based on government policy as recommended in *Time to Move On*¹⁶⁸. Since this policy was not resourced adequate to its requirements, many ended up in a nursing home - another congregated setting and one totally unsuited to meeting the needs of many of those so placed. This has significant consequences for the protection of their rights.

163 Smith P, Sherlaw-Johnson C, Ariti C and Bardsley M (2015) Focus on: hospital admissions from care homes. The Nuffield Trust and The Health Foundation, https://www.health.org.uk/sites/default/files/QualityWatch_FocusOnHospitalAdmissionsFromCareHomes.pdf
164 Desmond O'Neill, Robert Briggs, Iva Holmerova, Finbarr Martin https://www.irishgerontology.com/sites/default/files/basic_page_pdf/IAGG-ER%208th%20Congress%20-%20Abstracts%20Book%20%28Irish%20Ageing%20Studies%20Review%29.pdf p.102
165 Delivering Quality Medical in Irish Nursing Homes Current Practice, Issues and Challenges, <https://www.sageadvocacy.ie/media/1679/6078-report-medical-care-in-nursing-homes-web2.pdf>
166 Amanda Phelan & Brendan McCormack, Exploring Nursing Expertise in Residential Care for Older People in Ireland, <https://nhi.ie/wp-content/uploads/2019/05/nhi-aigna-research-exploring-nursing-expertise.pdf>
167 Ombudsman's Report, Wasted Lives, <https://www.ombudsman.ie/publications/reports/wasted-lives/OMBWastedLives2021.pdf>
168 <https://www.hse.ie/eng/services/list/4/disability/congregatedsettings/time-to-move-on-from-congregated-settings-%E2%80%93-a-strategy-for-community-inclusion.pdf>

Deprivation of liberty in nursing homes

There is a significant safeguarding component to the manner in which nursing home residents are effectively deprived of their liberty by virtue of the fact that they are obliged to live in such a setting. It is reasonable to form the view that many dependent older people 'put into' long-term nursing home care do not wish to be placed there and have not given their full consent. The reality of the nursing home option is that, in many instances, it is the only response available currently in the absence of adequate community and home-based care, and the shortage of supported housing options that would enable 'ageing in place'.

It is also the case that many so-called voluntary residents in nursing homes are *de facto* detained and deprived of their liberty. They live in a closed unit and are not allowed to leave the institution without prior permission. Buildings are commonly secured by key code locks as a safety mechanism, requiring residents to ask permission to leave the premises. This deprivation of liberty can extend as far as limiting people's access to recreational grounds outside of the building, justified by an assessment that the resident is a 'falls risk' or likely to 'escape'. It should be noted that many older dependent people are 'placed' in nursing homes as a quick means of discharging them from acute hospitals where there is an ongoing shortage of beds.

While security policies may be aimed at ensuring the safety of people in a residential care centre, the impact of such measures can be the *de facto* detention of all the people who reside within that centre. HIQA Guidance¹⁶⁹ notes that it is important that people are supported to live meaningful lives while living in residential care (enjoyment, learning new skills, socialisation), and that providers should not be overly risk-averse in this regard. If a person chooses to partake in something that involves a level of risk, and they are aware of these risks, then the provider should be supportive of their choice. Department of Health Guidelines¹⁷⁰ stipulate that any potential episode of restraint must be considered only where there is clear evidence that the potential benefit of restraint to the individual person, and the risk involved if restraint is not used, outweigh the possible negative effects on the person subject to the restraint. The typical 'closed unit' model operating in many nursing homes is clearly at odds with this thinking.

There is some anecdotal case-based evidence of use of incontinence wear to discourage requests by persons for assistance with toileting and of hoists being used to support persons getting in and out of bed, chair or shower, rather than encouraging and facilitating people to maintain mobility where possible. There is evidence in some instances of mobility aids not being left beside residents in order to discourage free movement around the place of residence. Such practices are clearly an infringement of personal liberty.

There is also some case-based evidence about the possible use of chemical restraint in nursing homes for containment in order to, for

169 https://www.hiqa.ie/sites/default/files/2019-03/Restrictive-Practice-Guidance%20_DCOP.pdf
170 Department of Health. Towards a Restraint Free Environment in Nursing Homes. <https://assets.gov.ie/18830/9ef5610bf0814bf792263e844e0d9378.pdf>

example, manage a person's tendency to wander, rather than for therapeutic reasons, which has the effect of people being detained in a particular setting against their will. This case-based evidence is reflected in international research that has pointed to the prevalence of potentially inappropriate medications in nursing homes and especially the use of multiple psychotropic drugs.¹⁷¹ Irish-based research¹⁷² has referred to inappropriate use of antipsychotic medications, as judged by American legislative guidelines, as being common in long-stay units in the west of Ireland. A more recent study¹⁷³ has noted that, despite the existence of guidelines for over a decade and national level efforts to improve dementia care, antipsychotic prescribing is still common, especially in nursing home settings. The report noted that nursing home staff struggled with the daily management of behavioural and psychological symptoms of dementia (BPSD) and suggested that this was a very complex area where much more research was required.

In practice, there may be some blurring of the clear distinction between medication being used for therapeutic reasons and medication being used to control behaviour in violation of basic human rights. HIQA Guidance on Restraint Procedures for Designated Centres¹⁷⁴ stipulates that, except in an emergency, a full assessment of a person is performed and recorded prior to restrictive practices being used and that a person who is subject to restrictive procedures is closely monitored to evaluate the risks to their physical, psychological and emotional wellbeing and to ensure the procedures are minimal in time and in extent. This HIQA Guidance is clear that administering sedatives to a person who wanders during the night, primarily for the convenience of staff, is an example of chemical restraint which is not acceptable in any residential care centre.

Covid-19 brought into sharp focus the inherent limitations of the nursing home model in relation to confinement and restriction of movement. This is a critical factor that should inform decision-making processes in relation to the 'placing' of people in residential care facilities and, in particular, how it impacts on their right to be protected and to free movement.

It has long been acknowledged that people have a clear preference for home care. The majority of people wish to live out their years and to die in their own homes¹⁷⁵ and, therefore, failure to support people to exercise their will and preference in this regard is fundamentally a failure to adequately protect them. In terms of safeguarding and in keeping with the provisions of the Council of Europe Statement on the Rights of Older

171 See, for example, [Potentially inappropriate medication use in nursing homes: an observational study using the NORGE-PNH criteria - PubMed \(nih.gov\)](#)

172 Murphy, J., O'Keeffe, S.T. Frequency and appropriateness of antipsychotic medication use in older people in long-term care, <https://link.springer.com/article/10.1007/s11845-008-0121-7>

173 Walsh, Kieran A.; Sinnott, Carol; Fleming, Aoife; Mc Sharry, Jenny; Byrne, Stephen; Browne, John P.; Timmons, Suzanne, Exploring antipsychotic prescribing behaviors for nursing home residents with dementia: a qualitative study https://cora.ucc.ie/bitstream/handle/10468/7151/8143_Preprint.pdf?sequence=1
<https://www.hiqa.ie/sites/default/files/2017-01/Guidance-on-restraint-procedures.pdf>

175 Donnelly, S., O'Brien, M., Begley, E. and Brennan, J. (2016), "I'd prefer to stay at home but I don't have a choice" Meeting Older People's Preference for Care: Policy, but what about practice? Dublin: University College Dublin.

Persons, the UN Convention on the Rights of Persons with Disabilities and the Assisted Decision-Making (Capacity) Act 2015, it is of crucial importance that the will and preferences of people (individually and collectively) in relation to how they receive long-term care and support are fully acknowledged and taken into account. This principle is at the core of safeguarding and protection of people's rights and needs to become more fully embedded in our culture and public consciousness generally.

There is clearly a need for a more detailed consideration of this matter since it raises very serious questions about the potential impact on safeguarding adults at risk and on ensuring that their human and legal rights are well protected. This is particularly relevant where a person is *de facto* detained in a facility in the first instance due to a lack of appropriate alternatives in the community.

General invisibility of nursing homes

While nursing homes are currently an integral part of our wider health and social care infrastructure, their lack of connection and integration into local communities, into the general HSE spectrum of care, and the general low level of awareness of nursing homes among the public can be said to compound the already existing vulnerability of residents.

In 2016, the **Forum on Long-term Care Report**¹⁷⁶ referred to the need to fundamentally question the social and cultural norms that have become embedded in society and which result in the model of long-term care that currently exists, but is not a model that reflects what people want and does not adequately enshrine a rights-based approach. This requires us to critically look at past and current practices in respect of long-term care provision and to explore alternatives that would provide a better model for safeguarding. As a society, we should not be victims of 'the system' as if it were impervious to change. There is no abstract system. The long-term care system that exists is the one that we as a society have chosen to create and continue to support on a daily basis. We make small changes at the margins but leave the system itself entirely intact. *"Currently we choose constantly to ignore, patch up and even rebuild the invisible asylum".*¹⁷⁷

Current model of long-term care: Implications for safeguarding

The current model of long-term care is rigid and lacks fluidity. It is not conducive to supporting people's legal and human rights and does not allow for adequate protection and safeguarding. The inherent policy and funding bias towards nursing home care runs totally contrary to the wishes and preferences of the vast majority of Irish people.

¹⁷⁶ Forum on Long-term Care Report, https://www.sageadvocacy.ie/media/1124/report_of_forum_on_ltc_for_older_people.pdf

¹⁷⁷ Alex Fox (2018), A new health and care system: Escaping the invisible asylum, <https://www.researchgate.net/publication/323527338>

Shortcomings of the current model of long-term care provision relevant to a safeguarding approach have been identified¹⁷⁸ as follows:

- A privatised nursing home sector operating independently and largely outside of public health policy and outside the acute hospital system.
- Little integration between health and social care supports and housing.
- Absence of community connectedness by nursing homes.
- People isolated from their communities.
- Poor clinical governance in some private nursing homes.
- People inappropriately 'put into' nursing homes against their wishes in the absence of community-based alternatives.
- People institutionalised in nursing home environments where they were more at risk of exposure to Covid-19 than if they were living in their own homes.

While arguments in favour of the current model cite efficient use of resources, there is inadequate attention afforded to other more important factors such as preventing the infringement of citizens' inalienable human rights, safeguarding vulnerable older people and maintaining well-being and quality of life in later years.

*"To enter our long-term health and care systems is to pass through an entrance which may open as rarely – and shut as resoundingly behind you – as any workhouse or asylum door".*¹⁷⁹

This, by its very nature, irrespective of the quality of care provided, frequently diminishes personhood and agency, undermines independence and choice and creates opportunities for abuse of people's rights. (See Appendix/Case Scenario1). It is almost certain that the absence of strong community connections for nursing home residents, with its concomitant isolation and loneliness, compounds their risk of being abused and having their rights infringed.

Making safeguarding an integral part of care in nursing homes

There has been a strong policy emphasis on 'person-centred' care in recent years. The need for such an approach is clearly self-evident and is an important consideration in ensuring that people are fully safeguarded under the current nursing home model. A 2016 Journal of Clinical Nursing editorial noted that many nurses (in common with many other care and health professionals) work in contexts and cultures that are inherently unsupportive of person-centredness'.¹⁸⁰ As nursing home care has

¹⁷⁸ Browne, M. (2020), Choice Matters, Sage Advocacy, <https://www.sageadvocacy.ie/media/2026/choicematters2020.pdf>

¹⁷⁹ Alex Fox (2018), A new health and care system: Escaping the invisible asylum, <https://www.researchgate.net/publication/323527338> ps. 2-3.

¹⁸⁰ <https://onlinelibrary.wiley.com/doi/full/10.1111/jocn.13681>

become more privatised, the individual support needs of people requiring long-term care can easily become lost in a profit-driven system. Public residential care facilities clearly also frequently fall short as is evidenced by the experience of the Áras Attracta residents.

Research relating to older people in residential care settings¹⁸¹ carried out in 2012 pointed to a strong prevalence of neglect and abuse of residents by staff. While practice may have changed in the intervening years, the findings have ongoing relevance in that there is strong anecdotal evidence of abuse and neglect in residential care facilities on an ongoing basis.

At the core of the current long-term care model is the reality that, while there are regulations and standards in place, people using these services are not able to define in any meaningful way or ensure compliance with what they personally need to feel safe. The reality is that nursing home residents have little real say and little influence on the structures and ethos that shape these institutions or little recourse to redress when their rights are infringed.

HIQA regulation and standards, while very necessary and important in themselves, may well be inadequate to fully assure high quality individually-tailored care in accordance with people's will and preferences. Regulations and standards are to a large extent limited to the enforcement of those tangibles of the environment and procedures which can be measured. The intangibles that have to do with a human setting, including safeguarding and supportive relationships, may frequently elude the controls of the regulatory process. It is also true that regulation deals only with what already exists. In a field as seriously lacking in innovation as the nursing home sector, regulation is still unable to play the role of creator of new models or planner of new systems. It is almost certain that business methods which underpin the private nursing home sector cannot always provide what makes for a good human environment where people are fully safeguarded.

HSE safeguarding services in nursing homes: A legal vacuum

It has been repeatedly noted that HSE Safeguarding and Protection Teams are operating in a 'legal vacuum' in the absence of primary adult safeguarding legislation. HSE safeguarding social workers do not have the legal right of entry to private nursing homes (where some 80 per cent of residents live) and must seek the agreement of private care providers to do so. While HIQA can take action to cancel the registration of a nursing home provider which fails to meet regulatory requirements, it does not currently have a legislative remit to investigate individual cases of abuse or neglect. It may also be the case that there is a potential conflict of interest arising from the fact that HSE Safeguarding and Protection Teams are charged with assessing concerns of abuse in HSE-run nursing homes.

181 Drennan, J., Lafferty, A., Treacy, M.P., Fealy, G., Phelan, A., Lyons, I. Hall, P. (2012) Older People in Residential Care Settings: Results of a National Survey of Staff-Resident Interactions and Conflicts. NCPOP, University College Dublin, https://www.safeguardingireland.org/wp-content/uploads/2020/02/Older-People-in-Residential-Care-Settings_Final-Proof_28Nov2012.pdf

A Red C Poll¹⁸² carried out for Safeguarding Ireland shows that almost one in four people do not know who to report adult abuse to. From this finding, it can be reasonably inferred that many nursing home residents would not know where to seek help if they were experiencing abuse, neglect or a denial of their rights.

While the provision of home-care services has been the subject of much public, political and policy debate in recent decades, there is still no legislative entitlement to or regulatory framework for home-care services despite a recommendation from the Law Reform Commission in 2011 for regulation of home-care.¹⁸³ The implications of this lack of regulatory framework for home-care has been starkly highlighted in a recent HIQA Report.¹⁸⁴ This policy failure can be said to be indicative of a tacit social acceptance of the current strong bias towards nursing home care.

Relatively little has occurred during the course of nursing home development in Ireland to move nursing homes, either in image or mode of operation, from the closed institution sphere to the public sphere of community responsibility. Regardless of the fact that that Government introduced regulation and quality standards for both public and private nursing homes and provided significant funding to the sector, it in no sense took over the planning or running of the nursing home sector. On the contrary, the trend towards divestiture by the State, which has been expedited in recent years, has resulted in a major gap emerging between the public health sector and the private nursing home sector.

The risks of persisting with our current long-term care system far outweigh the risks of radical change, including the need to ensure that nursing home residents are protected and enabled to assert their rights. Also, while it is difficult to predict what will constitute the point of no return, what is certain is that the nursing home model that we have promoted with diligence and resources is no longer tenable from a human rights and safeguarding perspective.

Issues to be addressed in the context of safeguarding adults at risk in nursing homes

A central question that arises from the foregoing discussion is whether or not nursing home residents can be adequately safeguarded. The appropriateness of congregated settings for older people requiring care and support needs to be fundamentally challenged. One of the main arguments for the use of the nursing home model has to do with cost and effectiveness. However, given the massive amounts of money invested directly and indirectly (tax breaks, capital grants, subsidies), it is not at all clear that such an approach is cost-effective.

182 <https://www.safeguardingireland.org/almost-one-in-four-do-not-know-who-to-report-adult-abuse-to/>

183 Law Reform Commission (2011), Legal Aspects of Professional Home Care, https://www.lawreform.ie/_fileupload/Reports/r105.htm

184 HIQA (2021), Regulation of Homecare: A Position paper, <https://www.hiqa.ie/sites/default/files/2021-12/Regulation-of-Homecare-A-Position-Paper.pdf>

“Safeguarding is a basic function of any health or social care service and all service providers need to take this responsibility seriously. There is a clear obligation on registered providers to have a Garda vetting disclosure for all staff and volunteers available for inspection in the nursing home. However, almost half of Health Service Executive (HSE) services were failing to provide evidence of Garda vetting on inspection in 2018”.

The Irish Human Rights and Equality Commission has stated that the vulnerability of people in congregated institutional settings to the impact of the Covid-19 pandemic points to the need to address the role of institutionalisation in public policy. This includes how care for older people, or people without the capacity to live independently, is treated in public policy.¹⁸⁵

By pushing people into nursing homes, we are denying their liberty and their right to choose where they want to live. Alternative models of care and support may or may not result in higher costs¹⁸⁶ but these costs are minimal compared to the impact of our present system as evidenced, in particular, in the Covid-19 experience. We need to acknowledge that there are people in nursing homes, not because they need to be there, but because the supports that they need to live in their home are not available. By adopting the current system, we have, perhaps unwittingly, placed people in an environment that is basically unsafe.

The 2018 HIQA overview report highlighted the need for stronger safeguarding measures to protect people who live in nursing homes.

*“Safeguarding is a basic function of any health or social care service and all service providers need to take this responsibility seriously. There is a clear obligation on registered providers to have a Garda vetting disclosure for all staff and volunteers available for inspection in the nursing home. However, almost half of Health Service Executive (HSE) services were failing to provide evidence of Garda vetting on inspection in 2018”.*¹⁸⁷

Can nursing home residents be adequately safeguarded?

Notwithstanding the urgent need to move quickly to an alternative community-based model of long-term care and support for older people, it is realistic to acknowledge that in the short-to-medium term the current nursing home model will continue to operate and that the private sector will continue to play a central role.

The following questions, therefore, have been identified¹⁸⁸ and need to be addressed in the short-term from the perspective of ensuring that adults at risk who require long-term care are safeguarded to the greatest extent possible.

- How can the roles of both HIQA and HSE Safeguarding Teams be put on a proper statutory footing as soon as possible to enable forensic investigation of allegations of abuse in all nursing home settings?
- How can a flexible system of moving in and out of nursing care units as warranted by changing care needs at different junctures be implemented?

¹⁸⁵ <https://www.ihrec.ie/app/uploads/2020/07/IHREC-Annual-Report-2019-English-version.pdf>

¹⁸⁶ The State currently spends over one billion euros a year on the Nursing Home Support Scheme, a figure that will undoubtedly increase as the population ages and if the current system remains intact.

¹⁸⁷ HIQA, Overview report on the regulation of designated centres for older persons – 2018 <https://www.hiqa.ie/sites/default/files/2019-08/2018-DCOP-Overview-Report.pdf> p.51.

¹⁸⁸ Browne, M. (2020), Choice Matters, Sage Advocacy, <https://www.sageadvocacy.ie/media/2026/choicematters2020.pdf>

- How can clinical governance be strengthened through more active engagement of community-based medical professionals – GPs, Geriatricians and Advanced Practice Nurses?
- How can the distinct nature of providing nursing care to frail older people and related specialist skills be provided for?
- How can nursing homes (both public and private) be better linked into local communities?
- How can the current disconnect between nursing homes and ‘normal’ social functioning and interactions be remedied?
- What positive role can a statutory-based independent advocacy service provide?
- How can local communities (including health and social care professionals and NGOs) forge stronger links with nursing homes in their area?
- How can broader participation in the affairs of the home by residents’ relatives and friends be accommodated?
- What is the optimum size, staffing ratio and level of staff training/ education required to ensure that care can be delivered safely and with due regard to people’s human rights?
- How can nursing care units be configured at local level as part of an inclusive community care and support hub?

Overview and Conclusion

The issues associated with Covid-19 in nursing homes that have been highlighted bring into sharp focus the need for better safeguarding and protection of nursing home residents.

A key question to be addressed is how quality of life, well-being and safeguarding in nursing homes can be brought to the forefront of our long-term care system and ensure that the rights of people, many of whom are at high risk, are protected – the right to privacy, dignity, choice and freedom of movement. What we have at present is a piecemeal, *ad hoc* response to needs which leaves adults at risk living in very insecure, vulnerable and precarious environments, some of them socially excluded and some not well-safeguarded, with little sense of entitlement or right.

Covid-19 has highlighted specific issues for nursing home residents. However, without concerted effort, this awareness may easily revert to the bleak scenario in nursing homes and in the long-term care infrastructure generally that existed prior to the pandemic and which to all intents and purposes still remains in place.

There is a very strong argument, from a safeguarding perspective, as well as a general human rights perspective, that the nursing home model as it currently exists in Ireland must become a thing of the past.¹⁸⁹ Older people who require care and support have a basic human right to live

¹⁸⁹ <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1748-3743.2012.00320.x>

in the community and be to be free of the strictures, exposure to harm, deprivation of liberty and choice, frequently associated with nursing homes.

There has never been a better opportunity to reconfigure our long-term care and support system and to develop structures and services that protect people's rights by moving them out of nursing homes into safe, supportive communities. We need to champion the right to community living for older people with care needs. Fundamentally, we need a health and social care system that supports citizens to live at home, or a place that feels like home, with care organisations that are part of and controlled by the local community. The State currently spends over one billion euros a year on the Nursing Homes Support Scheme, a figure that will undoubtedly increase as the population ages and if the current system remains intact. We need to find a better way to spend this money, a way that protects our most at risk citizens.

While we rebuild our long-term care and support systems, we can hardly want to reconstruct the broken nursing home system which - previously 'hidden in plain sight' - became exposed during the pandemic, including, in particular, inadequate clinical oversight and a total lack of governance protocols between the HSE and the private nursing home sector.

The extraordinary situation of nursing home residents which has been starkly exposed in the Covid-19 context is unacceptable, both from a safeguarding perspective and from a general human rights perspective.

Unnecessary exposure to infection, restriction of movement, denial of access to relatives, dying without the support of loved ones, people being transferred from acute hospitals without PCR testing and, almost certainly, people being vaccinated without their informed consent, are matters that need to be exposed for what they are – abuse, neglect and a breach of the most fundamental of human rights.

Safeguarding adults at risk from harm and abuse requires an integrated, multiagency, whole-system approach grounded in human rights principles and meaningful safeguarding legislation. This point is particularly apt in the case of nursing home residents and people in congregated settings generally.

The post Covid-19 climate will provide a good opportunity to address what was/is basically unsafe within our long-term care infrastructure and to find safer and more human ways to care for people with complex support needs.

The next chapter will discuss the issue of coercive control and its implications for safeguarding adults at risk.

Unnecessary exposure to infection, restriction of movement, denial of access to relatives, dying without the support of loved ones, people being transferred from acute hospitals without PCR testing and, almost certainly, people being vaccinated without their informed consent, are matters that need to be exposed for what they are – abuse, neglect and a breach of the most fundamental of human rights.

/ Chapter Six

Coercive Control of Adults at Risk

This chapter describes coercive control, how it operates and the extent to which current legislation is adequate in protecting adults at risk who are experiencing coercive control in their lives. Coercive control can operate in many settings, including in people's own homes and in residential care facilities. The chapter notes that, while coercive control is now, in certain contexts, a criminal offence under Irish law, there are significant shortcomings, limitations and difficulties attached to the application of the law for the purpose of providing protection against coercive control to many adults at risk.

What is coercive control?

Coercive control is a pattern of behaviour which is designed to exert control over another person. It is used - with intent by an abuser - to make a person dependent; to isolate them in order to exploit them; to deprive them of their independence; and to exercise control over their behaviour and choices.¹⁹⁰

Research¹⁹¹ shows that coercive control is a form of abuse and is often associated with domestic violence. It can also be linked to various forms of abuse such as emotional, physical, financial and sexual. It most likely occurs between two adults who are in close contact with each other but can also occur in the context of friendships where one person or group exerts control over another. This can have a serious impact, can damage a person's physical and emotional well-being, can cause them to change their routine behaviours and to lose contact with family and friends.

Coercive control can also take place in residential care settings where residents are forced to, or manipulated into, accepting certain routines and practices which they do not choose of their own volition. The evidence from Áras Attracta and Leas Cross reviews is indicative of care deficiencies consistent with institutional abuse and a coercive control and manipulation being operated by staff in these settings. This is particularly important from a safeguarding perspective in that many people in residential care facilities, particularly nursing homes, are there because they could not get the supports that they needed to live in the community.

Coercive control can involve regulating people's everyday behaviour. It can also lead to a person at risk becoming isolated from the general community and from medical, social and other supports as a result of the person exercising coercive control acting as a self-appointed gatekeeper. It can involve depriving people of the means needed for independence, lifestyle choice, resistance and escape. Coercive control can also operate in the form of exploiting people's resources and assets for personal gain through false promises, for example, promising an adult at risk that they will be 'looked after'.

Coercive control of adults at risk: the difficulty of detection

As coercive control most often exists within the context of a close relationship, it can be subtle and difficult to detect from the outside. The abuser may be careful to conceal it from the outside world.

Patterns of controlling or coercive behaviour can be well established before a single incident is observed or reported. In many cases the conduct can seem innocent - especially if considered in isolation from other incidents.

¹⁹⁰ See Women's Aid, <https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/>

¹⁹¹ Charlotte Barlow and Sandra Walklate (2021) Gender, Risk Assessment and Coercive Control: Contradictions in Terms? <https://academic.oup.com/bjc/article/61/4/887/6105801?login=true>

Due to the assumed relationship of trust and/or dependency that exists, the victim may not be aware of or be ready to acknowledge the abusive behaviour to which they are being subjected. As behaviour worsens, each incident of abuse becomes a new normal. Being under coercive control often reduces a person's ability to think independently or have time and space to seek support.

In many relationships, there are occasions when one person makes a decision on behalf of another, where responsibilities and duties are divided up, or when one partner takes control of a situation and the other has to compromise. The difference in an abusive relationship is that decisions by a dominant partner can become rules that, when broken, lead to consequences for the victim. Victims can be made to believe that the coercive control to which they are being subjected is somehow 'normal', 'for their own good', or otherwise acceptable.¹⁹²

Controlling or coercive behaviour can be overlooked by outside observers due to the fact that victims can sometimes be seen as colluding or consenting to the behaviour. In reality, the victim may feel helpless to resist or report the coercive control.

In targeting a person at risk, the perpetrators of coercive control may recognise that the victim can face additional barriers to accessing help or support. A victim's disability may, for example, seriously limit their ability to understand the nature of the abuse or its future impact on their lives; or the victim may lack the basic skills needed in order to communicate their distress to others. The context of a relationship and the relative positions of power within it can result in a victim being manipulated into believing that nobody else is trustworthy enough or able to care for them.

Signs of coercive control identified by Safeguarding Ireland include:

- Detaining a person at home.
- Restricting a person's movements.
- Constant monitoring of a person's whereabouts.
- Preventing contact with family or friends.
- Excessive contact via the phone, email, or social media.
- Keeping a person's phone from them.
- Controlling money or medical care.
- Imposing and making decisions on someone's behalf.
- Ongoing undermining of a person's independence.
- In serious cases, assault and violence.

¹⁹² <https://journals.sagepub.com/doi/10.1177/0265407516677060>

It is sometimes the case that a covert type of emotional abuse process (now commonly known as ‘gaslighting’)¹⁹³ is used where a person is manipulated into questioning their own reality by someone providing misleading information to create confusion in a vulnerable adult’s mind. Generally, this dynamic is only possible where there is an unequal power relationship or where a person is fearful of the negative consequences associated with challenging the false narrative.

Nature and extent of coercive control

Safeguarding Ireland commissioned surveys¹⁹⁴, carried out by Red C in late 2020 and early 2021, which explored public perceptions and understandings of coercive control. Of the representative sample of over 1,000 Irish adults –

- 40% said they didn’t understand the term coercive control
 - 25% said they were not familiar with the term coercive control
 - 15% said they had heard the term but did not understand it
- Just over a quarter (28%) said that they understood the meaning of the term.

When provided with an explanation of the term *coercive control* –

- 30% said they had witnessed this happening to someone they knew
- 3% said they had experienced it themselves.

Domestic abuse has been widely reported¹⁹⁵ as increasing during Covid-19. The levels of personal isolation, coupled with restricted access to support services, placed many people at risk in situations of heightened danger of abuse. **Women’s Aid Annual Impact Report 2020**¹⁹⁶ finds that the pandemic “*made the crisis level of domestic violence in Ireland more visible*”, with Women’s Aid support workers hearing more than 30,000 disclosures of domestic violence, including coercive control during 2020.

Sage Advocacy casework research¹⁹⁷ indicates that the reasons for referral to their service included:

- People being deprived of the basics for daily living, including food, electricity, heating.
- People being denied access to support services, including medical services.
- Financial abuse.
- Relatives making threats and engaging in intimidation, for example, threatening people that they will be ‘put into’ a nursing home.

¹⁹³ <https://www.verywellmind.com/is-someone-gaslighting-you-4147470#:~:text=Gaslighting%20is%20a%20form%20of,question%20their%20judgments%20and%20reality.>

¹⁹⁴ <https://www.safeguardingireland.org/wp-content/uploads/2021/05/Coercive-Control-presentation-FINAL.pdf>

¹⁹⁵ See for example <https://www.irishtimes.com/news/social-affairs/covid-19-restrictions-have-led-to-shadow-pandemic-of-abuse-1.4718553>

¹⁹⁶ Accessed 15/12/2021 at <https://www.womensaid.ie/about/policy/publications/womens-aid-annual-impact-report-2020/>

¹⁹⁷ <https://www.sageadvocacy.ie/media/2202/6376-sage-voc-report-fa-for-web.pdf>

The Sage Advocacy research also highlights the fact that, while a high proportion of crimes, as reported by their respondents, were perpetrated by boyfriends and girlfriends, in 15% of cases the perpetrator was an extended family member.

The Domestic Violence Act 2018¹⁹⁸

Coercive control has only recently been recognised as a criminal offence. In fact, only a handful of countries have developed and adopted new offences that specifically target coercive control. Much of the progress that has been made is seen as originating in the Council of Europe’s *Istanbul Convention on Violence Against Women*¹⁹⁹.

Article 33 of the Convention stipulates that:

“Parties shall take the necessary legislative or other measures to ensure that the intentional conduct of seriously impairing a person’s psychological integrity through coercion or threats is criminalised.”

In Ireland, coercive control became a criminal offence in 2019 with the enactment of The Domestic Violence Act 2018.

Section 39 (1) of the Domestic Violence Act 2018 states that:

A person commits an offence where he or she knowingly and persistently engages in behaviour that

- (a) is controlling or coercive
- (b) has a serious effect on a relevant person, and
- (c) a reasonable person would consider likely to have a serious effect on a relevant person.

Section 39(2) of the Act states that a person’s behaviour has a serious effect on a relevant person if the behaviour causes the relevant person—

- (a) to fear that violence will be used against him or her, or
- (b) serious alarm or distress that has a substantial adverse impact on his or her usual day-to-day activities.

The crime of coercive control, as defined in the Domestic Violence Act 2018, relates to abusive actions that are committed in the context of a current or past intimate relationship. The victim – referred to in the Act as ‘a *relevant person*’ – is defined in Section 39(4):

A person is a “relevant person” in respect of another person if he or she –

- (a) is the spouse or civil partner of that other person, or
- (b) is not the spouse or civil partner of that other person and is not related to that other person within a prohibited degree of relationship but is or was in an intimate relationship with that other person.

¹⁹⁸ <http://www.irishstatutebook.ie/eli/2018/act/6/enacted/en/html>

¹⁹⁹ <https://www.coe.int/en/web/istanbul-convention/text-of-the-convention>

It is important, therefore, to note that the Act requires that the perpetrator and the victim are at present or were at a time in the past in an intimate relationship.

The Domestic Violence Act 2018 amends and consolidates the law on domestic violence, repealing the Domestic Violence Act 1996 and the Domestic Violence (Amendment) Act 2002. It consolidates relevant provisions of the Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010, the Civil Law (Miscellaneous Provisions) Act 2011, the Courts and Civil Law (Miscellaneous Provisions) Act 2013 and the Children and Family Relationships Act 2015. The Act includes provisions which must be enacted in order for Ireland to ratify the Istanbul Convention.

The legislation makes the following changes:

- The Act has a non-exhaustive list of factors that a court must consider when deciding whether to make a domestic violence order. However, the list does not limit the court's discretion in making the order.
- It is not a requirement to be married in order to get a domestic violence order.
- The courts must offer information on support services to victims. The court can also recommend that the alleged perpetrator engages with a programme to address their problem behaviour and their engagement with such services can be considered when hearing proceedings for a variation order or an appeal of an order.

In addition to providing victims with the protection offered by the criminalisation of coercive control, the Act also offers a number of safeguarding measures.

Safety Order

A safety order is an instruction from the court which stops the violent person (the respondent) from committing further violence or threats of violence. The respondent does not have to leave the home. If the person is not living with the victim, the safety order prohibits (bans) them from watching or being near the victim's home and following or communicating (including electronically) with them or a dependent person such as a child. A safety order can last up to 5 years.

Since 1 January 2019, people in an intimate relationship but not cohabiting are also able to apply for a safety order. Previously, couples had to cohabit (live together) to be able to get a safety order, but this is no longer the case. The following people can apply for a safety order:

- Spouses and civil partners.
- Parents with a child in common.
- Partners in an intimate relationship including cohabitants (a couple living together) and dating partners (a couple not living together).
- Parents of an abusive child if that child is over 18.

- People residing with the respondent in a non-contractual relationship, such as two relatives living together.

The legislation does not provide protection in respect of people not included in the above categories, including persons who are not relatives, people who are not in an intimate relationship and people who are not living together. The limitations that arise as a result of these exceptions are discussed later in this chapter.

Protection Order

Between the time of making an application for a safety order (or barring order) and the court's determination (decision), there may be reasonable grounds for believing that the safety and welfare of a potential victim or of a dependent person is at risk. If so, the court can grant a protection order to prohibit the respondent from:

- Using or threatening to use violence.
- If the perpetrator is not living with the person, watching or being near their home.
- Following or communicating with the person or their dependant.

A protection order is temporary and only effective until the court hearing of the application for a safety order (or barring order).

Barring Order

A barring order requires the violent person to leave the home and prohibits (bans) the person from entering the home. The order also prohibits the person from:

- Further violence or threats of violence,
- Watching or being near the person's home, or
- Following or communicating (including electronically) with the person or a dependent person.

A barring order can last up to 3 years.

The following people can apply for a barring order:

- Spouses and civil partners.
- Cohabitants who live in an intimate relationship (the applicant must satisfy the property test, that is, they must have an equal or greater interest in the property than the respondent).
- Parents when the abuser is a non-dependent child.

Shortcomings of the Domestic Violence Act 2018 relating to coercive control

The Domestic Violence Act 2018 is particularly important in that it recognises coercive control as a criminal act. While many forms of violence and abuse are, in themselves, considered criminal, the criminalisation of coercive control *per se* removes any level of doubt

that may have existed up until now and gives a clear message as to how society views coercive control as an unacceptable form of abuse.

Furthermore, controlling or coercive behaviour can involve acts which amount to criminal offences in their own right or behaviour which falls short of criminal offending but, nevertheless, has a serious effect on a vulnerable victim. The recognition of coercive control as a criminal act, not only provides a new level of protection to victims, but can also be seen as useful in demonstrating an aggravated aspect of other crimes.

The creation of the offence of coercive control has undoubtedly placed into the consciousness of professionals - who are involved in safeguarding matters - the existence of the concept of coercive control, particularly in family-type situations. Its existence as both a crime and a risk factor offers professionals a resource and a motivation in dealing with abuse situations and removes some aspects of doubt and caution that may have previously hindered safeguarding actions.

While the criminalisation of coercive control is still rare in international terms, there is a growing acceptance that it is an important, necessary and effective tool in tackling abuse, especially in the domestic sphere.²⁰⁰

Throughout the world, legislative responses to domestic and intimate partner violence have, until now, focused largely on physical violence such as assault and threats. That limited vision of the issue blurs the fact that victims are often subjected to ongoing patterns of psychological abuse and control that cause harm beyond a one-time incident of physical violence and that often involve what is effectively a deprivation of liberty.

The Irish legislation, in common with similar legislation in other jurisdictions, is framed primarily in the context of the violence (both physical and psychological) that sometimes occurs or is threatened within intimate domestic relationships. It also targets abuse that persists or erupts after the breakdown of intimate relationships. While the legislation offers protection equally to both men and women, the origins of the legislation are closely linked with combatting domestic violence against women. While it can be argued that this limited focus is valuable in signalling that domestic, intimate partner violence of any kind is unacceptable, it leaves a vacuum in the area of safeguarding adults at risk from abusers who are not intimate partners.

The definition used in framing the offence of coercive control is quite restrictive and limited. Section 39(4) is quite specific in its wording and clearly does not encompass perpetrators who are not/were not intimate partners of the victim.

The Act provides inadequate legislative protection for people who are subject to abuse from an extended family member or a non-family 'friend'. While the Domestic Violence Act 2018 sets out provisions for safety orders, protection orders and barring orders, these orders, in general terms, are aimed at prohibiting behaviour that can be viewed as violent,

²⁰⁰ For an examination of US legislative developments, see Mahoney and Lieberman (2021), <https://www.law360.com/articles/1380900/legally-recognizing-coercive-control-can-help-abuse-victims>

threatening and causing fear - as opposed to the less visible but equally abusive behaviours that are associated with the concept of coercive control. A further limitation of the use of these orders is that it does not include extended family members such as children, siblings, nieces and nephews except where they are resident with the victim. Similarly, the use of the orders against non-family persons, such as so-called 'friends', is only possible where the perpetrator resides with the victim.

A typical example of a coercive control not covered under the 2018 Act is where a person is living with their niece, nephew, brother, sister or cousin and there is alleged emotional, physical and/or financial abuse. For example, it may be that coercion is used to access the person's account or ATM card. A safety order would not adequately protect the at risk person in such instances and it is not at all clear that the Domestic Violence Act 2018 is adequate to prevent a person from engaging in threatening and abusive behaviour and engaging in coercive control. Also, the Act does not support the person to have their relative removed from the house, with the result that they remain open to ongoing abuse.

Evidence from the Sage Advocacy report and other studies,²⁰¹ and detail from National Safeguarding Office Annual Reports, suggest a wide range of abusive behaviours toward adults at risk. Coercive control may be involved in many of these actions, some of which may be considered criminal in their own right. However, the emphasis on distinctly and obviously violent offenses, whether physical or psychological, is likely to relegate many types of coercive and controlling behaviours to a status where prosecution is less likely. This will most likely be the case where abuse of an insidious and nuanced nature is involved.

The importance of the classification of coercive control as a crime is that it offers a real prospect of safeguarding adults at risk from abuse that may be interpreted by some as 'low-level', 'normal', or somehow not deserving of attention. However, this safeguarding mechanism for adults at risk is not presently available under Irish law, unless the perpetrator is or was an intimate partner.

This shortcoming in the law also creates a further difficulty in that it increases the caution with which safeguarding services will approach cases where there is an absence of the intimate partner relationship. Personnel will be reluctant to take action against, for example, siblings where the abuse evidently comprises coercive control but where it cannot be defined as such under the law.

The shortcoming outlined above is not unique to the Irish situation. While there are minor differences, for example, between the Irish Domestic Violence Act 2018 and the corresponding legislation in England and Wales (Serious Crime Act 2015) and in Scotland (Domestic Abuse Act 2018), all three demonstrate a focus that is primarily domestic, intimate partner-oriented. The England and Wales legislation does, however, extend the definition of persons considered

²⁰¹ Naughton, C., et al. (2010) Abuse and Neglect of Older People in Ireland: Report on the National Study of Elder Abuse and Neglect. University College Dublin., available at: https://www.safeguardingireland.org/wp-content/uploads/2020/02/National-Prevalence-Study-_FullReport2010.pdf

“A person is guilty of coercive control when he or she engages in a course of conduct against a member of his or her same family or household, as defined in section 530.11 of the criminal procedure law, without the victim’s consent, which results in limiting or restricting, in full or in part, the victim’s behavior, movement, associations or access to or use of his or her own finances or financial information.”

“A person who, with a view to compel another to abstain from doing or to do any act which that other has a lawful right to do or to abstain from doing, wrongfully and without lawful authority.”

as perpetrators. In defining coercive behaviour, it refers to coercive or controlling behaviour in an intimate or family relationship and, in addition to intimate partners, includes people who are members of the same family providing that they live together. This addition would appear to deal, to a certain extent, with the shortcomings mentioned earlier. However, as it only relates to family members who are living together, it would appear to exclude, for example, siblings or other family relations who are not living in the same home as the victim. It does not include perpetrators who are not family members.

While most examples of the definition of coercive control as a criminal offence focus primarily on the domestic and intimate partner aspect of abuse, there are some jurisdictions that are, at least, considering a wider-ranging definition. Legislation currently being considered by the State of New York²⁰² includes a section dealing with coercive control that moves one step further than the England and Wales legislation, in that it includes family members irrespective of whether they share a household.

“Section 135.80 coercive control.

A person is guilty of coercive control when he or she engages in a course of conduct against a member of his or her same family or household, as defined in section 530.11²⁰³ of the criminal procedure law, without the victim’s consent, which results in limiting or restricting, in full or in part, the victim’s behavior, movement, associations or access to or use of his or her own finances or financial information.”

As noted earlier, it is possible to argue that adults at risk and the professionals charged with protecting them, have recourse to other instruments in the law. This is undoubtedly true, but it is difficult to find laws that are as capable of dealing with coercive control as the provisions of the Domestic Violence Act 2018 are, restricted though they are.

The existence of the crime of **coercion** as contained in the Non-Fatal Offences against the Person Act, 1997²⁰⁴, is one possibility. Section 9 of the 1997 Act states that –

‘A person who, with a view to compel another to abstain from doing or to do any act which that other has a lawful right to do or to abstain from doing, wrongfully and without lawful authority—

- (a) uses violence to or intimidates that other person or a member of the family of the other, or*
- (b) injures or damages the property of that other, or*
- (c) persistently follows that other about from place to place, or*
- (d) watches or besets the premises or other place where that other resides, works or carries on business, or happens to be, or the approach to such premises or place, or*

202 <https://www.nysenate.gov/legislation/bills/2021/S5650>

203 This includes persons related by consanguinity or affinity.

204 Non-Fatal Offences Against the Person Act 1997, section 9(1)

(e) follows that other with one or more other persons in a disorderly manner in or through any public place, shall be guilty of an offence’.

While the 1997 Act is not restricted by any insistence on, for example, an intimate partner relationship, it is, nevertheless, clear that only the most severe, blatant and violent examples of coercive control are likely to be prosecuted under this provision. The insidious nature of coercive control is very often hidden and hard to detect. This means that the value of Act is compromised with regard to the many types of coercive control that can be observed in practice in Ireland at present.

It is clear that coercive control often occurs through a series of incidents that, when viewed separately, may not be perceived as significant with reference to outdated definitions of wrongdoing. However, when considered together, such a series of incidents has the ability to cause significant harm to a victim. It is, therefore, important that the law allows all victims to obtain protection and redress on the basis of coercive control.

While much of the discussion presented above concerns the shortcomings of the Domestic Violence Act 2018 in the context of its definition of persons who can be prosecuted for the crime of coercive control (and the absence of many classes of family member from that definition), it is equally important to point to the use of coercive control by persons who are not kindred. While it is accepted that adults at risk may be victims of domestic violence and of coercive control within domestic and family situations, there are also many incidents of abuse of at risk adults that do not constitute domestic violence. Adults at risk can be the victims of abuse perpetrated by individuals whose relationship or connection with them does not fall within the scope of the relationships prescribed under the Domestic Violence Act 2018.

Case scenarios provided to Safeguarding Ireland by safeguarding professionals for the purposes of this research (see Appendix) include situations such as:

A man with mild intellectual disability who was coerced into allowing another person to move into his home; the newcomer then engaged in high levels of anti-social behaviour.

A young woman with a mild intellectual disability and autism who was enticed into an online relationship with a person who ‘groomed’ her and coerced her into sending him money. She believes this person is her boyfriend and agrees to send him explicit photographs of herself. Friends of the ‘boyfriend’ call on her regularly and discourage her from engaging with support services.

A man with an intellectual disability whose tenancy is at risk due to the use of his property by ‘friends’ for anti-social behaviour, including possible drug-dealing.

These and other such cases have been labelled ‘mate crime’ by some observers.²⁰⁵ The abuse most frequently involves the befriending and then

205 <https://arcuk.org.uk/realchangechallenges/files/2013/10/RCC-Mate-crime-PCJA.pdf>

the exploitation of an at risk adult. In some cases, the person is coerced into collaborating with the abuser in criminal activities. There are also situations where an at risk person is befriended by a neighbour, distant relative or an acquaintance in order to surreptitiously and dishonestly extract money and property from them. (This matter is dealt with more fully in Chapter Four above).

As with coercive actions perpetrated by non-intimate partner family members, these abuses do not fall under the definition of coercive control as contained in the Domestic Violence Act 2018. Safeguarding professionals are constrained by this shortcoming in the legislation.

Coercive control impinges in a negative manner on the human right of the individual to make independent choices regarding matters that are important to the quality of their lives. It is worth considering whether the shortcomings discussed above will impact on the degree to which adults at risk will be able to exercise fully the rights that will be granted them when the Assisted Decision-Making (Capacity) Act 2015 is fully commenced. It can be argued that coercive control, especially by non-intimate family such as siblings, adult children and others is likely to emerge as a considerable obstacle and challenge to the decision-making rights envisaged in the Act.

Convictions for the crime of coercive control have begun to occur in Ireland since the end of 2020.²⁰⁶ The implementation of this provision of the Domestic Violence Act 2018 has been widely welcomed as an important and necessary addition to the protections offered to victims in intimate partner situations. It has been pointed out that, prior to the 2018 Act, the many components of coercive control had to be taken as separate charges and that this clouded any clear view of the proper picture of intimate abuse.²⁰⁷

Information regarding prosecutions for the equivalent crime in England and Wales – controlling or coercive behaviour – does, however, point to two areas of potential concern.²⁰⁸ The first is that there has been a reluctance to pursue cases of controlling or coercive behaviour (CCB) as a standalone offence, without other ‘violent’ offences to charge alongside it. It was noted that CCB was generally charged alongside common assault, actual bodily harm, criminal damage, battery and sexual offences. Domestic abuse support services felt that some police officers were reluctant to label as domestic abuse anything other than physical or sexual violence. The relatively low prosecution rate (as a proportion of reported incidents) taken in conjunction with the relatively high custodial sentences handed down (in comparison with other domestic violence convictions) supports the concern regarding this issue. This feature of the implementation of the law would suggest a danger that the many abusive

²⁰⁶ See, for example, <https://www.irishtimes.com/news/crime-and-law/courts/circuit-court/man-convicted-of-coercive-control-and-multiple-assaults-on-ex-partner-1.4406638> and <https://www.irishtimes.com/news/crime-and-law/man-sentenced-to-three-years-in-prison-for-coercive-control-of-his-family-1.4596246>

²⁰⁷ Noeleen Blackwell, CEO Women’s Aid in <https://www.irishlegal.com/articles/man-convicted-of-coercive-control-for-first-time>

²⁰⁸ Review of the Controlling or Coercive Behaviour Offence, Home Office 2021, <https://www.gov.uk/government/publications/review-of-the-controlling-or-coercive-behaviour-offence/review-of-the-controlling-or-coercive-behaviour-offence>

behaviours that are not seen as physically violent may not be addressed in practice under the new legislation. The prominence of extreme and disturbing violence reported in the emerging convictions in Ireland could similarly have the effect of detracting from the value of the new Irish legislation in dealing with the more insidious and subtle forms of abuse to which vulnerable people are subjected.

The second area of concern is that the England and Wales review indicates a strong focus on intimate partner abuse and relatively little focus on coercive control by persons other than current or previous intimate partners. The England and Wales focus is most revealing when one considers the fact that the England and Wales legislation allows for the prosecution of alleged perpetrators other than intimate partners, i.e., people who are members of the same family.

It is crucial in the context of safeguarding adults at risk that the law be not only broadened to protect all potential victims, but also that the law be interpreted, understood and applied in a manner that recognises the full spectrum of behaviours of a coercive controlling nature that can impact on adults at risk.

Overview and Conclusion

A main shortcoming of the current system is the restrictive scope of the Domestic Violence Act 2018. The first difficulty is the narrow scope of the offence of coercive control under section 39. Section 39 provides that person commits an offence where he or she knowingly and persistently engages in behaviour that: (a) is controlling or coercive, (b) has a serious effect on a relevant person, and (c) a reasonable person would consider likely to have a serious effect on a relevant person.

A person’s behaviour has a serious effect on a relevant person if the behaviour causes the relevant person to (a) fear that violence will be used against him or her, or (b) serious alarm or distress that has a substantial adverse impact on his or her usual day-to-day activities. Section 39(4) restricts the application of the offence to intimate relationships. It defines that a person is “relevant person” in respect of another person if he or she (a) is the spouse or civil partner of that other person, or (b) is not the spouse or civil partner of that other person and is not related to that other person within a prohibited degree of relationship but is or was in an intimate relationship with that other person.

Section 39(4) specifically excludes the possibility of prosecuting a sibling, adult child, or other relative, or carer of an adult at risk for the offence of coercive control. This is entirely unsatisfactory, because psychological abuse in the form of coercive control can arise in a safeguarding context in non-intimate relationships.

Coercive control can be perpetrated in residential care settings and by home care providers. There is a clear need for better protection for people in residential care facilities where staff and other residents perpetrate abuse in the form of coercive control. There is a similar need to provide legislative safeguards where coercive control is perpetrated by a home care provider.

The Domestic Violence Act 2018 performs a very important task in criminalising coercive control. However, if the Act is to provide the protection of the law to the full range of adults at risk who are subjected to coercive control, then the definition of ‘relevant person’ (i.e., the perpetrator of coercive control) must be expanded to include all those persons who inflict this form of abuse on adults, particularly those who are at risk for whatever reason/s.

The offence of coercion under section 9 the Non-Fatal Offences Against the Persons Act 1997 does not address this regulatory gap, because the elements of that offence are entirely different to the offence under section 39 of the 2018 Act, and more difficult to establish. First, the mental element of section 9 requires that the perpetrator engage in behaviour *“with a view to compel another to abstain from doing or to do any act which that other has a lawful right to do or to abstain from doing”*. This is a higher threshold to meet than the mental element under section 39, which only requires an intention going to the behaviour that amounts to coercive control, rather than a specific intention as to the impact of the conduct on the victim. The act element of section 9 requires the use of violence or intimidation, or damage to property, or that the perpetrator persistently follows the victim (stalking), or watches and besets the premises in which the victim lives, works or carries on business. This is an exhaustive and prescriptive list which does not necessarily cater for the nuance and subtleties involved with psychological abuse and coercive control. By contrast, the act element of section 39 is far broader in its scope because it pertains to behaviour that is controlling and coercive and the 2018 Act does not define what sort of conduct is controlling and coercive.

This shortcoming could be addressed by an amendment to section 39 of the Domestic Violence Act 2018 to ensure the offence of coercive control applies outside of intimate relationships. Specifically, section 39(4) could be deleted and substituted for the following *“in this section, a person is a ‘relevant person’ in respect of another person if he or she is subject to the behaviour as set out in subsection (1).”*

A further shortcoming relating to the Domestic Violence Act 2018 is that of the limitation on who is eligible to apply for barring orders, safety orders and protection orders. Under section 11 of the 2018 Act, the Child and Family Agency has power to apply for certain orders for the purpose of child protection. The HSE, or a dedicated safeguarding regulatory body, should similarly have power to apply for protective orders for the purpose of safeguarding adults at risk. A further issue in relation to the Domestic Violence Act 2018 is that the categories of persons against whom a protective order can be sought is restricted by reference to their relationship with the victim.

The Domestic Violence Act 2018 performs a very important task in criminalising coercive control. However, if the Act is to provide the protection of the law to the full range of adults at risk who are subjected to coercive control, then the definition of ‘relevant person’ (i.e., the perpetrator of coercive control) must be expanded to include all those persons who inflict this form of abuse on adults, particularly those who are at risk for whatever reason/s.

Such an expansion of the definition would ensure that the general public can be made aware of this form of abuse and of its unacceptability; and that all those charged with enforcing, prosecuting and applying the law will be provided with effective legislative redress and related protection.

The next chapter will discuss the issue of self-neglect and its implications for safeguarding adults at risk.

/ Chapter Seven

Self-neglect by Adults at risk: Issues and Challenges

This chapter discusses self-neglect in the context of safeguarding adults at risk. It sets out the various dimensions of self-neglect. It discusses the interface between protecting adults who may be at risk and the right of each individual to live their life as they choose. People may be at risk of self-neglect for a number of reasons, including reduced decision-making capacity, mental health difficulties or an inability to manage their daily lives because of frailty associated with ageing. Current policies and legal provisions for dealing with self-neglect are outlined and there is some discussion of relevant practices in other jurisdictions.

Defining self-neglect

The HSE *Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures* ²⁰⁹ defines (17.1) self-neglect in vulnerable adults as -

- The inability or unwillingness to provide for oneself the goods and services needed to live safely and independently;
- Profound inattention to health or hygiene, stemming from an inability, unwillingness, or both, to access potentially remediating services;
- The result of an adult’s inability, due to physical and /or mental impairments or diminished capacity, to perform essential self-care tasks;
- The failure to provide for oneself the goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain;
- Self-neglect in vulnerable adults is a spectrum of behaviours defined as the failure to:
 - (a) Engage in self-care acts that adequately regulate independent living or,
 - (b) Take actions to prevent conditions or situations that adversely affect the health and safety of oneself or others.

Other definitions²¹⁰ may include or exclude an individual’s lifestyle choices which might be at variance with the standards normative in society. For example, the US National Association of Adult Protective Service Administrators defines self-neglect as an adult’s inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including:

- (a) Obtaining essential food, clothing, shelter, and medical care;
- (b) Obtaining goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety; and
- (c) Managing one’s own financial affairs excluding an individual’s lifestyle choice.

The US National Centers of Elder Abuse state that self-neglect generally manifests itself in an older person as a refusal or failure to provide themselves with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated) and safety precautions. Reference has been made²¹¹ to self-neglect as occurring along a spectrum ranging from mild

209 <https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf>
210 As referenced by Pickens S, Daniel M, Jones EC and Jefferson F (2021) Development of a Conceptual Framework for Severe Self-Neglect (SN) by Modifying the CREST Model for Self-Neglect. Front. Med. 8:654627. <https://www.frontiersin.org/articles/10.3389/fmed.2021.654627/full>
211 Pickens S, Daniel M, Jones EC and Jefferson F (2021) Development of a Conceptual Framework for Severe Self-Neglect (SN) by Modifying the CREST Model for Self-Neglect. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8165169/>

An unawareness to the hazardous and progressive decline in personal, social, physical, mental, and/or environmental domains leading to the inability to maintain culture and community standards of acceptable living that threatens one’s own safety, health, and quality of life.

to severe and to a need to give particular attention to what is termed severe self-neglect, defined as:

“An unawareness to the hazardous and progressive decline in personal, social, physical, mental, and/or environmental domains leading to the inability to maintain culture and community standards of acceptable living that threatens one’s own safety, health, and quality of life.” ²¹²

This definition, it is suggested, describes a phenomenon that is complex and progressive. It does, in addition, point to the lack of awareness to one’s hazardous state of health as an important element of the definition of self-neglect.

Self-neglect can be a result of a conscious decision to live life in a way that may impact on a person’s health, wellbeing or living conditions. In addition, it may impact in a negative way on other people’s living environments and quality of life. Self-neglect can be either non-intentional, arising from an underlying health condition, or intentional, arising from a deliberate choice. It has been argued²¹³, however, that severe self-neglect involving as it often does a refusal to accept support or interventions, is most often associated with functional, personal or mental decline.

Self-neglect is often seen in association with old age conditions such as mild to severe dementia and frailty, and other losses in physical, psychological and social domains.

Groups that may present with self-neglecting behaviours have been identified²¹⁴ as:

- Those with lifelong mental health conditions;
- Persons with degenerative neurocognitive disorders such as dementia or affective disorders such as depression;
- Those whose habit of living in squalor is a long-standing lifestyle with no mental or physical diagnosis;
- Self-neglect is common among those who consume large quantities of alcohol; the consequences of such drinking may precipitate self-neglect;
- Those who live alone, in isolation from social support networks of family, friends and neighbours.

Self-neglect may also include ‘self-disconnection’ in respect of utilities, defined as interruption to electricity or gas supply by consumers using pre-payment meters (PPMs) because of a lack credit on the meter or account. An associated issue is ‘self-rationing’, where customers limit either energy use to save money, or restrict spending in other areas to ensure sufficient funds are available to keep the PPM topped up. Self-disconnection or self-rationing, as an example of a dimension of self-neglect, would not normally present in a health care context.

212 Ibid. p.2.
213 Ibid.
214 <https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf> Par. 17.2

“Vulnerable people self-disconnect more often, more recently and for longer”

Research by Citizens Advice has shown that self-disconnection and self-rationing can have significant consequences for the health and wellbeing of consumers. Just under half of households felt it had a negative impact on wellbeing, but this was seen as much more negative among vulnerable people. “*Vulnerable people self-disconnect more often, more recently and for longer*”.²¹⁵

It is reasonable to suggest that this aspect of self-neglect could be mitigated by mandating utility providers to make contact with a householder after a fixed period to establish the facts of the situation and explore ways of addressing the matter.

Categorising self-neglect

Self-neglect is frequently not categorized as a form of abuse as there is no third-party involvement and is often considered separately from abuse generally. The HSE 2014 national policy and procedures and the final draft version of the HSE 2019 policy on adult safeguarding exclude self-neglect from their definition of “abuse” and instead designate a separate policy to self-neglect. However, the HSE (2014) **Safeguarding Vulnerable Persons at Risk of Abuse National Policies and Procedures**²¹⁶ does consider self-neglect to be a safeguarding matter and includes (Section 3) processes whereby concerns of extreme self-neglect can be referred to the HSE Safeguarding Teams.

Self-neglect is seen by many as a global public health and human rights issue that threatens, in particular, older people’s health and safety (Dong, 2017)²¹⁷. Self-neglect is one of the most common reports received by Adult Protective Services (APS) in the United States²¹⁸.

Research²¹⁹ has linked self-neglect in later life to traumatic personal life experiences, including experiences of suffering, loss, childhood abuse, and migration and traumatic life events in early years. Self-neglect has also been associated with high stress levels, economic vulnerability and mental health problems.

Extent of self-neglect in Ireland

In the Irish context, self-neglect is included as a category of safeguarding concern in the annual reports of the HSE National Safeguarding Office. In 2017, of the 10,000 plus concerns received, it was reported²²⁰ that 430 related exclusively to self-neglect, that is to cases where there was no alleged abuser or ‘person causing concern’.

215 <https://www.citizensadvice.org.uk/Global/CitizensAdvice/Energy/PPM%20self-disconnection%20short%20report.pdf> p.8.

216 <https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf>

217 Dong, X. Elder Self-Neglect: Research and Practice. Clinical Interventions in Aging. 2017;12 949-954 downloaded from <https://www.dovepress.com/> on 13-Jan-2022

218 See <https://selfneglect.org/living-with-self-neglect/intervention/aps/> Accessed 17/01/2022

219 Day, MR (2020), “Self-Neglect in Older Adults”, in Phelan, A(ed.), Advances in Elder Abuse Research – Practice, Legislation and Policy, Springer.

220 HSE National Safeguarding Office Annual Reports. 2017, 2018, 2019, 2020.

It is worth noting, however, that, in addition to these 430 concerns where there the alleged self-neglect involved only the ‘victim’, there were a further 100 plus concerns reported where other abuse types were involved. This would suggest that self-neglect was taking place in parallel with other types of abuse that did involve other persons. NSO data from following years indicates that this scale of self-neglect persists.

Policy approaches to self-neglect

Responding to cases of self-neglect poses many challenges. The seriousness of this issue lies in the recognition that self-neglect in adults at risk is often not just a personal preference or a behavioural idiosyncrasy, but a spectrum of behaviours associated with increased morbidity and impairments in activities of daily living.²²¹

The HSE Policy on **Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures**²²² includes the following Guiding Principles for a policy response to self-neglect:

- The definition of self-neglect is based on cultural understandings and challenges cultural values of cleanliness, hygiene and care. It can be redefined by cultural and community norms and professional training.
- A threshold needs to be exceeded before the label of self-neglect is attached – many common behaviours do not result in action by social or health services or the courts.
- There is a need to distinguish between self-neglect, which involves personal care, and neglect of the environment, manifested in squalor and hoarding behaviour.
- Some self-neglecting behaviour can have a serious impact on family, neighbours and surroundings and this needs to be recognised.
- It is important to build trust with people who self-neglect and negotiation is critical for successful intervention.
- Assumptions must not be made regarding lack of mental capacity and, as far as possible, people must be supported in making their own decisions.

A perspective provided to Safeguarding Ireland by some HSE safeguarding and protection personnel in the context of this Discussion Paper is that Safeguarding and Protection Teams tend to operate on the basis of supporting other professionals (e.g., public health nurses) and housing support services in undertaking assessment and intervention and, for the most part, tend not to become directly involved in self-neglect cases.

221 Naik, AD (2017), Evaluating Capacity for Safe and Independent Living Among Vulnerable Older Adults, https://link.springer.com/chapter/10.1007/978-3-319-44084-2_2

222 <https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf> see also Health Service Executive (2012b) HSE Policy and Procedures for Responding to Allegations of Extreme Self-Neglect Dublin: Health Service Executive. Available at: <https://www.hse.ie/eng/services/publications/olderpeople/selfneglect.pdf> (Accessed: 10/02/22).

Factors relevant to responding to situations of self-neglect

Professionals with a responsibility for dealing with situations of self-neglect (safeguarding social workers, public health nurses, housing officers, Garda Síochána and other health and social care professionals) can find working with people who self-neglect extremely challenging. People who neglect themselves often refuse help and supportive interventions from others, including family members.

Family, friends and community are all seen as having a vital role in helping adults at risk remain safe in the community. Visiting, listening and volunteer driving are examples of ways to reduce isolation. People wish to respect autonomy and may not wish to be intrusive. However, if concerned or aware of a significant negative change in behaviour, it is recommended that they consider making contact or alerting services.

Family or neighbours can sometimes be critical of professionals because they are seen as overly cautious in taking action that might improve the situation of the individual. People can find it difficult to understand that there are limitations to what professionals can do if the adult has decision-making capacity in relation to how they live.

Practice in other jurisdictions²²³

Self-neglect is a serious and complex health and social care issue. However, the area of self-neglect is contentious and is included under legislation in some jurisdictions and not in others.

In Scotland, self-neglect is included within their Adult Support and Protection (Scotland) Act 2007 Code of Practice.²²⁴ Since 2014, England has widened the remit of legislation to include self-neglect (Department of Health, 2014)²²⁵. In England, the inclusion of self-neglect within the remit of adult safeguarding, as a result of changes in adult social care law introduced under the Care Act 2014, has thrown into relief the ethical dilemmas arising from tensions between respect for autonomy on the one hand and the exercise of a protective duty of care on the other hand.

In the USA, self-neglect falls within the remit of Adult Protection Services (APS) and, in many states, is subject to mandatory reporting. However, across the USA, statutory categorisations of self-neglect differ, sometimes being independent of and sometimes included within definitions of neglect.²²⁶ However, Federal definitions of self-neglect are only considered guidelines.

223 See Mary Rose Day Paper, <https://www.sageadvocacy.ie/media/1688/final-ed-hand-out-self-neglect-safeguarding-and-autonomy.pdf> and Day, M. R. McCarthy, G. & Fitzpatrick, J. (2017) 'Self-Neglect in Older Adults a Global, Evidence-Based Resource for Nurses and Other Healthcare Providers' Springer, New York. <https://www.springerpub.com/self-neglect-in-older-adults-9780826140821.html>

224 Adult Support and Protection (Scotland) Act 2007: Code of Practice, <https://www.gov.scot/publications/adult-support-protection-scotland-act-2007-code-practice-2/>

225 See Department of Health (England), Care and Support Statutory Guidance (Department of Health 2014) at 233-234, paragraph 14.17.(updated 2022), <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>

226 Information extracted from <https://ncea.acl.gov/What-We-Do/Practice/Intervention-Partners/APS-Laws.aspx> accessed 12/01/2022

Each state determines its own self-neglect definitions, laws, management and treatments.

Addressing the issue of self-neglect

One of the key challenges in adult safeguarding is ensuring the wellbeing of adults where risk arises from self-neglect rather than from a third party, particularly where they do not wish to engage with the state's protective agenda. Research has identified that health and social care professionals often find self-neglect cases of this kind to be enormously challenging and fraught with ethical and legal dilemmas, particularly when adults are judged to have decision-making capacity and refuse support.²²⁷ Practitioners report feeling exposed when coping with disappointments and anxiety, and uncertain as to how to balance a duty of care with a person's right to privacy.

Organisational systems may not clearly locate strategic responsibility for complex cases that require flexible, multi-professional interventions, or facilitate effective practice, which resides in the ability to build relationships over time, to balance concerned curiosity with respect and persistence, to routinely assess mental capacity and to evaluate possible legal options.²²⁸

In England, where adults who self-neglect have died or suffered significant harm, Local Safeguarding Adults Boards (LSABs) have commissioned Serious Case Reviews (SCRs). These SCR's and other studies²²⁹ confirm the many challenges involved with safeguarding work involving self-neglect and point to a number of factors that need to be considered.

- The importance of creating a strategic and operational infrastructure for self-neglect practice that reaches across agencies;
- Specific training, supervision and support for staff;
- Improved and robust data capture and collection;
- Giving time toward building relationships with the persons involved in self-neglect;
- Exploring and understanding the person's life;
- Developing practitioners' legal literacy;
- Using creative interventions;
- Multi-agency working.

227 Braye, S., Orr, D., and Preston-Shoot, M. Conceptualising and responding to self-neglect: The challenges for adult safeguarding, https://www.researchgate.net/publication/254190334_Conceptualising_and_responding_to_self-neglect_The_challenges_for_adult_safeguarding

228 Braye, S., Orr, D., and Preston-Shoot, M. Serious case review findings on the challenges of self-neglect: Indicators for good practice, https://www.researchgate.net/publication/275248376_Serious_case_review_findings_on_the_challenges_of_self-neglect_Indicators_for_good_practice

229 See Self-neglect policy and practice: building an evidence base for adult social care Report 69. Published November 2014. <https://www.scie.org.uk/self-neglect/policy-practice/evidence-base>

As research²³⁰ confirms, a multi-disciplinary approach is required, informed by skilled and timely capacity assessments, understanding of available legal rules, training and supervision that challenges and supports. Care by consent is preferable, with relationship-building tuned to the unique experiences of each individual who self-neglects.

The right of people to self-determination

Much of the debate regarding self-neglect and safeguarding centres on the tensions between respect for autonomy on the one hand and the exercise of a protective duty of care on the other hand. The term autonomy is used here to denote an individual's self-determination and personal sovereignty, implying freedom to make one's own life choices. The right of the individual person to exercise control over their own life and, therefore, to make their own decisions about how they live and behave can, on occasions, result in self-neglect. (See Appendix/Indicative Case Scenario 8.)

The power of the State to override an individual's right to make decisions that may be seen as involving self-neglect are circumscribed by the move from a paternalistic approach to decision-making toward a situation in which the right of the individual to make their own decisions is protected in law.

Nevertheless, there are occasions in which the State can and does intervene in spite of the individual's right to self-determination. Examples include situations involving environmental health and/or housing regulations, particularly where self-neglect impacts on the health, living environment and quality of life of others.

Some experts in the field²³¹ suggest that the balance between autonomy and safeguarding has been overly shifted in favour of autonomy and that there is a need for a more nuanced approach to be adopted. However, this commentary is largely focused on cases of extreme and serious self-neglect, where the self-neglect led to deaths and serious injuries.

Individual freedoms and the right to privacy can require restrictions and limits on access to and the sharing of personal information and on limiting access to private property. These limits, while providing protection to the individual, also restrict and inhibit the actions of agencies and personnel charged with safeguarding duties. The ability and willingness of agencies to intervene often involves a delicate balance between respecting autonomy and ensuring safeguarding. Staff may be inhibited in their approaches as a result of limited legal knowledge and/or fears that strong interventions will result in proportionately negative outcomes for the individual who is suspected as being at risk. Establishing the capacity of a person who appears to self-neglect to make informed decisions for themselves is a further inhibiting factor for social care and health workers.

²³⁰ Ibid.

²³¹ Suzy Braye, David Orr & Michael Preston-Shoot (2017) Autonomy and Protection in Self-neglect Work: The Ethical Complexity of Decision-making, Ethics and Social Welfare, 11:4, 320-335, <https://www.tandfonline.com/doi/abs/10.1080/17496535.2017.1290814>. See also Pickens S, Daniel M, Jones EC and Jefferson F (2021) Development of a Conceptual Framework for Severe Self-Neglect (SN) by Modifying the CREST Model for Self-Neglect. Front. Med. 8:654627. <https://pubmed.ncbi.nlm.nih.gov/34079809/>.

Self-neglect in the context of coercive control

As noted earlier, data from the HSE National Safeguarding Office reports instances where cases of self-neglect involve other forms of abuse, allegedly perpetrated by persons other than the victim. This data coincides with research from the US²³² (Dong et al 2013) that finds that elder self-neglect was associated with increased risk for subsequent elder abuse, and also with increased risk for subsequent caregiver neglect, financial exploitation and multiple forms of elder abuse.

In the Irish context, indicative case examples provided to Safeguarding Ireland by safeguarding professionals in the context of research for this Discussion Paper (see Appendix) include situations where an individual experiencing self-neglect was sharing a household with other self-neglecting family members. There were indications that in this situation a 'family culture' of self-neglect existed and that a dominant member of the household was effectively responsible for maintaining that culture. It appeared probable that the control exercised by the dominant person created circumstances in which the less influential members had little perceived choice other than to continue to live in such circumstances. They were also effectively coerced into refusing supports or interventions from social and health care personnel.

While, as noted earlier, self-neglect is most often associated with living alone, it is important to recognise that such a state of dis-connectivity can equally apply to family and household situations; that such a culture of self-neglect can have built up over a considerable period of time; that there is a likelihood that the norms of the culture are maintained and possibly enforced by a dominant personality; and that weaker members of the household are effectively being abused.

The likelihood that self-neglect may, at least partly, be the result of abuse or control by others, and the prospect that self-neglect can leave 'victims' with a greater exposure to potentially abusive relationships and situations, would suggest that care must be taken in sensitively exploring ways in which safeguarding agencies can facilitate and encourage engagement with support services.

By assuming that a refusal to accept intervention should be accepted at face value, safeguarding staff may be increasing the vulnerability and exposure of people who self-neglect. The capacity to act autonomously may require long-term supports, including support from an independent advocate.

Current legal and regulatory provision for self-neglect in Ireland

There is no statutory provision in Ireland specifically directed at identifying, investigating and addressing cases of self-neglect under Irish law, other than potentially in situations where a person lacks decision-making capacity or is suffering from a Mental Disorder under the Mental

²³² Dong X, Simon M, Evans D. Elder self-neglect is associated with increased risk for elder abuse in a community-dwelling population: findings from the Chicago Health and Aging Project. J Aging Health, <https://journals.sagepub.com/doi/10.1177/0898264312467373>

Health Act 2001. Neglect by another person can be addressed by way of tort law currently, but only where a duty of care, breach of that duty and resultant harm can be established. Such a duty might be more readily established in cases of neglect by professional carers. There is no statutory duty on adult children to care for their parents or other adult relatives. Neglect can also be addressed by the law on professional negligence, or by way of contract law where there is a breach of a contract to provide professional care services to an adequate standard.

Self-neglect is a difficult area to legislate for because an empowerment approach to safeguarding might be regarded as a barrier to intervening in situations where a person who is engaged in self-neglect has full decision-making capacity. On the one hand, there is a perception that the principle of empowerment indicates that a person should be entitled to self-neglect where they have capacity to do so. On the other hand, the principle of empowerment can sometimes be relied on in practice to avoid intervening in situations of self-neglect where it would, in fact, be necessary and appropriate to do so. A reluctance to intervene in such situations might arise due to a perception that the risk of harm arising from the neglect is self-inflicted and would, therefore, be particularly challenging to address in a way that upholds the autonomy of the person who is self-neglecting.

It is evident that a person who is self-neglecting can sometimes pose an environmental risk to individuals who live or work in proximity to them. For example, dangerously cluttered houses can become a fire risk to the persons living next door, or neglect of farm animals can pose a risk to people using neighbouring roads. Commonly, extreme self-neglect can result in an accumulation of rubbish and vermin/rodent infestation that poses risks to persons and neighbours. In such instances, there may be a public safety interest in intervening to address the self-neglect in order to reduce the risk posed to third parties. Any steps taken on foot of such a risk might address the self-neglect only to the extent that it impacts on environmental safety or the safety of others. It is imperative that, in situations of self-neglect where intervention is prompted by concerns relating to environmental or third-party risks, the measures taken reflect a safeguarding and empowerment approach in respect of the person who is self-neglecting.

Overview and Conclusion

It is noted that the Health Information and Quality Authority and Mental Health Commission National Standards for Adult Safeguarding do not refer to self-neglect and that the final draft of the Revised HSE Adult Safeguarding Policy (2019) (not published) does not include self-neglect.

In considering whether any definition of neglect in adult safeguarding legislation should refer to self-neglect as a (sub)category of neglect, or whether self-neglect should be referred to as a safeguarding issue in its own right, it is suggested here that self-neglect – though often inter-connected with other forms of abuse – deserves to be considered as an issue in its own right, particularly given the especial challenges and characteristics that it involves.

Data protection legislation is seen by many as a barrier to the effective safeguarding of adults who self-neglect. An unambiguous clarity could be provided if there was a positive duty on agencies to cooperate in relation to adult safeguarding, particularly in relation to sharing information.

There is clearly a need to ensure that personnel concerned with safeguarding of adults at risk are provided with the skills, structures and policies that are necessary for dealing with cases of self-neglect. This is not to negate the major importance of the human right to autonomy, including the right to refuse supports, provided the individual has decision-making capacity.

Professionals will need to be able to operate in a context where appropriate provisions exist and where there is clarity regarding access, regarding sharing of information, regarding cooperation between agencies and regarding reporting mechanisms.

International research regarding self-neglect indicates clearly that there is much yet to be learned regarding the condition. Continued learning from experience and from shared information will be key to progress. Since life history is strongly associated with self-neglect, it needs to be understood in the context of antecedents and life experiences as well as the current context.

Self-neglect by adults at risk is an area where additional research and analysis is required in relation to both better understanding its context and developing appropriate policy and legislative responses. It is strongly suggested that self-neglect should also come within the remit of a National Adult Safeguarding Authority when established. It is understood that that the Law Reform Commission will address self-neglect within the context of its forthcoming report on **A Regulatory Framework for Adult Safeguarding**.

The question at the heart of the challenge of responding adequately to situations of self-neglect is how services charged with safeguarding can respect individual autonomy while, at the same time, exercise their duty of protection in the context of significant risks and refusal to engage with services.

There is a strong case to be made for a broader and more integrated approach to the issue of self-neglect in an overall safeguarding context at national level which would include Gardaí, health and social care personnel and local communities.

The next chapter will outline data sharing challenges relevant to implementing an integrated safeguarding approach and suggest ways to overcome these challenges.

The question at the heart of the challenge of responding adequately to situations of self-neglect is how services charged with safeguarding can respect individual autonomy while, at the same time, exercise their duty of protection in the context of significant risks and refusal to engage with services.

/ Chapter Eight²³³

Data Sharing: Challenges in Implementing an Integrated Safeguarding Approach

The purpose of this chapter is to outline data sharing challenges relevant to implementing an integrated safeguarding approach and to suggest ways to overcome these challenges. The chapter summarises existing legislative provisions relating to data sharing based on EU General Data Protection Regulation (GDPR) and Irish legislation. Relevant regulatory provisions are outlined and gaps which impact on an integrated approach to safeguarding adults at risk are identified. Some ways of addressing the gaps identified are outlined.

233 This chapter was authored by Níamh Ní Leathlobhair BL.

Why the matter of data sharing in a safeguarding context needs to be addressed

The most pressing challenge to information sharing between agencies for safeguarding purposes is a lack of clarity and guidance as to what data, if any, can be shared between individuals and organisations where there are concerns of abuse, neglect and exploitation of an adult at risk. A multi-agency and multi-disciplinary approach is often required to adequately safeguard an adult at risk, or group of adults at risk in a congregated setting. Therefore, there is a need to share personal data amongst different individuals and organisations, including public and non – public bodies, to ensure the adequate protection and support of an adult at risk. Stakeholders have consistently highlighted that effective information sharing is an integral aspect of the multi-agency and multi-disciplinary approach required to adequately safeguard adults at risk of abuse.²³⁴ The importance of sharing information and of relying on a legal basis to do so, is reflected in various guidelines relevant to the safeguarding of adults at risk.²³⁵

Many practitioners in the area of safeguarding are aware that the consent of the data subject provides a legal basis for information sharing. Importantly, there appears to be a reluctance in practice to invoke other legal bases for information sharing. The over-reliance on consent and reluctance to invoke other legal bases, might be explained by two perceptions that developed around the introduction of the GDPR into Irish law. First, there was an emphasis on the need to prohibit the sharing of personal data which was widely regarded as having been misused. Second, there was a perception that, although some exceptions were allowed, obtaining the consent of the person to whom data related was the only safe way of permitting the sharing of personal information. The requirement for consent tended to be viewed as the default. Other legal bases tended to be viewed as exceptions, rather than viable alternatives, to consent.

The over-reliance on consent as a legal basis for processing data presents a particular challenge in a safeguarding context for two reasons. First, in a safeguarding context where the data subject is an adult at

234 Donnelly S and O'Brien M (2019), *Falling Through the Cracks: The case for change*. Key Developments and next steps for Adult Safeguarding in Ireland. Dublin: University College Dublin; HSE, *Safeguarding Vulnerable Persons at Risk of Abuse*, National Policy & Procedures, December 2014, at pages 12, 19, 21; HIQA & MHC, *National Standards for Adult Safeguarding*, 2019, at page 49; Department of Health, *Evidence review to inform development of a national policy on adult safeguarding in the health and social care sector*, Final Report, July 2020 at pages 70, 84, 87, 164, 272 – 273, 487; Law Reform Commission, *Issues Paper on A Regulatory Framework for Adult Safeguarding (LRC IP 18 2019)*; Department of Health, *Law Reform Commission Issues Paper: A Regulatory Framework for Adult Safeguarding*. A response from the Department of Health, August 2020, at page 34; HIQA, *Regulation of Homecare: A Position Paper*, December 2021, at page 12; Sage Advocacy, *Submission to Data Protection Commission on Regulatory Strategy Consultation 2020 – 2025*, 10th February 2020; Data Protection Commission, *Regulatory Strategy Consultation*, April 2021 at page 13 – 14.

235 HIQA and Mental Health Commission, *National Standards for Adult Safeguarding*, 2019, at page 49 – 50; HSE, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures*, 2014, at page 25 – 30; HIQA, *National Standards for Residential Care Settings for Older People in Ireland*, 2016, at page 47, paragraph 3.1.5; HIQA and Safeguarding Ireland, *Guidance on a Human Rights – based Approach in Health and Social Care Services*, 2019, at pages 18 and 28.

risk, they might have reduced capacity due to a mental illness, disability or cognitive impairment. Relatedly, the data subject might be unable to clearly express or communicate their consent. Even where the data subject does have capacity to consent, the data controller might not realise this if the data subject's ability to communicate their consent is reduced. In such situations, the data controller might not communicate the request for consent in a manner that is capacity-building, or appropriate to the needs of the data subject. Second, obtaining consent may prejudice the provision of protection, particularly where the data subject is a person who poses a risk to an adult at risk, or where prompt exchange of personal data is required to safeguard an individual from harm.

Apart from consent, there are several legal bases for processing data. The greatest area of uncertainty is the extent to which agencies are permitted to process or transfer personal data to other agencies without obtaining consent from the data subject. Engagement with stakeholders for this project suggests that the laws on data protection might be misinterpreted in practice, or applied without consistency by data protection officers across different organisations involved in adult safeguarding. Given the difficulties that can arise when invoking consent as a basis for information sharing in practice, there is a need to clarify the circumstances in which it is permissible to invoke the several other legal bases for processing data.

Legal framework for information sharing

Data sharing is governed by the Data Protection Act 2018 and the Data Sharing and Governance Act 2019, which give effect to the EU General Data Protection Regulation (GDPR) and the Law Enforcement Directive (LED). The Data Sharing and Governance Act 2019 provides the legal basis for the sharing of data between public bodies and for making statutory provision for data governance within the public service. The EU General Data Protection Regulation and the Data Protection Act 2018 govern the processing of personal data generally. The Data Protection Act 2018 provides the legal basis for the sharing of personal data between all organisations (public and private) involved in safeguarding. The Data Protection Act 2018 also provides the legal basis for making detailed statutory provision for data sharing in the public interest.

Article 6 GDPR sets out six legal bases for processing personal data. Article 9 deals with special categories of personal data, which benefits from added protection. Special category personal data consists of data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, Trade Union membership, as well as genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation. Article 9 contains a general prohibition on the processing of special categories of personal data and outlines a number of exceptions to that general prohibition. In order to process special category personal data, such as health data, it is necessary to: (1) identify a legal basis for processing personal data generally under Article 6, and;

(2) identify an exception to the general prohibition on processing special category of sensitive personal data under Article 9.

The following sections sets out the provisions of Article 6 and Article 9, as well as other relevant data protection provisions, and their relevance to information sharing in the safeguarding context.

Article 6 GDPR legal bases for processing personal data

Article 6 provides the following legal bases for data sharing: (1) consent; (2) contractual necessity; (3) legal obligation; (4) vital interests; (5) public task; (6) legitimate interests.

(1) Consent

The first legal basis is consent and is provided for in Article 6(1)(a) GDPR and section 71(2)(b) of the Data Protection Act 2018. Article 7 GDPR and section 71(3) of the 2018 Act set out the conditions for consent. Consent as a legal basis creates difficulty in the safeguarding context for the reasons outlined above and this chapter therefore focuses on the other legal bases for data sharing.

(2) Contractual necessity

The second legal basis is “contract”, sometimes referred to as “contractual necessity” or “contractual performance”. This legal basis arises where processing is necessary for (1) the performance of a contract to which the data subject is party or (2) in order to take steps at the request of the data subject prior to entering into a contract. It is provided for in Article 6(1)(b) and recital 44 of the GDPR. There must be a direct contractual relationship between the data subject and the data controller for this legal basis to apply.²³⁶ For example, Article 6(1)(b) does not provide a legal basis for processing personal data where necessary for the performance of a contract between the data controller and a third party. It is also not sufficient for the data processing to be merely related to the contractual relationship. Instead, the data processing must be objectively necessary for the performance of the contract.²³⁷ This legal basis for information sharing is sometimes relevant in the safeguarding context, for example where contracts for care services arise. However, it is of limited use because the scope for data sharing would be restricted by the terms of the contract in question and, in particular, to processing that is necessary for the performance of the contract. Article 6(1)(b) is not sufficiently broad to allow for information sharing across all organisations for safeguarding purposes that fall outside the scope of what is necessary for the performance of a particular contract. As with many of the other legal bases, if processing special category personal data, (such as health data) is necessary for the performance of the contract, controllers will need to: (1) ensure that the legal basis provided for in Article 6(1)(b) actually applies, and; (2) identify a separate exception to the general prohibition of processing such data under Article 9 GDPR.

²³⁶ Data Protection Commissioner, Guidance Note: Legal Bases for Processing Personal Data, December 2019 at page 11.

²³⁷ Data Protection Commissioner, Guidance Note: Legal Bases for Processing Personal Data, December 2019 at page 11.

(3) Compliance with a legal obligation

The third legal basis is where “*processing is necessary for compliance with a legal obligation to which the controller is subject*”. This legal basis is provided for in Article 6(1)(c) GDPR and is not explicitly provided for in the Data Protection Act 2018. Article 6(3) GDPR provides that the legal obligation must be grounded on a provision of EU or national law. If grounded in national law, the legal obligation may be in the form of primary legislation (such as an Act of the Oireachtas), secondary legislation (such as a statutory instrument), or some common law requirement.²³⁸ The law grounding the legal obligation must comply with recital 41 GDPR, which requires that any legal basis or legislative measure should be clear and precise and that its application should be foreseeable to persons subject to it, in accordance with the case law of the Court of Justice of the European Union and the European Court of Human Rights. Article 6(3) GDPR provides that the purpose of the processing must be determined in the legal basis laid down by EU or national law. Article 6(3) also requires that the law grounding the legal obligation must meet an objective of public interest and be proportionate to the legitimate aim pursued. Article 6(3) also provides (but does not require) that the law grounding the legal obligation *may* specify: the general conditions governing the lawfulness of processing by the controller; the types of data which are subject to the processing; the data subjects concerned; the entities to, and the purposes for which, the personal data may be disclosed; the purpose limitation; storage periods; and; processing operations and processing procedures, including measures to ensure lawful and fair processing. Recital 45 makes it clear that the law grounding the legal obligation does not need to be a law that clearly obliges data controllers to engage in a specific act of data processing. The law grounding the legal obligation may be the basis for several processing operations, as long as those processing operations are actually necessary to comply with that obligation.²³⁹ The effect of recital 41 and recital 45 is that the law grounding the legal obligation would have to be sufficiently clear and precise to provide a legal basis for data processing, but doesn’t need to specify a legal obligation for each individual processing *activity* (such as recording, organising, storing or disclosing the information).

There is a legal obligation to share information relevant to safeguarding in some situations. For example, HIQA, the Mental Health Commission (MHC) and the Health Service Executive (HSE) are all required to notify specified information to the National Vetting Bureau regarding persons engaged in work or activities relating to vulnerable persons²⁴⁰ pursuant to section 19 of the National Vetting Bureau (Children and Vulnerable

²³⁸ Article 6(3) GDPR; Data Protection Commissioner, Guidance Note: Legal Bases for Processing Personal Data, December 2019 at page 14.

²³⁹ Data Protection Commissioner, Guidance Note: Legal Bases for Processing Personal Data, December 2019 at page 14.

²⁴⁰ The relevant work or activities relating to vulnerable persons are set out in Schedule 1, part 2 of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and include, inter alia, work or activity which consists mainly of a person having access to or contact with vulnerable persons in: a school or centre of education; a hospital or care centre which provides treatment to vulnerable persons; a designated centre within the meaning of section 2 of the Health Act 2007, or; an approved centre within the meaning of Part 5 of the Mental Health Act 2001.

Persons) Act 2012. The specified information relates to the person who is the subject of a vetting disclosure. Specified information is defined in section 2 as information concerning a finding or allegation of harm to another person that is received by the Bureau from (a) the Garda Síochána pursuant to an investigation of an offence or pursuant to any other function conferred on the Garda Síochána by or under any enactment or the common law, or (b) a scheduled organisation pursuant to subsection (1) or (2) of section 19. The legal obligation grounded in section 19 may be of some assistance in safeguarding adults at risk in certain circumstances. However, section 19 provides only for the sharing of information with the National Vetting Bureau. There is currently no common law or statutory provision grounding a positive legal obligation to share information with other organisations involved in safeguarding, or for more general safeguarding purposes, such as sharing information with a view to developing a care plan specifically tailored to individuals who are at risk.

There is also a legal obligation to share information relevant to safeguarding under the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012. Section 3(1) of the Act provides that a person shall be guilty of an offence if (a) he or she knows or believes that an offence listed in Schedule 2 has been committed by another person against a vulnerable person and (b) he or she has information which he or she knows or believes might be of material assistance in securing the apprehension, prosecution or conviction of that other person for that offence and fails without reasonable excuse to disclose that information as soon as is practicable to do so to a member of An Garda Síochána. Section 3 provides a legal basis for the transfer of information only to the Gardaí and only where an offence listed in Schedule 2, such as false imprisonment, assault causing harm or a range of sexual offences are suspected. Section 4 provides a defence where the accused person can show: (a) that the view of the vulnerable person (provided that he or she was capable of forming a view on the matter) was that the commission of that offence, or information relating to it, should not be disclosed to An Garda Síochána, and; (b) that the accused person knew of and relied upon that view. Section 19 of the Criminal Justice Act 2011 contains a similar legal obligation to share information that might be of material assistance in preventing, prosecuting or convicting the commission of offences relating to financial crime, company law offences and theft and fraud offences.²⁴¹

The legal obligations contained in section 3(1) of the 2012 Act and section 19 of the 2011 Act may be of some assistance in safeguarding adults at risk but provide a very limited legal basis for data processing. The duty to disclose only allows for the sharing of information with the An Garda Síochána and only where specific offences are suspected. The provisions do not cover many situations relevant to safeguarding, such as forms of financial, psychological or physical abuse, exploitation or neglect. The provisions do not provide for information sharing to alternative organisations who could appropriately intervene in situations where the adult at risk forms the view that the offence should not be reported to An Garda Síochána.

²⁴¹ Section 3(1) and Schedule 1 of the Criminal Justice Act 2011.

There is currently no statutory or common law provision which could ground a legal obligation to share information relevant for safeguarding outside of the narrow circumstances provided for in the National Vetting Bureau (Children and Vulnerable Persons) Act 2012, Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012, and Criminal Justice Act 2011. The introduction of a statutory obligation relating to safeguarding could provide a legal basis for processing personal data pursuant to Article 6(1)(c).

A statutory obligation of a general nature, for example a duty to safeguard adults at risk, could potentially provide a legal basis for organisations and individuals to share information with one another in order to achieve the objective of safeguarding an individual from a risk of harm. Such a general duty would have to be sufficiently clear and precise and foreseeable in its application to comply with recital 41. It could also cause difficulties in practice in the absence of clarity as to: (1) the circumstances in which it is necessary to share information to achieve compliance with a general obligation to safeguard; (2) exactly what personal data can lawfully be transferred having regard to the principle of data minimisation, and; (3) the entities to whom the data can or should be transferred with a view to safeguarding an individual at risk.

A statutory obligation specifically providing for the sharing of information among various entities involved with safeguarding might avoid those difficulties and better enable an integrated approach to safeguarding. In the absence of a statutory provision of a specific nature or appropriate guidance, there may be a reluctance among practitioners involved in safeguarding to share information in a manner that is, in fact, lawful, for fear of going beyond what is necessary and proportionate for achieving compliance with the law grounding the legal obligation to share the information. There is ample scope for reliance on Article 6(1)(c) as a legal basis for data processing, but only if legislation grounding a legal obligation to share information for safeguarding purposes is introduced. It is interesting to note the Department of Health’s response to the following question posed by the Law Reform Commission in its Issues Paper on **A Regulatory Framework for Adult Safeguarding** (LRC IP 18 2019):

“Do you consider that the existing arrangements for access to sensitive data and information sharing between relevant regulatory bodies are sufficient to underpin adult safeguarding legislation?”

The Department of Health replied as follows:

“Existing GDPR related legislation may enable information-sharing for specified purposes, but in practice appears to be perceived as a barrier. This may need to be addressed. It would assist if there was a positive and statutory duty on agencies to cooperate in relation to adult safeguarding, particularly in relation to information sharing. A positive duty would ensure that data sharing is mandated and implemented, rather than simply enabled.”²⁴²

²⁴² Department of Health, Law Reform Commission Issues Paper: A Regulatory Framework for Adult Safeguarding. A response from the Department of Health, August 2020, at page 34.

“Existing GDPR related legislation may enable information-sharing for specified purposes, but in practice appears to be perceived as a barrier. This may need to be addressed. It would assist if there was a positive and statutory duty on agencies to cooperate in relation to adult safeguarding, particularly in relation to information sharing. A positive duty would ensure that data sharing is mandated and implemented, rather than simply enabled.”

The legal obligation legal basis in Article 6(1)(c) provides for the sharing of personal data other than special category data. To process special category data such as health data, it is necessary to identify: (1) a legal basis in Article 6(1), and; (2) an exception to the prohibition on processing special category data in Article 9(2). The Article 9(2) basis for processing special category data could also be incorporated in any statutory obligation grounding the legal basis for data sharing under Article 6(1)(c).

(4) Vital interest

The fourth legal basis is where “*processing is necessary in order to protect the vital interests of the data subject or of another natural person.*” It is provided for in Article 6(1)(d) GDPR. The vital interests’ legal basis is useful for four reasons. First, it can be relied upon directly under the current framework, without the need for further statutory provision.²⁴³ Second, it can be relied upon to process data in emergency situations where it is not possible to obtain the consent of the data subject. Third, the vital interests of the data subject or another natural person also provide a basis for processing special category of personal data, such as health data, under Article 9 GDPR (albeit only where the data subject is incapable of consenting). Fourth, with updated guidance, the vital interest of a vulnerable adult can potentially be relied upon more expansively than in the past, to share information in non-urgent safeguarding situations.

The vital interest legal basis gives rise to the following issues set out below:

1. Whose vital interest can be relied upon?
2. What constitutes a vital interest and does it require urgency?
3. Requirement for data subject’s inability to consent to the processing of their special category data on the basis of vital interests.

Whose vital interest can be relied upon?

The vital interests of the data subject, or of another natural person, can be relied upon in order to process the data subject’s personal data. Recital 46 provides that processing personal data based on the vital interest of a natural person *other than the data subject* should in principle only take place where processing cannot be manifestly based on another legal basis. This means that in situations involving an adult at risk, their own personal data can be processed on the basis of their own vital interests, without having to discount the other legal bases provided in Article 6.

²⁴³ The vital interests’ legal basis in Article 6(1)(d) does not appear to be replicated in the Data Protection Act 2018. Section 55(1)(b)(iv) provides for the processing of personal data relating to criminal convictions and offences where processing is necessary to prevent injury or other damage to the data subject or another person or loss in respect of, or damage to, property or otherwise to protect the vital interests of the data subject or another person. Although this provision deals with vital interests, it relates to Article 10, rather than Article 6(1)(d) GDPR.

However, the impact of recital 46 means that the situation is slightly different where information relating to another person, for example the person who poses a risk, needs to be shared in order to protect the vital interests of the adult at risk. The vital interests of the adult at risk can only be relied upon to process the personal data of another person if no other legal basis in Article 6 can be relied upon in order to process that personal data. In the safeguarding context, it might be relatively straightforward to discount the possibility of relying on the other legal bases where there is a need to share information regarding a person who poses a risk to an adult at risk. For example, in the absence of consent, a contractual basis, and legislation grounding a legal obligation or public task, the only legal basis left to be considered is the legitimate interest basis, which generally can't be invoked by public authorities.

What constitutes a vital interest and does it require urgency?

The GDPR, the Data Protection Act 2018 and the Data Protection Commission's *Guidance Note on Legal Bases for Processing Personal Data* (December 2019) are of assistance in ascertaining what constitutes a vital interest.

Unlike the legal bases in Article 6(1)(c) (legal obligation) and Article 6(1)(e) (public task), the vital interests' legal basis in Article 6(1)(d) does not require further statutory provision in EU or national law and can be relied upon directly. Accordingly, it does not appear to be replicated in the Data Protection Act 2018.²⁴⁴ The vital interests of a data subject or another natural person can also provide a basis for the lawful processing of special category personal data under Article 9(2)(c) GDPR, if the data subject is incapable of giving consent.²⁴⁵

Recital 46 further indicates that a vital interest is an interest which is vital for the life of the data subject or another natural person. The Data Protection Commission has suggested that vital interests can be understood as mainly covering life-threatening situations and potentially situations which very seriously threaten the health or fundamental rights of an individual.²⁴⁶ Many situations that arise in a safeguarding context can be characterised as an emergency and the vital interests of an adult at risk can undoubtedly be relied upon to process data in light of the urgency of a situation.

244 Section 55(1)(b)(iv) provides for the processing of personal data relating to criminal convictions and offences where processing is necessary to prevent injury or other damage to the data subject or another person or loss in respect of, or damage to, property or otherwise to protect the vital interests of the data subject or another person. Although this provision deals with vital interests, it relates to Article 10, rather than Article 6(1)(d) GDPR.

245 Article 9(2)(c) provides that special categories of personal data can be processed where necessary to protect the vital interests of the data subject or of another natural person, where the data subject is physically or legally incapable of giving consent. The requirement that the data subject be incapable of giving consent may present a barrier in situations where personal data of a person who poses a risk to a vulnerable adult's vital interests is sought to be shared. That person posing a risk (the data subject) may be capable of giving consent, but seeking the consent could prejudice the provision of protection to the person whose vital interests are sought to be protected.

246 Data Protection Commissioner, *Guidance Note: Legal Bases for Processing Personal Data*, December 2019 at page 17.

“... this legal basis will not apply to all situations concerning the health or treatment of a data subject, but only where the processing is necessary to protect vital interests. As such, it is less likely that this legal basis would apply outside of an emergency situation, for instance where medical care has been planned in advance.”

The Data Protection Commission's *Guidance Note on Legal Bases for Processing Personal Data* gives the impression that the vital interests legal basis is invoked less frequently than the other legal bases and only in atypical situations where other legal bases are not appropriate.²⁴⁷ The appropriateness of other legal bases is only relevant when considering whether to invoke the vital interests of one person in order to process the personal data of another person.²⁴⁸ The impact of recital 46 is that the only circumstances in which the vital interests legal basis should be a last resort is where the vital interests of a person other than the data subject are being relied upon to share the data subject's personal data. The potential availability of other legal bases should not be a barrier to relying on the vital interests of an adult at risk in order to process that adult's own personal data.

The *Guidance Note* also gives the impression that the vital interest legal basis is invoked mainly in emergency situations and is less likely to apply in non-urgent situations. For example, the *Guidance Note* states:

“... this legal basis will not apply to all situations concerning the health or treatment of a data subject, but only where the processing is necessary to protect vital interests. As such, it is less likely that this legal basis would apply outside of an emergency situation, for instance where medical care has been planned in advance.”²⁴⁹

The above statement seems to conflate vital interests relating to the health or life of an individual with emergency or urgent situations. An interest can be vital regardless of whether it is under imminent or immediate threat. The safeguarding context gives rise to many situations that are not urgent or emergency in nature, but where the vital interests of an adult at risk nonetheless require protection. The fact that the vital interests' legal basis has been invoked infrequently and mostly in emergency situations to date should not be a barrier to invoking it in the safeguarding context where the vital interests of an adult who is at risk (albeit not imminently) require it. The *Guidance Note* acknowledges that most cases in which vital interests are the appropriate basis will involve medical or healthcare situations, including people in vulnerable mental states, and will often involve sensitive, special category data.²⁵⁰

Although the Data Protection Commission's *Guidance Note* on this legal basis indicates that it is most appropriate for atypical situations and emergencies, there is nothing in the GDPR or the Data Protection Act 2018 to suggest that this legal basis is to be limited to urgent or emergency situations. The vital interests' exception in Article 9(2)(c) is reflected in section 73(1)(b)(ii) of the Data Protection Act 2018. The processing of special category personal data is only permitted where the conditions for processing personal data set out in section 71 and one of the conditions set out in section 73(1)(b), are complied with. Section 73(1)

247 Data Protection Commissioner, *Guidance Note: Legal Bases for Processing Personal Data*, December 2019 at page 16.

248 Recital 46.

249 Data Protection Commissioner, *Guidance Note: Legal Bases for Processing Personal Data*, December 2019 at page 16.

250 Data Protection Commissioner, *Guidance Note: Legal Bases for Processing Personal Data*, December 2019 at page 17.

(b)(ii) provides that special category personal data can be processed where it is necessary to: (I) prevent injury or other damage to the data subject or another individual; (II) prevent loss in respect of, or damage to, property, or; (III) otherwise protect the vital interests of the data subject or another individual. Section 55, which provides for processing of personal data relating to criminal convictions and offences where necessary to protect vital interests, is in similar terms. The language of the section does not appear to require any imminent or immediate threat to a person's vital interests. The language of the section also indicates that vital interests may include the prevention of injury or other damage to an adult at risk, and the prevention of loss or damage in respect of the property of an adult at risk. In a safeguarding context this could extend to protecting an adult from the risk of financial abuse (which involves loss of property), or from the risk of physical and psychological abuse and neglect, even in situations that do not necessarily amount to an emergency in the sense suggested in the *Guidance Note*. It should not be necessary to permit an adult at risk to remain in an adverse situation until such time as their life or health is at an immediate and grave risk, before their vital interests can be relied upon to share information necessary for a timely intervention that could safeguard them from that risk.

Guidance from the Data Protection Commission on the issue of whether safeguarding an individual from a risk of harm *other than in an emergency situation* can be regarded as a vital interest within the meaning of Article 6, Article 9 and section 73(1)(b)(ii) would be beneficial to practitioners in establishing when this legal basis can be relied upon for information sharing. If the need to be safeguarded is characterised as a vital interest of vulnerable adults who are at risk of harm, then the legal basis in Article 6(1)(d), and the exception to the prohibition of processing special category personal data contained in Article 9(2)(c) and reflected in section 73(1)(b)(ii), can be relied upon directly to lawfully share information between organisations involved with safeguarding. In the absence of legislation providing for sharing of information pursuant to Article 6(1)(c) (legal obligation) or Article 6(1)(e) (public task), the vital interests of an adult at risk could be a useful basis for information sharing under the current framework. Given that the vital interests legal basis has not been frequently invoked and has mainly been relied upon only in emergency situations, it is likely and understandable that practitioners in the safeguarding field might be reluctant to rely on it going forward in situations that are perceived as non-urgent. Any reluctance to invoke this legal basis is likely to be compounded by the absence of updated guidance clarifying its application to the safeguarding context. Reliance on this legal basis going forward in practice is likely to be contingent on the provision of updated guidance from the Data Protection Commissioner, clarifying:

1. Whether the urgent or emergency situations envisaged in the current Guidance Note cover safeguarding scenarios that do not involve an immediate or grave risk to a vulnerable adult's life or health, or alternatively;
2. Whether the need to be safeguarded can be characterised as a vital interest, even in non-urgent situations;

Requirement for data subject's inability to consent to the processing of their special category data on the basis of vital interests

The requirement in Article 9(2)(c) that the data subject be incapable of giving consent to the processing of their special category personal data might pose a practical challenge in the safeguarding context, depending on whose special category data is sought to be shared. If the adult at risk is the data subject, the requirement is unlikely to pose a practical challenge to invoking the exception under Article 9(2)(c). On the one hand, it is often the case in safeguarding scenarios that a person does not have capacity or is otherwise is incapable of consenting to the sharing of their health or other special category data. On the other hand, it might not be appropriate to share the information if an adult at risk has capacity to consent to the sharing of their special category data and refuses to do so.

Different considerations arise where the special category data of another person is sought to be shared in order to protect the vital interests of an adult at risk. It is important to note that personal data, other than special category data, of one person can still be shared to protect the vital interests of another, regardless of their ability to consent, pursuant to Article 6(1)(d). For example, the name of a person who poses a risk to an adult at risk, their relationship with the adult at risk and the fact that they pose a risk, could be shared pursuant to Article 6(1)(d) without having to seek that person's consent. However, if the nature of the risk posed by a person relates to their special category data, that information would have to be shared pursuant to Article 9(2)(c), and only if the person were incapable of giving consent. For example, an adult at risk might be at risk from a family member with whom they reside, and the mental health of that family member may be relevant to the nature and extent of the risk they pose to the adult at risk. Alternatively, the risk posed by another person to an adult at risk might relate to that person's sex life, if they are in a sexual relationship with the adult at risk. The latter situation might arise where no offence listed in Schedule 2 of the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012 is suspected. The special category personal data outlined in those examples would have to be shared pursuant to Article 9(2)(c), and only if the person were incapable of giving consent.

The special category data outlined above would be relevant and necessary for assessing what measures should be put in place to safeguard an adult at risk. Article 9(2)(c) requires that the data subject must be incapable of consenting to the processing of their special category data, before the vital interests of the adult at risk can be invoked as a legal basis for sharing that data with safeguarding organisations. The person posing the risk may be capable of consenting, but the process of seeking their consent might exacerbate the risk posed to the adult at risk. In such a situation, Article 9(2)(c) does not provide a legal basis for processing the other person's special category data on the basis of the vital interests of an adult at risk, without that person's consent. It would, therefore, be necessary to identify an alternative exception to the prohibition on processing special category data under Article 9(2). The UK Data Protection Act 2018 caters for such situations

in Schedule 1, Part 2, paragraph 18, by providing for information sharing under the substantial public interest exception in Article 9(2) (g). Schedule 1, Part 2, Paragraph 18(2) provides that information can be shared where the controller cannot reasonably be expected to obtain the consent of the data subject or where obtaining consent would prejudice the provision of protection. There is no equivalent provision in Irish law, because no regulations providing for safeguarding as a substantial public interest have been made in Ireland, despite being required by section 51(3) of the Data Protection Act 2018. If no alternative exception in Article 9(2) can be relied upon, for example due to the absence of enabling legislation, it may be necessary to assess the risk posed to the adult at risk in the absence of crucial information regarding the special category personal data of the person who poses the risk. Carrying out an assessment of the risk posed to an adult at risk in the absence of crucial information relating to the nature and extent of that risk could result in (1) a process that is not capacity-building or empowering for the adult at risk, and / or (2) the implementation of measures that are inadequate, overly intrusive or inappropriate to the situation and risk posed to the adult in question.

(5) Public task

The fifth legal basis is where *“processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller”*. This is sometimes referred to as the “public task” legal basis and is provided for in Article 6(1)(e) GDPR. Article 6(3) GDPR provides that the basis for processing pursuant to Article 6(1)(e) must be grounded on a provision of EU or national law, which meets an objective of public interest and is proportionate to the legitimate aim pursued.

Similar to the legal obligation basis set out in Article 6(1)(c), the public interest task or official authority providing this legal basis must be grounded in either primary legislation (for example an Act of the Oireachtas), secondary legislation, or the common law. Article 6(1)(e) cannot be directly relied upon to invoke this legal basis and accordingly is provided for in section 38 of the Data Protection Act 2018.²⁵¹ Section 38(1) provides that processing personal data shall be lawful to the extent that such processing is necessary and proportionate for (a) the performance of a function of a controller conferred by or under an enactment or by the Constitution, or (b) the administration of any non-statutory scheme, programme or funds where the legal basis for such administration is a function of a controller conferred by or under an enactment or by the Constitution.

The public interest element is a clear enabler for sharing information in the context of safeguarding adults at risk. For example, it might be in the public interest for HIQA or the HSE to share information for safeguarding purposes where it relates to functions carried out by those bodies pursuant to the Health Act 2007. However, further statutory intervention in the form of ministerial regulations made pursuant to section 38(4) is

²⁵¹ Relatedly, section 42 of the Data Protection Act 2018 provides for processing of personal data for the purpose of archiving in the public interest, and for scientific or historical research in accordance with Article 89 GDPR.

required before this basis can be relied upon to share information in a safeguarding context. The regulations should specify the processing of personal data which is necessary for the performance of a task carried out in the public interest by a controller, or which is necessary in the exercise of official authority vested in a controller. The regulations are required to specify the personal data that may be processed, the circumstances in which it can be processed, to whom the data may be disclosed and other conditions appropriate to impose on the processing of such personal data.

The data controllers most likely to rely on this legal basis are public authorities, or other natural or legal persons governed by public law. The reason for this is that public authorities are expressly prevented from relying on the alternative legitimate interest basis provided under Article 6(1)(f) for processing data in the performance of their tasks.²⁵² Although private bodies tend to rely on the legitimate interest basis, they are not necessarily precluded from relying on the public task basis. Recital 45 GDPR provides that it should be for EU or national law to determine whether the data controller is governed by public law or by private law. An entity governed by private law can invoke this legal basis to process data where necessary to carry out a task in the public interest, including for health purposes, such as public health and social protection and management of health care services.

Public bodies may not rely on the public task legal basis contained in Article 6(1)(e) when disclosing information to other public bodies.²⁵³ The reason for this is that information sharing between public bodies is governed by the Data Sharing and Governance Act 2019, which disapplies section 38 of the Data Protection Act 2018 from data processing within the scope of the 2019 Act. In a safeguarding context, public bodies can share certain information with one another with relative ease pursuant to the Data Sharing and Governance Act 2019. However, in the absence of regulations made pursuant to section 38(4), public bodies such as the HSE cannot rely on the legal basis in section 38 to share information with private entities that may be involved in safeguarding an adult at risk.

(6) Legitimate interest

The sixth legal basis is where *“processing is necessary for the purposes of the legitimate interests pursued by the controller or by a third party, except where such interests are overridden by the interests or fundamental rights and freedoms of the data subject which require protection of personal data, in particular where the data subject is a child.”* This legitimate interest legal basis is provided for in Article 6(1)(f) GDPR. Article 6(1)(f) can be relied upon directly and accordingly is not provided for in the Data Protection Act 2018. The Data Protection Commission’s *Guidance Note* stipulates that three elements should be considered when assessing whether to process data under the legitimate

²⁵² Recital 47 also stipulates that the legitimate interests’ legal basis contained in Article 6(1)(f) shall not apply to the processing by public authorities in the performance of their tasks, because it is for the legislator to provide by law for the legal basis for public authorities to process personal data.

²⁵³ Section 6(2) of the Data Sharing and Governance Act 2019 restricts the application of section 38 of the Data Protection Act 2018.

interest legal basis: (1) identify a legitimate interest pursued by the data controller or a third party; (2) demonstrate that the intended processing of the data subject’s personal data is necessary to achieve the legitimate interest; and (3) balance the legitimate interest against the data subject’s interests, rights, and freedoms.

The legitimate interest legal basis has been described as versatile and flexible²⁵⁴ and may, therefore, be a useful one to invoke in the context of safeguarding. The legitimate interest grounding the legal basis for data processing may be a legitimate interest of the data controller itself, or a legitimate interest of a third party (for example the intended recipient of the data). The concept of legitimate interest covers a largely undefined and potentially wide range of interests. There is no requirement for further statutory intervention to define what might constitute a legitimate interest, because Article 6(1)(f) can be relied upon directly. The Data Protection Commission’s *Guidance Note* indicates that legitimate interests may include commercial interests, individual interests, or broader societal benefits and that this legal basis could be appropriate in a wide range of situations.

Recital 47 sets out unequivocally that processing personal data for the purpose of preventing fraud constitutes a legitimate interest of the data controller concerned. The prevention of fraud as a legitimate interest is particularly relevant in safeguarding situations where an adult at risk is exposed to a risk of financial abuse. Data processing for direct marketing purposes may also (but does not necessarily) constitute a legitimate interest.²⁵⁵ Recital 47 sets out that a legitimate interest could exist where there is a relevant and appropriate relationship between the data subject and the controller, for example where the data subject is a client or in the service of the controller. In a safeguarding context, the relationship between an adult at risk and a private care provider could give rise to a legitimate interest on the part of the private care provider, or a third party such as the HSE, to safeguard that adult. The care provider could accordingly rely on the legitimate interest in safeguarding the adult at risk (an interest pursued either by the care provider itself or the third party) in order to disclose relevant personal data to another organisation involved in safeguarding. Similarly, the consumer relationship between an adult at risk and a financial institution could also give rise to a legitimate interest in safeguarding that adult. This would provide a legal basis for the financial institution to share information regarding a risk of financial abuse with another organisation, for example the Department of Social Protection, the National Shared Services Office (which has responsibility for payment of pensions to public servants) or the HSE. Recital 47 also provides that the existence of a legitimate interest would need careful assessment including whether a data subject can reasonably expect at the time and in the context of the collection of the personal data that processing for that purpose may take place. It is likely that the standard for assessing what a data subject can “reasonably expect” in terms of data processing is an objective standard. It would, therefore, not be necessary to consider whether a lack of capacity on the part of an adult at risk impacts what they can reasonably expect in terms of data processing.

254 Data Protection Commissioner, *Guidance Note: Legal Bases for Processing Personal Data*, December 2019 at page 21.
255 Recital 47.

The legitimate interest legal basis has two potential drawbacks. First, it cannot be relied upon by public authorities who process personal data in the performance of their tasks.²⁵⁶ The rationale for this is that it is for the legislature, rather than a public body itself, to provide for the legal basis for public authorities to process personal data.²⁵⁷ Therefore, it would not be appropriate for a public authority to decide independently what constitutes a legitimate interest, in circumstances where it has been allocated a task to carry out in the public interest by legislation. By contrast, it is appropriate for private entities to pursue legitimate interests not set out in statute. It is possible for public authorities to invoke the legitimate interest basis when processing data for a reason other than performing their tasks as a public authority. This might arise for tasks that are ancillary to the substantive tasks of the public body, for example transparency, office management, or financial accountability.²⁵⁸ Accordingly, the legitimate interest legal basis tends to be relied upon by private entities more so than by public bodies.

Second, this legal basis imposes heightened obligations on data controllers to balance the legitimate interests they are seeking to pursue by data processing with the rights and interests of the data subject. The requirement for a balancing exercise is a useful protection to ensure the data subject’s rights are thoroughly considered before their personal data is processed. However, the complexity of the balancing exercise may result in inconsistent approaches among the separate organisations involved with safeguarding and may even result in reluctance on the part of organisations to invoke this legal basis in order to share information.

The balancing exercise should take into account the rights and interests of the data subject in a general sense and should not be limited to a consideration of their rights and interests as they relate to their privacy and data protection rights. For example, in a safeguarding context, the balancing exercise should consider an at risk adult’s data protection and privacy interests, as well as their interest in being safeguarded from harm. The balancing test should take into account the reasonable expectations of the data subject, in the context of their relationship with the data controller.²⁵⁹ Recital 47 sets out that where personal data is processed in circumstances where the data subject does not reasonably expect further processing, the data subject’s interests and fundamental rights could in particular override the data controller’s interest.

A further issue with the balancing exercise is that the data controller would have to ensure that the correct person’s fundamental rights and interests are being balanced with the legitimate interest in safeguarding. The data subject is the person whose data is being processed. This might be the adult at risk, or it might be a person who poses a risk to that adult at risk. Where the legitimate interest pursued is safeguarding and the data subject is the adult at risk sought to be safeguarded, it is likely that the interests of the data controller and the data subject

256 Article 6(1) and Recital 47 GDPR.
257 Recital 47 GDPR.
258 Data Protection Commissioner, *Guidance Note: Legal Bases for Processing Personal Data*, December 2019 at page 21.
259 Recital 47 GDPR; Data Protection Commissioner, *Guidance Note: Legal Bases for Processing Personal Data*, December 2019 at page 23.

will align, such that the balancing exercise will result in the data being shared with another organisation. Where the data subject is a person who poses a risk to the adult at risk, it is likely that their interests will be in conflict with the legitimate interest of the data controller in safeguarding the adult at risk. In such a situation, the interests of the data subject might include an individual or organisation's right to a good name (or commercial reputation) and right to earn a livelihood. These interests would have to be balanced with the legitimate interest in safeguarding, which encompasses the at risk adult's interest in being protected from the risk of harm. The balancing exercise in such a scenario will be more complex due to the conflicting interests and it may be less likely to lead to an outcome where the data controller shares information with another organisation involved with safeguarding. The safeguarding context might also give rise to situations where the data controller must balance its own interests (such as commercial reputation, or right to earn a livelihood), against the legitimate interest of another organisation (such as the HSE) in safeguarding an adult at risk under the data controller's care. Given the complexity of the balancing exercise, the range of interests to be accounted for and the different perspectives from which those interests might be balanced, there is a risk of inconsistent approaches to the legitimate interest legal basis across the separate organisations involved in safeguarding.

The Data Protection Commission's *Guidance Note* suggests that, in line with the principle of accountability set out in Article 5(1), data controllers should keep a record of the assessment undertaken to determine whether the data controller's legitimate interests were overridden by the interests, freedoms and rights of the data subject.

Risk of inconsistency in approach to information sharing due to reliance by public and private bodies on the different legal bases of public task and legitimate interest

Article 6(1) expressly prevents public authorities from relying on the legitimate interest basis when processing data in the performance of their tasks. The upshot of this is that public authorities are likely to rely on the public task legal basis provided for in Article 6(1)(e), whereas private entities are likely to rely on the legitimate interests' legal basis provided for in Article 6(1)(f). It is, therefore, not necessarily open to the Health Service Executive, the Mental Health Commission, or other statutory bodies involved in safeguarding to invoke legitimate interests as a legal basis for sharing information relating to an adult at risk, or any risk to which they are exposed. By contrast, it is open to entities that are not public authorities or statutory bodies, such as private home care providers or private residential care facility operators to rely on the legitimate interest basis.

On the one hand, it may be that there is little difference between the two legal bases in practice, and that the exact same data analysed under Article 6(1)(e) or Article 6(1)(f) could be shared with other organisations involved with safeguarding. On the other hand, a practice whereby separate entities invoke different legal bases as a means of sharing the same information, based purely on the public or private character of that entity, may give rise to a significant challenge to achieving an integrated

approach to information sharing in the context of safeguarding. Other legal bases contained in Article 6, such as the consent, contractual necessity, vital interest and legal obligation bases, can be relied upon regardless of the public or private character of the data controller. This ensures some degree of consistency in approach to information sharing, in that the same data will be treated or analysed in broadly the same way by different organisations in similar situations, in line with the legal basis invoked. In a safeguarding context, the different analysis required on the part of each entity depending on whether it is invoking Article 6(1)(e) public task or Article 6(1)(f) legitimate interest could result in inconsistency as to the information that is shared between different safeguarding organisations in practice.

The ability to access information, which is often provided by another entity involved in safeguarding, is often a crucial factor in determining what measures should be taken to safeguard an adult at risk. It does not seem justifiable that the information might be rendered more or less accessible depending on the legal basis invoked, purely due to the public or private character of the organisation controlling that information. A consistent approach to information sharing across all organisations involved in safeguarding is more likely to be achieved in practice if all organisations are relying on the same legal basis for sharing the same information in similar situations. For example, it might be conceptually neater if all organisations involved in safeguarding could rely on the same legal obligation under Article 6(1)(c) to share information. This would ensure that broadly the same analysis could be conducted in relation to the same data by all entities, regardless of their public or private character.

Article 9 GDPR - processing special category personal data

As mentioned above, special categories of personal data benefit from added protection under Article 9 GDPR. Special categories include data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, Trade Union membership, as well as genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation. Article 9(1) prohibits the processing of special category personal data, other than in the circumstances provided for in the exceptions to the prohibition set out in Article 9(2). Special category data, in particular data concerning health, is highly relevant to the safeguarding context. Other categories such as genetic data, religious or philosophical beliefs, as well as a person's sex life could also be potentially relevant to a safeguarding context. To process special category data, it is necessary to identify: (1) a legal basis in Article 6(1) and; (2) an exception to the prohibition on processing special category data in Article 9(2). The purpose of this section is to consider the exceptions in Article 9(2) that are relevant to safeguarding.

The first relevant exception arises where the data subject gives "*explicit consent to the processing of the personal data for one or more specified purposes, except where Union or Member State law provide that the prohibition in Article 9(1) may not be lifted by the data subject.*" The consent exception is provided for in Article 9(2)(a). As mentioned above,

it is not always possible or appropriate to seek the consent of the data subject because the data subject might have reduced capacity, or reduced capacity to communicate consent, or alternatively because the seeking of consent from the data subject might prejudice the provision of protection.

The second relevant exception arises where processing is necessary for the purposes of carrying out obligations and exercising specific rights of the controller or data subject in the field of employment, social security and social protection law. It is provided for in Article 9(2)(b) GDPR and section 46 of the Data Protection Act 2018. In terms of legal obligation, Article 9(2)(b) provides that health data may be processed where necessary for the purposes of carrying out the obligations and exercising specific rights of the controller or of the data subject in the field of employment, social security and social protection law. However, this can only be done to the extent authorised by EU or national law, or a collective agreement pursuant to national law. The law providing for such processing must provide for appropriate safeguards for the fundamental rights and the interests of the data subject. Section 46 of the Data Protection Act 2018 provides for processing of health data under this exception, subject to suitable and specific measures being taken to safeguard the fundamental rights and freedoms of data subjects.

The third relevant exception arises where *“processing is necessary to protect the vital interests of the data subject or of another natural person where the data subject is physically or legally incapable of giving consent”*. It is provided for in Article 9(2)(c) and is considered above under the heading 4. Vital interests, and in particular under the subheading entitled *“Requirement for data subject’s inability to consent to the processing of their special category data on the basis of vital interests.”*

The fourth relevant exception arises where *“processing is necessary for reasons of substantial public interest”*. This is provided for in Article 9(2)(g) GDPR and in section 51 of the Data Protection Act 2018. The public interest element is a key enabler in the context of safeguarding. Regulations are required to be made under section 51(3), to authorise the processing of special category data where necessary for reasons of substantial public interest. Those regulations shall identify the substantial public interest concerned, and the suitable and specific measures to be taken to safeguard the fundamental rights and freedoms of data subjects in processing their personal data which is authorised by the regulations.²⁶⁰ Unfortunately, no regulations have been made under section 51(3) to date and this exception can, therefore, not be relied upon by organisations involved with safeguarding to share special category data where necessary to safeguard adults at risk.

By contrast in the UK, the Data Protection Act 2018 provides an explicit legislative basis for processing special category data where necessary to protect adults at risk and does so on the basis of the substantial public interest exception in Article 9(2)(g).²⁶¹ Schedule 1, Part 2 of the UK Data Protection Act 2018 deals with substantial public interest conditions.

²⁶⁰ Section 51(4) of the Data Protection Act 2018.

²⁶¹ Section 10(3) of the UK Data Protection Act 2018.

Paragraph 18(1) provides that special category personal data can be processed where necessary for reasons of substantial public interest,²⁶² and where necessary to protect an individual from neglect or physical, mental or emotional harm, or to protect the physical, mental or emotional well-being of an individual,²⁶³ where the individual is aged 18 or over and is at risk.²⁶⁴ An individual is at risk where the controller has reasonable cause to suspect that the individual: has needs for care and support; is experiencing, or is at risk of, neglect or physical, mental or emotional harm and, as a result of those needs is unable to protect himself or herself against the neglect or harm or the risk of it.²⁶⁵ Paragraph 18(1)(c) requires that the processing is carried out without the consent of the data subject for one of the reasons set out in paragraph 18(2). Those reasons are as follows: (a) in the circumstances, consent to the processing cannot be given by the data subject; (b) in the circumstances, the controller cannot reasonably be expected to obtain the consent of the data subject to the processing and; (c) the obtaining the consent of the data subject would prejudice the provision of protection.²⁶⁶ The UK Data Protection Act 2018 also refers in its schedules to the processing of personal data in the context of the Care Act 2014 (which provides a legislative framework for safeguarding at risk adults) and the Mental Capacity Act 2005 (which provides the legal framework in relation to those adults whose decision-making capacity is at issue).

The fifth relevant exception arises where processing is necessary for the purposes of preventative or occupational medicine, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services. The exception is contained in Article 9(2)(h) and the purposes provided for are highly relevant to the safeguarding context.²⁶⁷ The purposes must be grounded in EU or national law, or in a contract with a health professional. Section 52 of the Data Protection Act 2018 provides a grounding in national law for data processing under this exception and does not appear to require the introduction of further regulations. Section 52(1)(d) is potentially useful in the safeguarding context because it provides that processing special category data shall be lawful where necessary for the provision of medical care, treatment or social care. Section 52(2) sets out that the processing must be undertaken by a health practitioner or a person who in the circumstances owes a duty of confidentiality to the data subject which is equivalent to that which would exist if the person were a health practitioner.²⁶⁸ Section 52 would, for example, enable a health or safeguarding practitioner, who owes the requisite duty of confidentiality to an adult at risk, to process the health data of that adult at risk, by sharing it with an organisation involved in safeguarding, where necessary to provide social care to that adult at risk.

²⁶² Paragraph 18(1)(d).

²⁶³ Paragraph 18(1)(a).

²⁶⁴ Paragraph 18(1)(b)(ii).

²⁶⁵ Paragraph 18(3).

²⁶⁶ Paragraph 18(2).

²⁶⁷ Recitals 52 and 53 elaborates on the processing purposes provided for in Article 9(2)(h) – (i).

²⁶⁸ Article 9(3) also provides for the requirement for a relationship of confidentiality.

The sixth relevant exception arises where processing is necessary for reasons of public interest in the area of public health. This exception is provided for in Article 9(2)(i) and in section 53 of the Data Protection Act 2018.²⁶⁹ Reasons of public interest in the area of public health include ensuring high standards of quality and safe health care. Section 53 does not appear to require the introduction of further regulations.

Article 10 GDPR

Article 10 GDPR sets out a legal basis for the processing of personal data relating to criminal convictions and offences. It is provided for in section 51 (relating to special category personal data) and section 55 of the Data Protection Act 2018. Section 55(3) requires regulations that would allow for the processing of Article 10 data where necessary to assess the risk of or to prevent fraud, corruption and bribery, and to ensure network and information systems security. The processing of Article 10 special category data similarly requires the introduction of regulations pursuant to section 51(3)(b).

Article 23 GDPR

Article 23 provides a mechanism to restrict the scope of the rights of data subjects and the obligations of data controllers set out in Articles 12 – 22, 34 and Article 5 (insofar as its provisions correspond to the rights and obligations provided for in Articles 12 to 22).²⁷⁰

These obligations encompass the data controller’s obligation to provide information to the data subject regarding the data processing, for example the identity of the controller, and the purpose and legal basis for processing.²⁷¹ It also includes the data controller’s obligation to communicate a personal data breach to the data subject,²⁷² and to inform the data subject as to the erasure or rectification of their personal data, or restriction on processing.²⁷³

The rights that can be restricted include the data subject’s right to obtain information from the data controller regarding the processing of his or her data,²⁷⁴ the right to receive their personal data from the controller in a portable (machine readable) format,²⁷⁵ the right to rectification of inaccurate personal data,²⁷⁶ the right to be forgotten²⁷⁷ and the right to restriction of processing.²⁷⁸ Importantly, the data subject’s right to object to the data processing based on the legal basis provided for in Article 6(1)(e) (public task) or Article 6(1)(f) (legitimate interest) under Article 21, can be restricted pursuant to Article 23.

269 Recitals 52 and 53 elaborates on the processing purposes provided for in Article 9(2)(h) – (i).
270 Data Protection Commission, Limiting Data Subject Rights and the Application of Article 23 of the GDPR, June 2019.
271 Article 13 and Article 14 GDPR.
272 Article 34 GDPR.
273 Article 19 GDPR.
274 Article 15 GDPR.
275 Article 20 GDPR.
276 Article 16 GDPR.
277 Article 17 GDPR.
278 Article 18 GDPR.

Such a restriction must be grounded in EU or national law must respect the essence of the fundamental rights and freedoms and be a necessary and proportionate measure in a democratic society to safeguard the various interests listed in Article 23(1)(a) – (j). Section 60 of the Data Protection Act 2018 sets out the legal framework to meet the requirements of Article 23.

Section 60(3)(b) is very useful in a safeguarding context, because it can be relied upon directly to restrict rights and obligations when sharing personal information contained in an opinion expressed confidentially to a person who has a legitimate interest to receive it. Section 60(3)(b) provides a basis in national law for restricting the rights of the data subject, and the obligations of the controller, where the personal data consists of an opinion about the data subject expressed confidentially by another person, to a person with a legitimate interest in receiving the information. In a safeguarding scenario, the data subject about whom the opinion is expressed could be an adult at risk, or the person who poses a risk to an adult at risk. The opinion could include personal data identifying the adult at risk, or the person who poses the risk, and information regarding the nature of the risk. The person expressing the opinion would have to do so to a person who has a legitimate interest in receiving it, and on the basis that it would be treated confidentially. This could encompass a wide range of scenarios, but a simple example is a person disclosing a safeguarding concern to a person or organisation involved with the care of an adult at risk, in the hope that the information would be used to safeguard that adult from the risk of abuse or neglect.

Section 60(3)(b) doesn't provide a legal basis for data sharing. However it does mean that where a legal basis is established under Article 6, and under Article 9 if necessary where special category data is involved, the data controller can process the data subject’s information without being constrained by the obligations and rights provided for in Articles 12 – 22, Article 34 and Article 5.²⁷⁹ Once it is established that there is a legal basis for processing the data, section 60(3) can be relied on to avoid the obligation to inform an adult at risk, or person posing the risk, that their personal data is being processed for safeguarding purposes. Additionally, if the data is being processed because it is necessary for the performance of a public task (Article 6(1)(e)) or to pursue a legitimate interest (Article 6(1)(f)), section 60(3) can usefully be relied upon to restrict the data subject’s right to object to their information being shared on these legal bases.

It is clear that section 60(3) can be relied upon directly for two reasons. First, the wording of the section provides that the rights and obligations are restricted, indicating that this is so without the need for further legislative action. Second, section 60(4) provides an option for the Minister to prescribe requirements to be complied with when the rights and obligations are restricted in accordance with section 60(3), but it is clear that the provision can be relied upon without the introduction of ministerial regulations.

279 To the extent that the provisions in Article 5 correspond to the rights and obligations contained in Article 12 – 22.

Section 60(5) is potentially useful in the context of safeguarding, in that it provides for the making of regulations restricting the rights and obligations where necessary for the protection of the data subject. Regulations may restrict the rights and obligations if the application of those rights and obligations would be likely to cause serious harm to the data subject's physical or mental health, and may do so only to the extent which, and for as long as the harm is likely to be caused.²⁸⁰ Regulations may also restrict the rights and obligations relating to personal data kept for, or obtained in the course of, the carrying out of social work by a public authority, public body, a voluntary organisation or other body.²⁸¹ Regulations may also be made pursuant to section 60(6) restricting the rights and obligations for the purpose of safeguarding important objectives in the general public interest.²⁸² Examples of objectives in the public interest relevant to the safeguarding context include:

- Preventing, detecting, investigating or prosecuting breaches of ethics for regulated professions;²⁸³
- Taking any action for the purposes of considering and investigating a complaint made to a regulatory body in respect of a person carrying out a profession or other regulated activity where the profession or activity is regulated by that body, and the imposition of sanctions on foot of such a complaint;²⁸⁴
- Preventing, detecting, investigating or prosecuting breaches of the law which are subject to civil or administrative sanctions and enforcing such sanctions;²⁸⁵
- Protecting members of the public against financial loss or detriment in various circumstances;²⁸⁶
- Protecting health, safety, dignity, and well-being of individuals at work against risks arising out of or in connection with their employment;²⁸⁷
- Protecting against discrimination or unfair treatment in the provision of goods and services; and²⁸⁸
- Safeguarding public health, social security, social protection and humanitarian activities.²⁸⁹

Section 60 is relevant to the safeguarding context but cannot be relied upon to restrict rights and obligations in the absence of the regulations required by section 60(5) and section 60(6).

²⁸⁰ Section 60(5)(a).
²⁸¹ Section 60(5)(b).
²⁸² Section 60(6).
²⁸³ Section 60(7)(d).
²⁸⁴ Section 60(7)(e).
²⁸⁵ Section 60(7)(f).
²⁸⁶ Section 60(7)(k).
²⁸⁷ Section 60(7)(l)(i).
²⁸⁸ Section 60(7)(l)(ii).
²⁸⁹ Section 60(7)(o).

Law Enforcement Directive

The Law Enforcement Directive (LED) is transposed into Irish Law through Part 5 of the Data Protection Act 2018. The LED provides the equivalent of a legal basis for data processing where necessary for the performance of a function of a “competent authority” (defined by section 69) for the purposes of “*the prevention, investigation, detection or prosecution of criminal offences, including the safeguarding against, and the prevention of, threats to public security, or “the execution of criminal penalties”*”. Sections 71 – 73 of the Data Protection Act 2018 provides for processing of special categories of personal data for the purposes of the LED, which includes processing that is necessary for reasons of substantial public interest. Section 73(1)(ix) provides that special category personal data may be processed for reasons of substantial public interest, where authorised by regulations made pursuant to section 73(2). Importantly these sections require the introduction of regulations which would authorise such data sharing and identify the public interest concerned.²⁹⁰

Data Sharing and Governance Act 2019

The Data Sharing and Governance Act 2019 was fully commenced as of 7 July 2021. Section 9 provides that data sharing means the disclosure of information, including personal data. Part 4 provides for Data Sharing Agreements between public bodies. The 2019 Act does not provide for the sharing of information to non-public bodies and is, therefore, of limited use in the context of safeguarding. Section 5 provides that the 2019 Act shall not apply to special categories of personal data, other than for the purposes of Parts 5, 8 and Chapter 3 of Part 9. Therefore, special category personal data can be processed under the 2019 Act for the purposes of public service information (Part 5), personal data access portal (Part 8) and governance (chapter 3 of Part 9). The impact of this is that the 2019 Act may provide a legal basis for sharing some forms of personal information between public bodies, but it cannot be relied upon to share special category data, such as health data, except in limited circumstances. The introduction of a statutory code of practice for the sharing of data between public bodies would be beneficial for clarifying the circumstances and type of data that can be shared between public bodies for safeguarding purposes. The Data Sharing and Governance Act 2019 provides a limited facility for the sharing of data in the context of safeguarding but does not provide for a positive obligation to share data in circumstances when the safeguarding of vulnerable adults is necessary for their protection.

²⁹⁰ Section 73(1)(ix) and section 73(2) of the Data Protection Act 2018.

Overview and Conclusion

The current data protection framework does not adequately provide for or enable the sharing of information between the various individuals, private bodies, regulatory bodies and voluntary organisations involved with safeguarding adults at risk. There is a pressing need for appropriate legislation, ministerial regulations and clarification around the sharing of data in the context of adult safeguarding. The main shortcoming is the absence of a positive obligation to share data where necessary to safeguard an adult who is at risk of harm. The absence of regulations made under the Data Protection Act 2018 is another shortcoming and means that various legal bases cannot be relied upon to share information in a safeguarding context. A related shortcoming is the absence of guidance from the Data Protection Commission as to how the legal bases for sharing information under the existing framework might be invoked in the context of safeguarding.

Legal bases for data processing which could usefully be relied upon (in particular the public interest and substantial public interest bases) cannot be invoked due to a lack of ministerial regulations required by various provisions of the Data Protection Act 2018. For example, section 38 requires regulations so that personal data (other than special category data) can be shared for the purpose of performing a task carried out in the public interest or in the exercise of official authority, for the purposes of Article 6(1)(e). Section 51 requires regulations so that special category personal data can be shared for reasons of substantial public interest, for the purpose of Article 9(2)(g). Both public interest provisions are key enablers in the safeguarding context but cannot be relied upon in the absence of ministerial regulations. Section 51 and section 53(3) require regulations to process personal data, including special category personal data, where necessary to assess the risk of or to prevent fraud, corruption and bribery, and to ensure network and information systems security, for the purpose of Article 10. Section 60 provides a mechanism for restricting rights and obligations of data subjects and controllers for the purposes of Article 23 but requires regulations. Section 73 provides for the processing of special category personal data in the public interest for the purposes of the Law Enforcement Directive but requires regulations pursuant to section 73(2). The conditions for sharing data cannot be met due to the lack of necessary regulations being in place. The absence of ministerial regulations is a pressing issue and a significant barrier to the sharing of information between organisations involved with the safeguarding of vulnerable adults. The absence of regulations also hinders the development of a guidance document. The lack of regulations is a serious omission, particularly given the high levels of abuse of adults at risk in Irish society, the lack of full commencement of the Assisted Decision-Making (Capacity) Act 2015 and the absence of adult safeguarding legislation.

The legal bases which *can* currently be relied upon (such as consent, contractual necessity, legal obligation, vital interests and legitimate interests) do not adequately cater for the range and complexity of situations encountered in the safeguarding context. For example, the main drawback of the vital interest legal basis provided for in Article

6(1)(d) and Article 9(2)(c) is that it only allows for the sharing of special category personal data, including health data, where the data subject is incapable of giving consent.²⁹¹ This does not cover situations where it would be impractical for, or prejudicial to, the provision of protection to seek the consent of the data subject to the sharing of their sensitive information. Situations where the data subject refuses to consent, or where it is counterproductive to the safeguarding objective to seek consent, would likely be covered by the legal obligation legal basis,²⁹² if a positive obligation to share data for safeguarding were placed on a legislative footing. Such situations could also be covered by the public interest²⁹³ or substantial public interest²⁹⁴ legal basis, if regulations were introduced to allow for these legal bases to be invoked in a safeguarding context.

To the extent that the existing legal bases can be relied upon under the current framework, clarity as to what information can be shared, by whom, to whom, and in what circumstances, would be beneficial.²⁹⁵ For example, there may be scope for increased reliance on the vital interest legal basis contained in Article 6(1)(d). However, updated guidance from the Data Protection Commission on the applicability of this legal basis to the safeguarding context is required for this to be achieved in practice.²⁹⁶ The Data Protection Commission has noted the importance of protecting vulnerable groups.²⁹⁷ It has also acknowledged that respondents to its regulatory strategy consultation process cited instances where an incapacitating perplexity around data sharing resulted in vulnerable adults enduring prolonged exposure to adverse situations.²⁹⁸ The Data Protection Commission proposed engaging with stakeholders to provide guidance and proposed clarifying the bases for data sharing so that individuals are not at risk as a consequence of over caution on the part of data controllers.²⁹⁹ Engagement between the Data Protection Commission and advocacy groups is underway with a view to providing guidance on information sharing for the purpose of safeguarding.

A significant challenge in practice is inconsistent approaches to data sharing within and across the different organisations involved in safeguarding. Much of this inconsistency is likely due to a lack of understanding and clarity around the legal bases for sharing information in a safeguarding context. Such inconsistency would undoubtedly be addressed by the introduction of dedicated safeguarding legislation, legislation providing for data sharing in the context of safeguarding and the introduction of regulations pursuant to the Data Protection Act 2018,

291 Article 9(2)(c).
292 Article 6(1)(c).
293 Article 6(1)(e).
294 Article 9(2)(g).
295 Sage Advocacy emphasised the need to provide clarity to agencies dealing with adults at risk on data collection and sharing in circumstances where people may be suffering from abuse, neglect, and / or exploitation in its Submission to Data Protection Commission on Regulatory Strategy 2020 – 2025, 10th February 2020.
296 Even with such guidance, this legal basis cannot be relied upon to share special category data in circumstances where the data subject is capable of consenting and refuses to do so, due to the restriction in Article 9(2)(c).
297 Data Protection Commission, Regulatory Strategy Consultation, April 2021, page 13.
298 Data Protection Commission, Regulatory Strategy Consultation, April 2021, page 13.
299 Data Protection Commission, Regulatory Strategy Consultation, April 2021, pages 14 and 15.

or guidance from the Data Protection Commission. Additionally, there is a risk of inconsistent approaches to data sharing under the legitimate interest legal basis contained in Article 6(1)(f), because of the complex balancing analysis required for invoking that basis. There is a further risk of inconsistent approaches as between public bodies (that rely on the public task legal basis) and private bodies (that tend to rely on the legitimate interest legal basis). The different legal bases that tend to be invoked by public and private bodies means that broadly the same data and circumstances will be subjected to dissimilar legal analysis, depending on the public or private character of the body undertaking the analysis.

The challenges associated with data sharing in a safeguarding context could be addressed in four ways:

- 1) The introduction of legislation providing for a positive obligation to share data in particular circumstances when necessary for safeguarding purposes;
- 2) The introduction of ministerial regulations pursuant to the various provisions of the Data Protection Act 2018 outlined above;
- 3) The introduction of a statutory Code of Practice for the sharing of information between public bodies pursuant to the Data Sharing and Governance Act 2019;
- 4) In the absence of safeguarding legislation and of regulations under the Data Protection Act 2018, guidance is urgently required from the Data Protection Commission specifically on data sharing in the context of adult safeguarding.

The next chapter will discuss the role of independent advocacy in ensuring that adults at risk are protected and have their human and legal rights upheld as far as possible.

/ Chapter Nine

Role of Independent Advocacy in Safeguarding Adults at Risk

It is widely acknowledged that independent advocacy has a necessary and critical role to play in ensuring that adults at risk are protected and have their human and legal rights upheld as far as possible. Independent advocacy is particularly important where people are vulnerable because of place of residence, or a lack of trusted relatives, or of networks characterised by trust, honour and integrity and, even more so, for people who have reduced decision-making capacity. This chapter argues the case for independent advocacy to be made a central component of safeguarding and for legal provision to be made for the practice of independent advocacy.

Why independent advocacy is important for safeguarding

A right to independent advocacy is crucially important for people who are at risk of abuse, exploitation or coercive control, or who are living in residential care situations where their will and preferences may not be upheld. The concepts of autonomy and self-determination require that the person be placed at the centre of all decisions affecting them. Such participation can be greatly enhanced by the involvement of an independent advocate.

Independent advocacy can make a contribution to the safeguarding of adults at risk by:

1. Ensuring in a general way that all of the rights of adults at risk are safeguarded;
2. Enhancing people's right to have their voices heard and to participate in the making of decisions regarding their lives, including, in particular, their place of care and their finances;
3. Supporting the will and preferences of an adult at risk and ensuring that as far as possible the individual remains in control of their life;
4. Empowering people to speak up for themselves;
5. Ensuring that valid consent is obtained in any interventions relating to a person's care or the management of their finances, whether or not there is any question about their decision-making capacity;
6. Ensuring that the proper assessment protocols are adhered to when a person's capacity is being assessed.

Sometimes, the intervention of an independent advocate for an adult who may be at risk of abuse or exploitation may be indicated or necessary to ensure that the person is safeguarded. The role of the independent advocate can include, for example,

Clarifying the fact that families or service providers have no legal right to make decisions for an adult at risk unless duly appointed in accordance with the law, e.g., attorneys under an Enduring Power of Attorney or a Ward of Court Committee;

- Assisting people to identify and deal with coercive control, whether by relatives or care and support personnel;
- Ensuring that people's finances are used for their benefit only;
- Ensuring that an at risk adult in a residential care setting is not subject to degrading treatment or to deprivation of liberty;
- Acting as an intermediary/support person where an adult at risk experiences difficulty in asserting their will and preference, for example, in relation to place of care;
- Encouraging families and service providers to engage purposefully and proactively with adults at risk in maximising their decision-making capacity;

- Engaging on a non-instructed advocacy basis with people who are at particular risk as a result of a lack of decision-making capacity (see below).

In carrying out one or more of these roles, the independent advocate is giving effect to the Guiding Principles set out in Section 8 of the Assisted Decision-Making (Capacity) Act 2015 with particular reference to 6(b) – the need to respect a person's right to dignity, bodily integrity, privacy, autonomy and control over their financial affairs and property.

The role of independent advocacy has been stated comprehensively in the Sage Advocacy **'Quality Standards for Support and Advocacy Work with Older People'**³⁰⁰ document which provides a useful framework for developing a role for independent advocacy in decision-making processes and in ensuring that people at risk are safeguarded to the greatest extent possible.

There are a number of key considerations relating to the role of independent advocacy in safeguarding adults at risk.

- People with reduced decision-making capacity who require care may be vulnerable, not only because of their individual needs, but also because, historically, care provision has tended not to have been based on an approach that maximizes choice, supported decision-making and independence.
- There is a need to explore alternative ways of facilitating agency by people with reduced decision-making capacity as provided for in the Assisted Decision-Making (Capacity) Act 2015; independent advocates can play an important role in this regard.
- There is a crucial and important distinction between decisional autonomy and the ability of a person on their own to execute those decisions.
- For many people with reduced decision-making capacity, there are likely to be some aspects of their lives where they can make decisions and others where they are unable to so do. Recognising these aspects and providing support accordingly is at the very core of independent advocacy.
- It is crucially important from a safeguarding perspective that long-term care and support is provided at the appropriate level to those who require it – in other words, adequate but the least restrictive in terms of enabling individuals to maintain independence and autonomy to the greatest extent possible. Independent advocacy has a clear role here.

³⁰⁰ <https://www.sageadvocacy.ie/media/1336/quality-standards-for-support-and-advocacy-work-with-older-people-final-061015.pdf>

- There are instances where relatives or others simply make decisions for older people who are frail but who still have capacity. A Red C Poll carried out for Safeguarding Ireland in February 2020³⁰¹ found that more than half of respondents (58%) felt that they could make decisions - or did not know or were not sure whether they could make decisions - for people who had capacity. Only 41% knew that they could not make decisions for a person with capacity, but who was old or frail.

Non-instructed advocacy

Many adults at risk may not be able to instruct an advocate but should be entitled, on an equal basis as with all others, to independent advocacy, either as a legal right or as part of best practice. Non-instructed advocacy is where the advocate acts independently of the individual, in some cases through necessity, as in cases where the individual's decision-making capacity is compromised and/or the individual is not able to give informed consent to the involvement of an independent advocate. Capacity to instruct or understand can be diminished for a number of reasons, including, for example, mental health difficulties, dementia or intellectual disability.

While independent advocacy usually requires the consent and agreement of the person in order for an advocate to become involved, advocates can also take on a critically important safeguarding role in situations where a person who may not be able to consent. Typically, such people may be at greater risk of having their legal and human rights breached. It may frequently be the case that, where a person is not in a position to instruct an advocate or to give consent, there are actual or potential safeguarding issues arising from the manner in which they are being cared for. Based on a non-instructed advocacy approach, its underlying principles and its *modus operandi*, an advocate can legitimately take on the role of exploring with those responsible for the care of the individual how the latter's human rights are being protected, including their right to liberty, dignity and bodily integrity and their absolute right not to be subjected to degrading treatment.

An independent advocate, working on a non-directed advocacy basis, can raise legitimate questions on behalf of the person being supported about the basis for healthcare professionals believing that a person does not have the capacity to choose their place of care, to take risks and to make decisions. For example, in the case of a decision that an urgent admission to a residential service is necessary, an independent advocate can draw attention to the HIQA definition of Emergency Admission as used in its standards for residential services for people with disabilities and the standards for older people, viz. 'an admission to a residential service that is unplanned, unprepared or not consented to in advance'.³⁰²

Safeguarding sometimes requires that an independent advocate intervenes in order to ensure that those responsible for the care of adults

301 <https://www.safeguardingireland.org/wp-content/uploads/2021/06/Safeguarding-Ireland-RED-C-Public-Awareness-Research-Summary.pdf>

302 <https://www.hiqa.ie/sites/default/files/2017-01/National-Standards-for-Older-People.pdf> p.81

at risk are at all times guided by the legal and human rights of those in their care. This is essential in order to fully implement the provisions of the UN Convention on the Rights of Persons with Disabilities. However, a non-instructed advocacy intervention should only be made following significant efforts to communicate with the person and taking into account the risks to the person if they do not have an independent advocate as well as the likely benefits to the person of having an advocate.

For individuals with severe communication difficulties, an advocate acting on a non-instructed basis will, where possible, spend time finding out if a person is able to express a view and getting to know the person's preferred method of communication. The non-instructed advocate can also act as an observer ensuring that the person is receiving appropriate services and support.

The spirit and principles of the Adults with Incapacity (Scotland) Act 2000 have value and relevance³⁰³ in informing non-instructed advocacy:

- An intervention must benefit the individual.
- An intervention must be the least restrictive option.
- Account must be taken of the past and present wishes of an individual.
- There must be consultation with significant others in an individual's life.
- An individual should be encouraged to exercise their own will and self-determination.

The Mental Health (Care and Treatment) (Scotland) Act 2003³⁰⁴ (Section 259) states that every person with a mental disorder shall have a right of access to independent advocacy. It places a duty on NHS Boards and local authorities, in collaboration, to secure the availability of independent advocacy services within their relevant Boards or authority. The Act's Code of Practice states:

'Where a patient has a degree of incapacity, or cannot for any reason clearly say whether or not they would like an independent advocate, an MHO/hospital managers/appropriate person should consider how an independent advocate may be involved. MHOs/hospital managers/appropriate persons should pay particular attention to the patient's past wishes, the views of people supporting them and any advance statement or other record of a patient's prior comments on having an independent advocate. The right of access to independent advocacy is for each patient and is not limited only to those who are best able to articulate their needs'.³⁰⁵

303 https://www.siaa.org.uk/wp-content/uploads/2021/02/SIAA_Non_Instructed_Advocacy.pdf

304 <https://www.legislation.gov.uk/asp/2003/13/contents>

305 <https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2017/06/mental-health-law-in-scotland-interim-guidance-on-patient-representation-provisions/documents/independent-advocacy---interim-guidance/independent-advocacy---interim-guidance/govscot%3Adocument/Mental%2Bhealth%2Bact%2B-%2Bindependent%2Badvocacy%2B-%2Binterview%2Bguidance.pdf>

Non-instructed advocates operate on the basis that they do not have direct permission for their work from clients and will sometimes receive a referral from a third party. The role of the advocate in such situations is to ensure, as a minimum, that the client is content with their presence when they visit. By building up a picture of communication possibilities and following leads from clients where possible, they will often be able to take informal direction from clients who cannot formally instruct. Because they do not have direct consent from their clients, a non-instructed advocate needs to ensure that they have considered all options for their clients and continue working from an independent perspective.

A 2013 UK publication,³⁰⁶ involving collaboration by a number of agencies, notes that one area which remains of some concern with regard to non-instructed advocacy is that of consent, which is inherently connected to ‘instruction’. If an individual does not have capacity to instruct an advocate, they will also be unlikely to have the capacity to consent to the involvement of an advocate with regard to their care. The matter of consent needs to be kept under continuous review, for example, by making every effort to establish some form of communication and thereby gain at least some level of consent from the service user.

It is reasonable to suggest that adults at risk because of reduced decision-making capacity may be those most at risk of abuse and exploitation and of not having their human and legal rights and dignity respected and, therefore, most in need of intervention by an advocate. The provision of non-instructed advocacy to people with reduced decision-making capacity must fully take into account that people are (or certainly have been) part of a wider community that includes family, service provider staff and friendship networks, and that these may offer an insight into the person’s will and preferences.

Need for legislative provision for independent advocacy in Ireland

The current advocacy landscape in Ireland is quite varied in terms of responsibilities, funding and independence. The National Advocacy Service for People with Disabilities is funded by the Department of Social Protection through the Citizens Information Board while statutory funding for other advocacy services at national and local levels is provided by the HSE. The absence of a legislative remit for independent advocacy, other than under the Mental Health Act 2001, results in an advocacy environment that is unclear, and in a varied understanding of what advocacy is and is not.

It is generally acknowledged that Ireland does not have adequate legislation and procedures to ensure that adults at risk are safeguarded. Independent advocacy in Ireland has been described as a practice without context or a legislative base.³⁰⁷ For example, there is no current

306 <https://opaal.org.uk/app/uploads/2015/09/An-Advocates-Guide-to-Non-Instructed-Advocacy-2013.pdf>
307 Browne, M. (2018), Advocacy in Ireland Scoping Document, Safeguarding Ireland, <https://www.safeguardingireland.org/wp-content/uploads/2018/10/Advocacy-Scoping-Document-Final-310818.pdf>

effective mechanism to compel service providers to facilitate access to an independent advocate as is required under HIQA Standards. Indeed, the Report of the Oireachtas Joint Committee on Health and Children on the Role of Advocacy in Health and Social Care Services in Ireland³⁰⁸ commented that the lack of statutory powers for advocacy acts as a barrier of access to advocates by people at risk.

The Assisted Decision-Making (Capacity) Act 2015 makes provision for the Director of the Decision Support Service (DSS) to develop a Code of Practice “for the guidance of persons acting as advocates on behalf of relevant persons” (Section 103 (2). The reference to the Code of Practice is the only reference to advocacy in the 2015 Act. A Draft Code of Practice for Independent Advocates has been developed by the DSS and has been the subject of public consultation.

A critically important point that should be noted is that, despite the concept of independent advocacy coming much more to the fore in policy discourse since the legislation was passed, there is no provision for advocacy included in the General Scheme of the Assisted Decision-Making (Capacity) (Amendment) Bill published in November 2021. However, the Joint Committee on Children, Equality, Disability, Integration and Youth Report on Pre-legislative Scrutiny of the Bill³⁰⁹ has recommended (Recommendation 35) that independent advocacy should be defined in the Bill and that a provision should be inserted establishing a general right of relevant persons to independent advocates and should include legislative powers for advocates to carry out their role in line with the person’s will and preferences.

Under the Adult Safeguarding Bill 2017,³¹⁰ provisions were made for adults at risk to have access to an independent advocate. Under the Bill, the Safeguarding Authority (to be established) can arrange for a person who is independent (an ‘independent advocate’) to be available to represent and support an individual. The conditions for appointment of an independent advocate as set out in Article 12(3) of the Bill are that the Authority considers that, were an independent advocate not to be available, the individual would experience substantial difficulty in doing one or more of the following:

- (a) Understanding relevant information
- (b) Retaining that information
- (c) Using or weighing that information as part of the process of being involved
- (d) Communicating the individual’s views, wishes or feelings (whether by talking, using sign language or any other means).

308 Joint Committee on Health and Children; Report on the Role of Advocacy in Health and Social Care Services in Ireland, <https://www.drugsandalcohol.ie/25068/1/JCHC-Report-on-the-Role-of-Advocacy-in-Health-and-Social-Care-Services-in-Ireland.pdf>
309 https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/joint_committee_on_children_equality_disability_integration_and_youth/reports/2022/2022-04-08_report-on-pre-legislative-scrutiny-of-the-general-scheme-of-the-assisted-decision-making-capacity-amendment-bill-2021_en.pdf
310 <https://data.oireachtas.ie/ie/oireachtas/bill/2017/44/eng/initiated/b4417s.pdf> That Bill fell with the dissolution of the 32nd Dáil in January 2020. The Legislation Programme for Autumn 2021 included a Health (Adult Safeguarding) Bill which focuses on safeguarding vulnerable or at risk adults in the context of their interactions with the health sector.

In its Issues Paper, **A Regulatory Framework for Adult Safeguarding**, the Law Reform Commission (LRC) discussed the question of whether there should be a statutory independent advocacy service established for adult safeguarding. The need for legislative provision for independent advocacy has been argued for many years. Indeed, the 1996 **Report of the Commission on the Status of People with Disabilities, A Strategy for Equality**³¹¹, recommended that authority for independent advocacy should be set out in legislation and that access to an advocate should be a legislative entitlement, where necessary to ensure access to justice.

It is noted that many respondents to the **The Deprivation of Liberty Safeguard Proposals Public Consultation**³¹² recommended that the legislation should make provision for the appointment of an independent advocate and that a panel of independent advocates should be established by the Director of the DSS, and that the legislation should encompass a definition of an ‘independent advocate’.

There is a clear argument that new legal provision for an independent advocacy service is essential for the State to comply with the requirements of the UNCRPD and the Assisted Decision-Making (Capacity) Act. An independent advocacy service with statutory rights and provision for more proactive investigative mechanisms is clearly necessary, particularly to ensure that people with reduced decision-making capacity residing in institutions and congregated care settings (whether public, private or managed by NGOs) are informed of their legal rights and assisted in accessing them.

An advocacy service with statutory rights would also be important to underpin the practice of non-instructed advocacy where an advocate acts independently of the individual in situations where an individual’s decision-making capacity may be significantly reduced and they may be unable to give informed consent for an advocacy intervention. Safeguarding often demands that an independent advocate must intervene in order to ensure that those responsible for the care of such individuals are at all times guided by the legal and human rights of at risk adults in their care. The documented experiences relating to the management of the care of ‘Grace’³¹³, the abuse allegedly perpetrated in the recently reported ‘Brandon’ case and the treatment of people in Leas Cross and Áras Attracta in recent years clearly make the case for such interventions and, in addition, highlight the need for legislative provision for independent advocacy.

Since the commencement of the Mental Health Act 2001, there is statutory provision for legal advocacy for people with mental health difficulties, even though the term ‘advocacy’ is not mentioned. The 2001 Act provides for a person to be appointed independent legal

311 A Strategy for Equality, available at <https://nda.ie/Disability-overview/Key-Policy-Documents/Report-of-the-Commission-on-the-Status-of-People-with-Disabilities/A-Strategy-for-Equality/A-Strategy-for-Equality-Report-of-the-Commission-on-the-Status-of-People-with-Disabilities/>

312 The Deprivation of Liberty Safeguard Proposals: Key Findings of the Public Consultation, <https://www.gov.ie/en/publication/3f88c4-the-deprivation-of-liberty-safeguard-proposals-report-on-the-public-/>

313 It is noted that no prosecutions have issued in relation to the ‘Grace’ case.

representation in the review process of involuntary detention.³¹⁴ The Disability Act 2005 provides an entitlement to advocacy for persons with a disability, while the Citizens Information Act 2007 provides for the establishment of a Personal Advocacy Service (PAS).³¹⁵ There are a number of references in HIQA Standards to the role of advocacy and the need to make provision for people to have access to independent advocates.

The LRC, in its *document, A Regulatory Framework for Adult Safeguarding*, raised the question as to whether it would be sufficient to commence the relevant provisions of the Citizens Information Act 2007 providing for a Personal Advocacy Service. The Personal Advocacy Service provided for under the Act was regarded as a significant development at the time and was very much welcomed by those who had been campaigning for equal rights for people with disabilities. However, the context and the dynamic have changed radically since then due to the publication of the UN Convention on the Rights of Persons with Disabilities and the development of a related policy emphasis on the rights of people with disabilities at international and national levels. In Ireland, clearly, the Assisted Decision-making (Capacity) Act 2015 was a watershed.

It is now clear that the Personal Advocacy Service (PAS) as envisaged and provided for in the 2007 legislation is no longer fit for purpose in that its provisions do not adhere to international human rights norms, particularly the right to access justice and to receive an effective remedy.

- There is an absence of a requirement for pro-active outreach to vulnerable groups, e.g., those with reduced decision-making capacity and those in residential care services;
- Applicants for PAS must have already identified a need for a specific social service relating to their disability;
- Personal advocates have the power to decide whether or not a particular course of action is appropriate – this approach does not allow for people’s right to assert their will and preferences and to self-determine.

Need for a National Advocacy Body

The LRC, in its document, **A Regulatory Framework for Adult Safeguarding**, considered the matter of a National Advocacy Body (9.17) and posed the question as to whether there was a need for a national advocacy body in the context of adult safeguarding (Q.9.3).

314 Section 16(2)(b), Mental Health Act 2001. This narrow construction of advocacy was criticised at the time by the Forum of People with Disabilities in their report, Advocacy – A Rights Issue (Dublin: Forum of People with Disabilities, 2001). This argued for a broader approach to advocacy and suggested that advocacy should be a legislative entitlement for all vulnerable individuals in society, not just people with disabilities

315 The Personal Advocacy Service was deferred by the Government in the light of budgetary circumstances at the time and the service has not been established. The National Advocacy Service for People with Disabilities (NAS) has been established by the Citizens Information Board on a non-statutory basis.

This matter had been already mooted in a 2018 Safeguarding Ireland Scoping Document on Independent Advocacy in Ireland.³¹⁶

A range of bodies are involved in supporting and funding independent advocacy in Ireland - HSE, Department of Social Protection, Department of Health, Mental Health Commission, Decision Support Service and HIQA. There is also involvement on the part of the Department of Children, Equality, Disability, Integration and Youth and the Department of Justice.

Equally relevant is the number of agencies now delivering advocacy services to adults at risk – National Advocacy Service for People with Disabilities (NAS), Sage Advocacy and the Irish Advocacy Network at national level and Cork Advocacy Service (CAS) – the latter an independent, volunteer-resourced advocacy project developed and operated by The Social and Health Education Project (SHEP). The Patient Advocacy Service is a free, independent and confidential advocacy service for patients of HSE-funded Public Acute Hospitals and HSE-operated Nursing Homes operational since 2019. It is provided by the National Advocacy Service for People with Disabilities (NAS) and commissioned by the Department of Health National Patient Safety Office.

This range of agencies and organisations involved in supporting, funding and delivering advocacy services to adults at risk points to an important and clear need for a Government-led and more integrated and streamlined approach to the matter.

There is a strong argument that a National Advocacy Body should be constituted in parallel with, or as part of, safeguarding legislation. This is necessary in order to ensure that there is a national integrated framework for developing independent advocacy and within which current arrangements, funding and reporting responsibilities could be better integrated.

The role and functions of the National Advocacy Body as set out in the LRC Issues Paper are seen as relevant and appropriate, and could be added to or amended once a Safeguarding Authority has been established.

- a. Enabling access by all vulnerable or at risk adults to independent advocacy;
- b. Integrating the various funding strands for advocacy and related reporting structures;
- c. Providing for uniform access to independent advocacy by all vulnerable or at risk adults;
- d. Overseeing funding requirements;
- e. Setting standards, awarding qualifications and providing training;
- f. Preparing, publishing and monitoring the implementation of codes of practice;

³¹⁶ <https://www.safeguardingireland.org/wp-content/uploads/2018/10/Advocacy-Scoping-Documents-Final-310818.pdf>

- g. Conducting research, monitoring and evaluating services; and
- h. Implementing and maintaining data information systems.

While a National Advocacy Body could operate as an independent agency, this may not be realistic given the likely financial requirements of setting up a National Adult Safeguarding Authority with regional offices. It may be possible to locate the National Advocacy Body within the National Adult Safeguarding Authority, depending on how the role and functions of such an authority are constituted. There does not appear to be any obvious home for such a body within existing agencies. The critical consideration and requirement in this regard is that independent advocacy needs to be consolidated and mainstreamed in its own right and, ideally, in parallel with the establishment of a National Adult Safeguarding Authority.

Provision for independent advocacy in other selected jurisdictions

Accurate, comprehensive and up-to-date information regarding advocacy provision in other countries is somewhat difficult to access in a form that would be useful for the purpose of application in the Irish context. Considerable advocacy work is carried out by voluntary and non-profit organisations in other jurisdictions, many of which are special interest groups. In some cases, these same organisations provide a range of services to their particular client group and membership. Funding for their activities typically comes from a variety of sources, including government. There is also some lack of clarity about the legislative basis for much of the advocacy work being carried out. For example, a review of advocacy provision in Northern Ireland found that there was no clear statutory duty or strategic framework to provide independent advocacy services in the jurisdiction.³¹⁷

There has been considerable emphasis placed internationally on the development of approaches to advocacy in the context of mental health legislation, legal capacity and related matters. Many countries, including Australia, Canada and New Zealand, have been gradually moving from approaches that were rooted in guardianship-type legislation to one that better reflects a rights-based approach and the provisions of the UNCRPD. This, in turn, has necessitated changes in the approaches taken regarding advocacy provision by health authorities, social care authorities and by the NGO sector.

The UK experience³¹⁸

Advocacy in England, Scotland, Wales and Northern Ireland is shaped, to a large degree, by the various country-specific pieces of legislation that provide for statutory advocacy provision.

³¹⁷ Review of Advocacy Services for Children and Adults in Northern Ireland. RQIA. 2016, <https://www.rqia.org.uk/RQIA/files/d7/d79ff542-b906-4118-b56d-ac405f10d9f2.pdf>

³¹⁸ The practice and underpinning legislation in selected jurisdictions is covered comprehensively in the Law Reform Commission in the Issues Paper, The Regulatory Framework for Adult Safeguarding.

The various Acts require local NHS Boards (Health & Social Care Boards/ Trusts in Northern Ireland) and Local Authorities to provide access to advocacy services. These various authorities across the UK commission mainly voluntary, specialist, non-profit organisations to deliver the advocacy service, thereby ensuring that the service can be viewed as being an independent advocacy service.

Scotland

People covered by the Mental Health (Care and Treatment) (Scotland) Act 2003, have a legal right to independent advocacy³¹⁹. The role of the advocate is to help people to understand their rights, work out their options, express their views and make decisions. The role of the advocate is not restricted to mental health situations. Under Section 6 of the Act, local authorities have a duty to consider advocacy provision.

The Mental Health (Scotland) Act 2015 builds on the right to independent advocacy services provided for in the Mental Health (Care and Treatment) (Scotland) Act 2003. It requires local authorities, Health Boards and the State Hospitals Board for Scotland to provide information to the Mental Welfare Commission about how they are meeting their duties under the 2003 Act to provide independent advocacy services, at least every two years.

National guidelines relating to the commissioning process in respect of advocacy are published, usually, at a national level³²⁰. The independent advocacy provider organisation, in many instances, also delivers other services to a special-interest group and/or to the wider community.

Northern Ireland

In Northern Ireland, the five Health and Social Care Trusts have responsibility for commissioning advocacy services from independent advocacy providers. These are commissioned through a tendering process. Advocacy services are commissioned across various programmes of care, primarily within children & adult learning disability, child & adult mental health, and adult physical disability. Specific advocacy services for conditions such as dementia and autism are commissioned on a short-term basis, as and when required.

Independent advocacy providers are responsible for the delivery of the advocacy services for which they have agreed contracts in place with either the HSC Board or trusts. Independent advocacy providers are supported by the HSC Board and individual trusts to work in specific services and localities, engaging with patients, service users and carers in both acute and community settings.

Providers also engage with the HSC Board and individual trusts through attending regular management, policy, service delivery and budgetary meetings.

³¹⁹ <https://www.legislation.gov.uk/asp/2003/13/part/17/chapter/2/crossheading/advocacy>

³²⁰ For example, see Advice for commissioners on the provision of advocacy services under the Mental Health (Care and Treatment) (Scotland) Act 2003. <https://www.gov.scot/publications/independent-advocacy-guide-commissioners/>

Independent advocacy providers have expressed a strong desire to extend their advocacy well beyond what is stipulated in the legislation and express concerns regarding the tenuous and uncertain nature of funding. Although independent advocacy is increasingly mentioned in more and more legislation, in policy and in practice documents, advocacy provision is not keeping pace.³²¹ Gaps in provision are noted, especially with regard to access for children and young people, for adults with physical disabilities, for older people, carers and people from minority ethnic communities.

England

The Care Act 2014 requires Local Authorities in England to arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or review, if required. Section 67 of the Act provides that, where one of a number of conditions applies, the local authority must arrange for a person who is independent of the authority (an “independent advocate”) to be available to represent and support the individual for the purpose of facilitating the individual’s involvement. The conditions, as specified under section 67(4), are that the local authority considers that, were an independent advocate not to be available, the individual would experience substantial difficulty in doing one or more of the following:

- a. Understanding relevant information;
- b. Retaining that information;
- c. Using or weighing that information as part of the process of being involved;
- d. Communicating the individual’s views, wishes or feelings (whether by talking, using sign language or any other means).

An independent advocate must be appointed to support and represent the person for the purpose of assisting their involvement if the conditions are met and if the individual is required to take part in one or more of the following processes described in the Care Act:

- A needs assessment
- The preparation of a care and support or support plan
- A review of a care and support or support plan
- A safeguarding enquiry
- A safeguarding adult review
- An appeal against a local authority decision under Part 1 of the Care Act.

³²¹ See, for example, https://archive2021.parliament.scot/S5_HealthandSportCommittee/Inquiries/CGOV037_Scottish_Independent_Advocacy_Alliance.pdf

The Mental Capacity Act 2005³²² (Sections 35-41) requires that provision be made for access to an Independent Mental Capacity Advocate in relation *inter alia* to:

- Provision of serious medical treatment
- Provision of accommodation by NHS body (hospital or home care)
- Provision of accommodation by a local authority for people who lack capacity to agree to the arrangement.

Wales

In Wales, Section 181 of the Social Services and Well-being (Wales) Act 2014 provides that regulations may require a local authority to arrange for advocacy services to be made available to people who need care and support (whether or not those needs are being met by a local authority), subject to a number of restrictions. A statutory code of practice on the exercise of social services functions in relation to advocacy under Part 10 of the Act has been published.³²³ It states that local authorities, when exercising their social services functions, must act in accordance with the requirements contained in the code of practice. The Code (Par.7) sets out the requirements for local authorities to:

- (a) ensure that access to advocacy services and support is available to enable individuals to engage and participate when local authorities are exercising statutory duties in relation to them, and
- (b) to arrange an independent professional advocate to facilitate the involvement of individuals in certain circumstances.

The Code of Practice (Par.47) further provides that local authorities:

“must arrange for the provision of an independent professional advocate when a person can only overcome the barrier(s) to participate fully in the assessment, care and support planning, review and safeguarding processes with assistance from an appropriate individual, but there is no appropriate individual available”.

Australia

In Australia, the *National Disability Insurance Scheme Act 2013* (NDIS)³²⁴ stipulates (part 2) that the role of advocacy in representing the interests of people with a disability is to be acknowledged and respected, recognising that advocacy supports people with disability by:

- a. Promoting their independence and social and economic participation;
- b. Promoting choice and control in the pursuit of their goals and the planning and delivery of their supports;
- c. Maximising independent lifestyles of people with disability and their full inclusion in the community.

322 <https://www.legislation.gov.uk/ukpga/2005/9/contents>

323 <https://gov.wales/sites/default/files/publications/2019-12/social-services-and--well-being-wales-act-2014-part-10-code-of-practice-advocacy.pdf>

324 <https://www.legislation.gov.au/Details/C2016C00934>

An independent advocate³²⁵ under the legislation is understood to mean a person who:

- Is independent of the Agency, the Commission and any NDIS providers providing supports or services to the person with disability.
- Provides independent advocacy for the person with disability, to assist the person with disability to exercise choice and control and to have their voice heard in matters that affect them.
- Acts at the direction of the person with disability, reflecting the person with disability's expressed wishes, will, preferences and rights.
- Is free of relevant conflicts of interest.

The Act acknowledges the important role of advocates (including independent advocates) and other representatives of persons with disability; and requires registered NDIS providers to cooperate with and facilitate arrangements for advocates (including independent advocates) and other representatives of persons with disability.

The Netherlands³²⁶

In the Netherlands, persons with psychosocial disabilities subject to involuntary and voluntary measures have a right to the individual support of a patient advocate. Since 1982, the support of patient advocates has been organised and facilitated by the Dutch National Foundation of Patient Advocates in Mental Health Care. The manner in which patient advocates have to perform their statutory tasks has been elaborated in rules of conduct formulated by the Foundation. Some cornerstones in the Dutch model are - independence from the psychiatric hospital; easy accessibility; confidentiality; receptivity to a person's questions and complaints; an orientation to the individual patient's legal position; promotion of the persons' healthcare-related interests; and the requirement of a person's consent for actions.

Independent advocacy in the context of decisions about how long-term care is to be provided

Many instances involving decisions about long-term care and support require inputs from a broad range of healthcare professionals. While there is an obvious case-management role involved in bringing all of these voices together, an independent advocate has a critically important role to play where there is any potential safeguarding concern. An independent advocate can make a vital contribution in maintaining a focus on the right to personal liberty while health and social care professionals seek to make the 'right' decision in relation to an individual. The independent advocate's role is particularly important where an application for wardship or an application for the Nursing Homes Support Scheme is being considered, in order to ensure that the presumption

325 https://www.dss.gov.au/sites/default/files/documents/12_2018/disability-advocacy-fact-sheet.pdf

326 https://www.mhe-sme.org/wp-content/uploads/2021/03/MHE_Access_to_Justice_Refelction_Paper_March_2021.pdf

of capacity principle is adhered to. It is also essential that independent advocacy is available to all persons admitted to residential care facilities or who are forced to remain in an acute hospital because of a shortfall in community care supports.

The Supreme Court decision in the AC case³²⁷ which refers to a woman who was allegedly being “detained” by Cork University Hospital (CUH) against her wish and against the wishes of her adult children, strongly supports the case for independent advocacy. For example, Paragraph 327 of the Judgement states as follows –

“There does not appear to have been any person not involved in the disputes who could have taken on the role of ascertaining, so far as possible, Mrs. C.’s wishes and if necessary advocating in favour of the proposal that she go home with her family... it might have assisted in resolving the matter if there had been an independent person through whom her views could have been put forward.”

The Judgement also includes reference to the need to ensure that the voice of the person is heard independently of all other voices. Paragraph 326 notes a concern that the case *“has proceeded to this point on the basis of arguments between third parties, and decisions of courts, ... without her voice being heard”*. Paragraph 397 of the Judgement states that *“It is essential that the voice of the individual be heard in the process, and if she cannot speak for herself then some person must be found, who is not otherwise involved in any dispute, who can speak for her.”*³²⁸

Under current policy and practice, many adults at risk, older people in particular, are living in residential care centres because there is no suitable alternate residence for them. An independent advocate can bring into the discussion the potential negative impact arising from having to live in a congregated setting and the associated risks which became very obvious with the onset of Covid-19. An independent advocate can trigger and facilitate a discussion on whether admission to residential care is absolutely necessary and if there is no other appropriate, practicable and less intrusive way of providing the care. An independent advocate, using a systematic and engaged approach with an individual over a period of time, may be able to ascertain the will and preference of a person with reduced decision-making capacity or communication difficulty or both.

Given that adults at risk who require long-term care and support may experience barriers in having their voice heard by professionals (and also by family members), it is crucially important for people to have access to an independent advocacy service to support them and enable them to speak for themselves, or, where appropriate, to speak on their behalf. The independent advocate can be particularly valuable in creating a bridge between the service providers/professionals and service users/patients.

It is important, of course, to recognise that many professionals who provide social and health care services to people – nurses, doctors,

327 <https://www.casemine.com/judgement/uk/5dfc6a614653d042431b0cbc>

328 Ibid.

social workers - see advocacy as part of their role. While the advocacy component to the role of health and social care professionals is significant, at the same time, it is also necessary to recognise that service providers and professionals may sometimes experience a conflict between advocacy and their primary role in an organisation. For this reason, an independent advocacy service should be regarded as a vital part of safeguarding the rights of persons at risk and should be provided for accordingly. Also, while the role of families and relatives as advocates is crucially important, there is an additional and necessary perspective that independent support and advocacy can bring to ensure that the voice of the person is clearly articulated in all circumstances, and, particularly, where crucial decisions are being made in relation to medical interventions, place of living and long-term care arrangements.

Role of Guardian ad Litem (GAL)

In exploring whether there is a distinction between the role of a Guardian ad Litem (GAL) and an independent advocate, it is useful to note the view expressed by the Irish Human Rights Commission in 2005 in a Submission to the Court.³²⁹ In the opinion of the Commission³³⁰ regarding the role and function of a GAL acting for an adult lacking legal capacity, the GAL should bring their skills to bear in order to determine the wishes and instructions of the adult party and to relay same to the Court. Thus, the GAL must advocate on behalf of the adult in a manner which respects the dignity of the adult and which best vindicates the party’s right of effective access to the Court. The Commission submitted that the constitutional rights to self-determination and autonomy, coupled with the guarantee of equality before the law, require that the role of the GAL acting on behalf of an adult litigant, be limited to bringing the will and preferences of people to the attention of the court. Thus, the role of a GAL acting on behalf of an adult is more limited than the dual role played normally by a GAL acting on behalf of a child who must both relay the wishes of the child, having due regard to the child’s age and understanding, to the court and also inform the court of their views regarding the best interests of the child. Taking this perspective into account, it is clear that a GAL working with an adult at risk would be expected to act in a similar manner to that of an independent advocate. Clearly, since a GAL is appointed by the court, they should be well placed to safeguard people’s legal and human rights. Whether this happens in practice is not at all clear.

Empowerment as an underlying advocacy principle

Throughout the process of engagement, as well as safeguarding adults at risk, independent advocacy should also act to empower people and to equip them with the skills to identify abuse and exploitation where it occurs and to deal with it assertively. Empowerment refers to a process where, through the provision of information and support,

329 The cases, Legal Aid Board V District Judge Brady and in the matter of G, concerned a mother’s legal representation in child care proceedings affecting her child. The mother had a reduced capacity to give instructions to her lawyers. In the course of the case, her legal team applied to Judge Brady to have an expert appointed to give assistance in taking her instructions. As there was no specific mechanism for this, District Judge Brady ordered the Legal Aid Board to seek sanction for the costs of the assistance.

330 https://ihrec.ie/download/doc/sub_ihrc_preliminary_legal_aid_board_v_judge_brady.doc

people are enabled to assert their rights, make choices and decisions and contribute to wider policy-making in the areas that affect their lives. Provision of basic information on an individual's rights and entitlements can, in itself, be hugely empowering. An advocate can build up a person's confidence simply by listening to and supporting an individual to express an opinion or work through options for themselves. The basic aim is to assist people to be as autonomous as possible (even if this is more time-consuming for an advocate than direct representation) while acknowledging a person's right to be mistaken, to take risks and to seek outcomes that may appear not to be the best options in the situation.

Put simply, the goal of independent advocacy for people with reduced decision-making capacity, e.g., those with dementia, people with intellectual disability or other reduction in cognitive functioning, is to support them as individuals in achieving what they wish, in having access to what they value and in maximising their ability to assert their human and legal rights, especially where crucial decisions are being made about where they are to live.

As has been outlined throughout the Discussion Paper, adults at risk sometimes experience abuse and exploitation at the hands of individuals, including family members. In some instances, this is perpetrated by people who are charged with supporting and caring for them. It is of critical importance that adults at risk have access to an advocacy service that is independent of both service providers and family members.

Overview and Summary

Independent advocacy refers, essentially, to advocacy support provided by an organisation that is structurally and financially autonomous and is independent from the services that deliver health and social care, as well as from the family of the person to whom the advocacy service is being provided. For this reason, an independent advocacy service should be regarded as a vital part of safeguarding vulnerable persons' rights and enabling them to live with dignity.

The focus on independent advocacy for people whose decision-making capacity is in question, while critically important, must not result in a failure to ensure that other groups, e.g., frail older people, people experiencing mental health difficulties, those at risk of exploitation (financial, sexual and emotional) and those who are subjected to coercive control, are given due attention from a safeguarding perspective.

Key points

- It is strongly suggested that independent advocacy provides adults who are at risk of various types of abuse and exploitation with an additional and necessary safeguarding pathway.
- Legislative underpinning for the practice of independent advocacy in Ireland is clearly required to overcome current blockages, e.g., independent advocates not having the right of access to residential care facilities, not being allowed to accompany people in forums where decisions about their long-term care are being made.

- Crucially, there is a need to embed the practice of independent advocacy as a core component of safeguarding, and legislation should provide for right of access by all individuals to an independent advocate, especially where there is any question about a person's capacity.
- In addition to the clear need for formal and legal acknowledgement of the role of professional advocates and legislative underpinning for the practice of advocacy, there is a need for better coordination and oversight of existing advocacy services and agreed national quality standards for independent advocacy.
- It is clear that people who are the victims of different forms of abuse (financial, physical, psychological or sexual) and/or are being subjected to coercive control, can benefit from the support of an independent advocate in order to ensure that they can deal with the abuse and be safeguarded and protected.
- Despite the fact that a Draft Code of Practice for Independent Advocates has been developed by the Decision Support Service in relation to implementing the Assisted Decision-Making (Capacity) Act 2015 and that HIQA Standards for Residential Care Services stipulate that residents should have access to an independent advocate, there is still no legislative right for a person to have access to an independent advocate.
- People who are at greater risk because of reduced decision-making capacity and who may not be able to give consent or instruct an advocate may be in particular need of the support of an independent advocate acting in a non-instructed advocacy role.

It has been argued³³¹ that what is required, in the context of mental health services, is the establishment of a national, independent advocacy service that is placed on a statutory footing and is accessible to all individuals with mental health difficulties, including those in hospitals, day centres, training centres, clinics and throughout the community. From a safeguarding perspective, this point is equally applicable to all adults at risk and particularly to those whose decision-making capacity is in question and those who are being subjected to coercive control or other forms of abuse.

While the provisions for supported decision-making included in the Assisted Decision-Making (Capacity) Act 2015 will address many of the issues affecting people with reduced decision-making capacity, there will be an ongoing need for independent advocacy in order to ensure that a person is provided with the appropriate level of decision support – decision-making assistant, co-decision-maker, decision-making representative or attorney.

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³³¹ Fiona Coyle, in The Assisted Decision-Making (Capacity) Act 2015: Personal and Professional Reflections <https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/assisteddecisionmaking/admca-personal-and-professional-reflections.pdf> p.117

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The next chapter will discuss how the general social support infrastructure (formal and informal) can be used to address the issue of abuse and exploitation of adults at risk.

/ Chapter Ten

Realising the Potential of the Social Support Infrastructure in Safeguarding Adults at Risk

This chapter looks at safeguarding adults at risk in the context of the range of individuals, groups and organisations that may be in a position to detect risk, observe or suspect harmful behaviours, witness criminal acts or form part of a process of sharing information that could result in a risk to a vulnerable adult being identified and appropriate action taken.

The level of relationship, responsibility and/or interaction that people may have with an at risk adult will vary greatly, with some people being much more likely to become aware of safeguarding issues than others would be. In this chapter, the various actors involved are identified and considered by grouping. (Some actors could be members of several groupings). The potential of each grouping or category to intervene in the social and cultural context within which abuse occurs and thereby help to safeguard adults at risk is explored.

The social milieu within which abuse occurs

There is substantial scope for confusion, ignorance and misconceptions regarding what constitutes abuse of vulnerable adults, both among the public generally and among vulnerable adults themselves. There is also, generally, a relatively low level of awareness about how perceived abuse should be dealt with, how and to whom it should be reported, and how adults at risk can be better safeguarded. Amongst professionals and agencies, there are also likely to be mixed perceptions, an under-recognition of responsibilities, confusion regarding lines of demarcation, roles and obligations, reporting pathways, and, very importantly, the rights of vulnerable adults to control their own lives, to make their own decisions and to have their will and preferences respected.

Also relevant in the context of safeguarding is the concept of well-being, in particular, the factors that shape an individual's ability to live life and engage in activities without fear of harm, including safety and security in respect of living environment. It is clear that a well-being framework cannot be adequately advanced without accepting shared responsibility for protecting and empowering adults at risk of abuse. ***The First Report on Well-being Framework for Ireland***³³² is relevant to safeguarding in that it focuses on measuring if the situation is getting better or worse and on Ireland's relative performance internationally.

Key actors in a safeguarding context

While everybody has a role to play in safeguarding at risk adults, there are some categories of people and groups who might have a heightened role. The categories of people and groups who have a heightened role in safeguarding at risk are identified below. Some of these categories refer to what can be termed informal social support networks involving relatives, neighbours and social networks. Others are formal supports in the sense that they are associated with service providers and professionals.

The person who is at risk or vulnerable

In an ideal world, each individual person would be aware of threats to their well-being, would be able to recognise abusive behaviour for what it is, would know how to seek support and protection, would not be afraid to seek help and would be encouraged and empowered to do so by families, social networks and professionals engaging with them.

However, the extremely low level of reporting by the person experiencing the abuse clearly indicates that there are considerable barriers to self-referral. For example, as noted in Chapter Three above, the NSO Annual Report 2020 indicates that only 2% of referrals were classified as being made by 'self'.

Clearly, there is a need to explore this matter further with particular reference to why people may not report abuse and what might be done

³³² <https://www.gov.ie/en/press-release/fb19a-first-report-on-well-being-framework-for-ireland-july-2021/>

to deal with the various barriers that exist, including lack of awareness, institutionalisation, coercive control and/or dependence on a caregiver. In addition to being supported and empowered to recognise and report abusive behaviours, there would be value in assisting adults at risk to develop the skills and knowledge needed in order to minimise their exposure to exploitation and abuse.

Family members

Family members are well placed to observe abuse and can potentially be powerful advocates for their vulnerable kin in confronting and reporting abusive and unacceptable behaviours, whether by people or institutions, or by other relatives. However, there are in reality many factors that contribute to them not doing so. In many instances, family members may be responsible for the abuse. The NSO Annual Report 2020 indicates that 22% of all persons allegedly engaging in abuse were an 'immediate family member'. This rose to 50% where the adult at risk was aged 65+. The percentages for 'other relatives' were 3% and 5% respectively.

It should be noted that the effectiveness of a family member in recognising and identifying risk of abuse will depend on the frequency of their interactions with the vulnerable adult, their proximity geographically, their feelings of responsibility for the adult, their understanding of what constitutes abuse, their position and role within the family – for example, their position *vis a vis* other family members, their skills, abilities and access to information and records, their ability to negotiate interactions with service providers, their fears regarding institutional reactions to complaints, and their knowledge of how incidents and risks should be reported and dealt with.

Family members may be blind to certain forms of abusive behaviour and may share in a culture that accepts and condones certain abuses as 'just part of life' rather than an infringement of a person's human and legal rights. Other factors could include a sense of entitlement, for example, to family property, frustration at being burdened with a caring role or a stressful personal situation. The NSO Annual Report 2020 indicates that only 3% of referrals to HSE Safeguarding Teams were classified as being made by 'family'.

Neighbours and friends

Neighbours and friends can be well placed to detect risks and abusive situations. In many instances, they have the opportunity to observe the vulnerable person – and possibly their interaction with others such as care providers, family, casual callers and others – on an ongoing, frequent and regular basis. They may be trusted by the vulnerable person with information and news that is not as easily shared with family and professionals. They may be asked for advice and guidance.

While neighbours and friends can be particularly important supporters for adults at risk who are without strong family supports, they can also be responsible for abuse. However, in comparison with other categories of potential perpetrators, they constitute a very small proportion. The NSO Annual Report 2020 indicates that only 3% of all persons allegedly causing concern were a 'neighbour/friend'. This rose to 5% where the adult at risk was aged 65+.

Neighbours and friends may be reluctant to take action on behalf of a vulnerable adult for a number of reasons which could include unwillingness to 'interfere' in a family situation, fear of retribution, friendship with the alleged abuser, consideration for their neighbour/friend's privacy, fear of a perpetrator, acceptance of some forms of abuse as being 'normal' or unavoidable, or simply a lack of knowledge and/or skill in how to report abuse or risk.

The NSO Annual Report 2020 indicates that 3% of referrals were classified as being by 'other', which would appear to be the only category into which friends and neighbours could fit.

Reporting mechanisms and pathways should also provide for information from concerned members of the public, including neighbours and friends, who wish to report a suspicion or knowledge of risk or abuse. Chapter Three above has provided data on unsolicited reports made to HIQA. There should be more emphasis on fostering a culture within which there is zero tolerance at societal level of any abuse of adults at risk and clear reporting pathways identified.

Concerned members of the public may observe and react to incidents and situations without having a complete or adequate understanding of the context in which the incident occurs and thus may report concerns where there is no actual abuse or threat of abuse. However, it is important to recognise that the development of a culture where people are awake to safeguarding issues and are willing to report them far outweighs the risks attaching to over-reporting or reporting incidents that turn out to lack a real basis for concern. People may also report 'abusive' situations that arise because a person with high support needs is living in an inappropriate environment and requires an alternative form of care and support.

Health and social care workers in institutional settings

Institutional settings, for the purpose of this section, are taken to mean both residential and day-care service settings, including hospitals (A&E, outpatients' departments and day hospitals). These settings could, in addition, be sub-divided into those operated and managed by the HSE; those operated by the voluntary sector; and those operated and managed by private providers.

Staff employed in such settings are likely to have frequent, regular and often long-term interactions with individual vulnerable adults. In many instances they will also be in a position to observe evidence of abuse at the point in time when vulnerable adults are admitted to the facility or service. Some staff members will be in positions to observe the interactions that occur between vulnerable adults and others, including other service users; other staff members; visiting family members, friends, and neighbours. As noted in Chapter Three above, research has shown that nursing home staff have witnessed widespread abuse in nursing homes. However, it is less clear how staff have dealt with such abuse.

It should be noted that this grouping encompasses a wide range of staff categories, including front-line care assistants, nursing staff, doctors, facility maintenance personnel, administration workers, managers and

social workers. Staff will have widely different levels of training, education and experience; differing specialities and skills; different levels of responsibility and authority; different line management and reporting positions; widely varying levels of remuneration; and they may have substantially different levels of interaction with service users, some of it face-to-face and some of it indirect, such as access to personal data and belongings.

It is reasonable to expect that workers in these circumstances would be well placed to observe and detect risk and abuse, and that the culture and focus of these workplaces would encourage, enable and require that cases be recorded and reported. In order to comply with HIQA regulations and standards, these facilities and services, whether HSE, voluntary sector or privately operated and managed, should have clear procedures in place for the effective identification and management of safeguarding concerns.

However, this may not always be the case. Given the high proportion of instances in which 'other service users' (53%) and 'staff' (17%) are cited as the person allegedly causing concern³³³, there is a need to take all necessary steps in order to provide adequate and effective safeguarding to vulnerable adults in residential care settings. At a minimum, there is a need to ensure that HIQA and Mental Health Commission National Standards for Adult Safeguarding Standards³³⁴ and HSE Safeguarding Vulnerable Persons at Risk of Abuse, National Policies and Procedures³³⁵ are universally applied and adhered to.

In order for individual staff across all disciplines and occupations to be effective in contributing to the safeguarding of vulnerable adults a number of actions are important.

- There needs to be a strong and clear organisational culture that encourages, enables and directs staff with regard to identifying, raising and reporting safeguarding concerns.
- Staff need to be made aware of the range of behaviours that constitute abuse.
- Staff need to be clearly informed regarding the unacceptability of over-riding service users' choices in favour of the directions of family members and others.
- Staff need to be encouraged and enabled to understand and respond to abusive behaviours that some might perceive as 'trivial' or not deserving attention.

Anecdotal and research evidence referenced elsewhere in the Discussion Paper suggests that nursing home residents may be at particular risk of being 'side-lined' by relatives and others, particularly regarding their finances and property assets, and regarding the possibility of returning

³³³ NSO Annual Report 2020, <https://www.hse.ie/eng/about/who/socialcare/safeguardingvulnerableadults/nationalsafeguardingofficereport2020.pdf>

³³⁴ HIQA and MHC, National Standards for Adult Safeguarding. 2019, <https://www.hiqa.ie/sites/default/files/2019-12/National-Standards-for-Adult-Safeguarding.pdf>

³³⁵ HSE Safeguarding Vulnerable Persons at Risk of Abuse, National Policy & Procedures, 2014 <https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf>

to their own homes. Staff and management need to be clear as to the impropriety of acting in a complicit manner with others, such as family members, in such circumstances.

While some categories of staff may not see safeguarding as falling within the scope of their job description, it will be necessary to ensure that all staff are clear that safeguarding is indeed everyone's responsibility and duty.

It is also possible that staff will, on occasions, witness events and actions that - while causing minor concern - may not be seen as warranting reporting or further actions. However, staff need to be supported and enabled to share information, where appropriate, that could paint a more complete picture of a potential risk or case of abuse. It is recognised that many staff may have concerns and reservations regarding data protection and privacy issues. Staff need to be supported in grasping the legal obligations and restraints that apply here.

The effective safeguarding of a vulnerable person can depend on, and benefit from, the willingness of staff to share and exchange relevant information. It is, therefore, critical that there is a clear understanding on the part of staff and their superiors of professional and legal responsibilities with regard to confidentiality and the exchange of information. (The barriers to information sharing between agencies in the context of data protection legislation have been discussed above in Chapter Eight).

The NSO Annual Reports identify 'voluntary agencies' as the highest referral source (65% in 2020) for safeguarding concerns, which appears to include settings such as those being considered here. (This may be due to high numbers referred by disability services and relating to peer-on-peer abuse). 'Hospital staff' and 'other HSE staff' accounted for just 4% and 2% of referrals respectively in 2020.

Health and social care workers in community settings

Vulnerable adults interact in the community setting with a variety of health and care workers. These include general practitioners, public health nurses, home care workers, personal assistants, social workers, pharmacists, chiropodists, meals-on-wheels providers, occupational therapists and physiotherapists, amongst others.

These workers can be employed by the HSE, by private providers, by voluntary organisations, or directly employed by the vulnerable adult or their family. The interactions can occur in the person's home or in other settings such as doctor's surgeries, health centres, day care centres and out-patient clinics.

As with the residential care settings, this grouping encompasses a wide range of skills, functions, specialities, levels of responsibility and authority. Some of the people involved here will have a clear understanding of their roles and responsibilities *vis-a-vis* the identification of risk and abuse and how they should respond to it; others will not necessarily see this as part of their role.

The diverse and sometimes fragmented nature of how services are provided by workers in this grouping can result in a poor level of information sharing, with a potential for risks and abuse being overlooked and not acted on. The effective safeguarding of a vulnerable person can depend on, and benefit from, the willingness of staff to share and exchange relevant information. It is, therefore, critical that there are effective and adequate procedures in place that enable and require collaboration and sharing regarding safeguarding issues.

While it is likely that some degree of abuse will be committed by persons within this grouping, and while it is also possible that care workers may act in a complicit manner in depriving vulnerable adults of their autonomy in decision-making at the behest of family, it is also evident that some of the highest levels of reporting of safeguarding concerns comes from within this group.

The NSO Annual Report 2020 shows that Public Health Nurses/ Registered General Nurses (8%), along with Primary, Community and Continuing Care Staff (7%) are highly likely, relative to other categories, to make referrals. However, surprisingly perhaps, the Carer/Home Help³³⁶ category accounts for only 2%, of referrals, as is also the case with GP referrals (2%).

The health and care workers in this community settings grouping also includes both staff and volunteers in the NGO sector who work with vulnerable adults. While this category is somewhat different to statutory or state-funded services in that it involves volunteer workers, volunteers in bodies such as the Society of St. Vincent de Paul and meals-on-wheels services visit people in their homes, and, therefore, can be effective in identifying and reporting situations of risk and/or abuse.

Staff in financial institutions

Staff in financial institutions such as banks, building societies, post offices and credit unions will be in a particularly advantageous position from which to detect and act on instances of actual or suspected financial abuse or exploitation. (The issue of financial abuse has been dealt with in Chapter Four above).

Unusual withdrawal patterns, sudden movements of cash, transfers of access powers to other persons, rapid deterioration of a person's financial assets, escalating borrowings or overdrafts, and abnormal issues with debt and the ability to pay, for example, standing charges, are amongst the warning signs. The lack of effective monitoring by either the Post Office or the Department of Social Protection was clearly a factor in the practice which resulted in a recent conviction of a man for fraudulently claiming his deceased parents' pension for over 30 years.³³⁷ (It is not clear whether the social welfare payment agency in place was a Type 1 or a Type 2 agency).

³³⁶ The Home Help category mainly includes non-clinical staff, many of whom may not have relevant qualifications - this raises the issue of supporting people to refer and importance of safeguarding training for all frontline health and social care workers.

³³⁷ <https://www.irishtimes.com/news/crime-and-law/courts/circuit-court/man-jailed-for-claiming-dead-parents-pensions-for-33-years-1.4804170>

There has been considerable progress in the awareness of financial institutions regarding the potential for exploitation of vulnerable adults. However, the shift away from face-to-face interactions and from the traditional levels of personal contact in this sector toward increased online and impersonal ways of doing business, with the parallel reduction in the accessibility of local bank branches, creates barriers to the detection and management of risk and abuse. There continue to be major gaps in the practice of Post Offices and Credit Unions. For example, An Post, while it is a national network with a central office, still operates to regulations from 1921. On the other hand, credit unions are all separate entities with no central office and the approach is informal and local which may give rise to difficulties. Nominations of monies³³⁸ in both post offices and credit unions, which are provided for in legislation, may also facilitate this informality. Achieving an appropriate balance between an informal approach and positive safeguarding of at risk adults is a major consideration.

There are also significant barriers for many people, particularly those in older age-groups, in managing and controlling their own financial affairs as they struggle with online interactions. There is a need to ensure that the financial sector maintains an adequate and accessible human presence for safeguarding purposes, and that effective tech-driven systems are implemented that are capable of signalling potential abuse. There is a clear need for safeguarding awareness training for all credit union and post office personnel

Financial abuse has been consistently recorded as an issue in research generally, as well as in NSO Annual Reports. For example, 10% of total cases in 2020 fitted into that category. For vulnerable adults aged 80+ years, that percentage rose to 23%. While blatant and major financial abuse rightly attracts attention and the possibility of criminal prosecution³³⁹, it is equally clear that other forms of financial abuse are, in many situations, considered as being somehow acceptable. These include control, management and use of a vulnerable person's financial assets by family members, the petty pilfering of monies by carers and the imposition of extra charges by some nursing home operators.

Vulnerable adults, particularly older people with private assets and pensions, are now more likely to avail of the services of financial advisors. Equally, vulnerable adults who are experiencing financial difficulties may be availing of the Money Advice and Management Service (MABS). People involved in the delivery of these services are also well placed to identify financial abuse.

Department of Social Protection (DSP) staff

The DSP distributes considerable amounts of money to a wide range of vulnerable adults, including payments and supports such as pensions, illness or disability benefits, payments to carers and other social

³³⁸ See https://www.citizensinformation.ie/en/death/money_matters_after_a_death/access_to_money_after_a_death.html

³³⁹ See, for example, Judgement in Conroy vs. Ó Ceallaigh case, <https://www.thejournal.ie/taxi-driver-seamus-conroy-disputed-will-court-5636620-Dec2021/>

welfare payments. The DSP operates a Safeguarding Unit (SGU) which investigates cases where there are allegations or suspicions of abuse involving these payments. Allegations are brought to the SGU's attention by external sources (sometimes anonymous), by concerned family members or members of the public, and by the staff of other agencies such as the HSE or An Garda Síochána.

The SGU only takes direct action – for example to suspend payments – when there is evidence that the regulations attaching to a particular DSP scheme are being broken. In other instances, the SGU refers concerns and transfers information to HSE Safeguarding and Protection Teams and/or to An Garda Síochána. However, it is important to note that The SGU only takes direct action when a complaint is made and there does not appear to be an inbuilt safeguarding approach. For example, it does not appear that there is any random checking of agency arrangements that have been in place for some time. While the DSP is correctly focused on fraud against the Department, there is an equally important need to ensure that a social welfare payment beneficiary is actually receiving the payment.

The DSP is well placed to receive information regarding, and/or to actually detect, both risks of financial abuse and actual instances of financial abuse. The operation of collaborative and information-sharing procedures with other agencies is crucial to the DSP's effectiveness in this area.

It is worth noting that the DSP is not the only government department that manages the distribution of funds to a wide population, some of whom may be vulnerable. A further example is the Department of Agriculture, Food and the Marine which oversees a wide range of payments to farmers. The National Shared Services Office administers the pension payments of retired civil servants and others (something in the order of €5 billion per annum) and clearly has a responsibility to monitor possible financial abuse, which may not be the case at present.

Family solicitors

Family solicitors appear well-positioned to detect instances where vulnerable adults are at risk of, or actually experiencing, exploitation and abuse, especially regarding control, access to and exploitation of property and other financial assets. They should also be in a position to detect cases of coercive control, influencing of wills and inheritances, dominating and influencing of at risk adults in relation to cases involving litigation for damages, and manipulation of assets in order to avoid transfers to the State arising from Inheritance Tax or to the Nursing Homes Support Scheme. (Safeguarding issues relating to nursing home care have been discussed in Chapter Five above).

Solicitors may be cautious in reporting evidence of risks or alleged abuse due to concerns with client confidentiality and data protection. There is also anecdotal evidence of solicitors representing both a vulnerable person and their family member when arranging transfers of property and

assets (this despite a requirement by the Law Society³⁴⁰ that this should not happen). As with financial institutions, there is a need to ensure that family solicitors do not enter into situations that can involve conflicts of interest or where a vulnerable person is treated as not having decision-making capacity.

Adults at risk or other connected people may decide to inform family solicitors of concerns. In such circumstances, the solicitor could be seen as either a person who would resolve the issue or a link in a chain of communication to official agencies. Guidelines for lawyers on this matter could usefully be developed.

Independent advocates

Independent advocates appointed by organisations such as Sage Advocacy and the National Advocacy Service for People with Disabilities (NAS) are very well placed to observe and report cases of risk and/or abuse. Their independent status ensures that they can act with or on behalf of a vulnerable adult, even in the face of resistance from service providers, family or others. It is evident that many vulnerable adults live in situations where they are subject to the wishes and vested interests of people and institutions that are considerably better resourced and/or more influential than they are. Independent advocates can provide the vulnerable adult with a voice in situations of risk and/or abuse. They have an especially important role in cases where concerns exist regarding risks and abuse that are hidden from view. The role of independent advocates operating on a non-instructed advocacy basis is also important in that it can involve carrying out a witness/observer role in respect of people with reduced decision-making capacity.

As with family solicitors and other actors such as clergy, vulnerable adults may relate their concerns to the independent advocate in the hope that the advocate would resolve the matter, or simply with the expectation that the advocate would inform the relevant safeguarding authorities.

Others whose role brings them into regular contact with vulnerable adults.

This grouping traditionally included local retailers, postal workers, publicans and clergy, all of whom were in roles that allowed them to observe the condition and circumstances of vulnerable adults. While this remains the case in close-knit community settings most often associated with rural areas, it is likely that these roles do not now carry the same degree of contact in more densely populated urban settings. However, there is value in ensuring that such personnel are encouraged to take note of incidents of risk and that they are directed to appropriate sources of information and reporting mechanisms.

However, there is a caveat here in that some people in roles of this nature were sometimes complicit in coercing vulnerable people into decisions that they were not happy with and, in some cases, were perpetrators of abuse.

³⁴⁰ See S.I. No. 375 of 2012, SOLICITORS (PROFESSIONAL PRACTICE, CONDUCT AND DISCIPLINE — CONVEYANCING CONFLICT OF INTEREST) REGULATION 2012 <http://www.irishstatutebook.ie/eli/2012/si/375/made/en/pdf>

Persons appointed to legally represent a vulnerable adult.

This grouping currently includes Committee (person) or Joint Committee (persons) appointed by court order to deal with the person's affairs in conjunction with the Wards of Court Office; an individual appointed as Attorney for a person who is vulnerable or at risk, pursuant to a General or Enduring Power of Attorney; agents appointed under social welfare legislation; and a Care Representative appointed by the Circuit Court to apply for a state loan in relation to the Nursing Homes Support Scheme.

Once the Assisted Decision-Making (Capacity) Act 2015 has commenced, it will also include people who are appointed a co-decision maker, decision-making assistant, or decision-making representative, court friends and general and special visitors.

HSE Safeguarding and Protection Teams

HSE Safeguarding and Protection Teams (SPTs) are in place in all nine HSE CHO areas and work with services, families and community organisations to stop abuse and to ensure that people are safeguarded.

Safeguarding Teams receive information from multiple sources, including HSE staff, DSP SGU staff, HIQA, voluntary agencies, management and staff of residential care facilities and day-services, members of the public, local authority tenancy officers, housing association staff, hospital staff, individuals at risk, family and neighbours of adults at risk, as well as anonymously. The Safeguarding Teams do not themselves seek out alleged cases; they are, rather, recipients of information from other sources. The Teams make enquiries, investigate and, where appropriate, escalate cases to the point where safeguarding actions are implemented. This can include referrals to An Garda Síochána, to HSE services, to primary healthcare and, on occasion, to the Courts.

While HSE SPTs are in many cases the 'go-to' reporting point for concerns regarding risk and/or abuse in the case of vulnerable adults, the work of the SPTs is restricted in many respects. Their remit does not include investigation of alleged abuse cases where the victim, aged under 66 years, is not suffering from a disability. In addition, the HSE is very limited and has virtually no statutory powers to investigate concerns of adult abuse, neglect or exploitation outside of HSE-controlled settings. They do not have a right of entry or inspection with regard to private dwellings, including privately operated nursing homes.

Tusla

Tusla's primary concern is with young people and children and, as such, Tusla has limited responsibility for the safeguarding of at risk adults. However, Tusla may have information regarding the risk to an adult person where that person was previously in the care of Tusla as a child or where Tusla staff identify concerns *vis-a-vis* an adult in the course of their interaction with a child.

An Garda Síochána

Members of An Garda Síochána are likely, in the course of their work, to be well placed to identify actual abuse or potential risk of abuse. While their primary concern and focus will be on preserving the peace and dealing with situations that involve criminal acts, their work will also bring to their attention instances of abuse or risk that are not obviously criminal in nature.

In addition to investigating cases where criminality is suspected, An Garda Síochána is also likely to be the public service to which people will report their concerns and suspicions. In this context, An Garda Síochána has a crucial role in the process of safeguarding vulnerable adults.

The functions of An Garda Síochána, as set out in Section 7 of the *Garda Síochána Act 2005*, are to provide policing with the objectives, *inter alia*, of protecting life and property, vindicating the human rights of each individual, preventing crime, bringing criminals to justice, including by detecting and investigating crime and other matters. Vindicating the human rights of each individual is a particularly important function for Gardaí in relation to adults who are vulnerable to abuse and exploitation.

For the purpose of achieving the objectives referred to in the Act, the Garda Síochána is directed to co-operate, as appropriate, with other Departments of State, agencies and bodies having, by law, responsibility for any matter relating to any aspect of that objective.

There would appear to be potential for An Garda Síochána at national level to work more collaboratively with other agencies working with vulnerable groups, particularly the HSE Safeguarding and Protection Teams, in dealing with and preventing abuse of vulnerable adults which is more prevalent throughout Irish society than is sometimes understood.

Informal culture relating to the management of people's assets

In addition to the practice in post offices and credit unions, the somewhat informal culture that underpins much of the practice relating to the management of people's finances is reflected in a number of pieces of legislation. For example, there is a wide list of 'specified' persons contained in Section 47(7) of the Nursing Homes Support Scheme Act 2009 which includes at (e) a relative of the person who is not less than 18 years of age. Section 47 (1) provides that a specified person may act on behalf of another person in relation to any matter under this Act, including but not limited to, any application, appeal review or the giving of consent under section 7(13), where the other person is not of full mental capacity.

This is a very wide authority under the Act without any oversight of the decisions being made. This is further facilitated by many of the NHSS forms where the focus is on getting a signature on the form and, frequently, it would appear, no questions being asked. Many people are being asked to sign forms admitting a person to a nursing home without the consent of that person and it is almost certain that many do not understand this as a serious breach of a person's human and legal rights.

In highlighting the fundamental difficulties with the informal culture that currently operates and the absolute need for stronger legislation, regulations and changes in practice, the requirements of Article 4 of UNCRPD³⁴¹ are pivotal.

- a. To adopt appropriate legislative, administrative and other measures for the implementation of the rights recognised in the present Convention;
- b. To take appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination;
- c. To take into account the protection and promotion of human rights... in all policies and programmes;
- d. To refrain from engaging in any act or practice that is inconsistent with the Convention;
- e. To take all appropriate measures to eliminate discrimination on the basis of disability by any person, organisation or private enterprise.

Multiple actors, roles, responsibilities and interactions in a safeguarding context

The non-exhaustive listing above demonstrates that there are many individuals and organisations that have potential roles to play in safeguarding at risk adults by identifying, reporting and taking immediate action regarding concerns. This is particularly relevant at the early stages of a concern emerging. Figure 10.1 illustrates the existing range of actors and roles in the context of safeguarding adults who may be at risk of abuse and exploitation.

It is suggested that there should be a targeted focus on the potential of each actor identified in Figure 10.1 to contribute to developing a culture and broad social support infrastructure within which the issue of abuse and exploitation of vulnerable adults can be better addressed and within which the concept of safeguarding can be more effectively embedded.

341 https://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf

Figure 10.1 Actors and Roles

Actor	Observe and Identify	Report to an Intermediate	Report Formally	Record. Investigate	Decide	Develop Safeguarding Actions	Involve in Implementing Safeguarding Actions
Adult at risk	▶	▶					▶
Family members	▶	▶	▶				▶
Neighbours/Friends	▶	▶	▶				▶
Health and care workers in institutional settings	▶	▶	▶				▶
Health and care workers in community settings	▶	▶	▶				▶
Staff in financial institutions	▶	▶	▶				▶
DSP Staff	▶	▶	▶	▶			▶
Family solicitors	▶	▶	▶				▶
HSE Private Property Accounts	▶	▶	▶	▶			
Nursing Home Support Scheme	▶	▶	▶	▶			
Independent advocates	▶	▶	▶				▶
Others with regular contact	▶	▶	▶				▶
Members of the public	▶	▶	▶				
Persons appointed to legally represent	▶	▶	▶				▶
HSE SPTs				▶	▶	▶	▶
Tusla staff	▶	▶	▶				▶
An Garda Síochána	▶	▶	▶	▶	▶		▶

As is suggested in Figure 10.1, there is much potential for the participation and involvement of many of the actors discussed above in implementing safeguarding plans and actions. The process of dealing with safeguarding concerns can be seen to go full circle and, in many instances, a wide range of human resources can be mobilised in order to mitigate and remove risk.

Overview and Conclusion

The perspective outlined in this chapter demonstrates the wide range of groups and individuals directly or indirectly involved in interfaces where the abuse of vulnerable adults can be identified and responded to. This clearly shows that there is very wide potential for a more multi-faceted and inter-disciplinary approach to safeguarding. It is suggested that greater recognition of the wide range and variance in the nature of the relationships which can be involved in detecting and reporting abuse would result in a stronger culture of safeguarding throughout society. The categories of relationships with a potential safeguarding role include familial, neighbours, social networks, health and social care professionals, legal professionals, Gardaí and consumer/service providers.

The proximity and nature of the relationship which these individuals have with an adult at risk will determine their ability both to identify the risk of harm and to assist in implementing an appropriate response. The detection and reporting of abuse will clearly often be of secondary concern to the primary purpose for which many of the individuals outlined above interact with the vulnerable adult. Since the categories listed span such a wide spectrum of entry points to a person’s life, there are clear challenges in implementing a cohesive approach, even amongst those sharing relationships of the same nature (such as GP, home care assistant or residential care provider), unless such cohesion is actively facilitated and encouraged.

A key issue is that individuals who are in a position to detect, report and assist in safeguarding people against abuse are often the same individuals who might perpetrate abuse or otherwise pose a risk to a vulnerable adult. The risk that an adult might be exposed to an adverse situation in the context of their relationship with one of the categories as listed increases the need to ensure that such a risk is capable of being identified within the context of that vulnerable adult’s relationship or interactions with a different individual involved in their life. For example, a neighbour, family member, care giver or health care provider might be guilty of neglect, or physical, psychological or financial abuse. Such abuse or neglect might only be identified if it comes to the attention of another individual who interacts with the adult at risk, e.g., a GP or a care attendant.

There is a clear need for all of the categories and individuals listed to develop safeguarding antennae in relation to people who are potentially at risk of abuse. This requires greater public and professional awareness of what constitutes risk and abuse and how it should be dealt with and reported.

The various groups of professionals and agencies listed each has their own roles and responsibilities. There are factors which impact on their ability to work collaboratively, not least, limitations to sharing information, agency boundaries and gaps in safeguarding legislation.

The following are required in order to make safeguarding central to our policy and social support infrastructure:

- An overarching National Adult Safeguarding Authority³⁴²;
- Information and awareness-raising aimed at both the general public and professionals;
- Training in safeguarding adults at risk for all professionals engaging with the public;
- Identifying clear pathways for reporting abuse;
- Enhanced structures and procedures for inter-agency and intra-agency collaboration and information sharing;
- Clearly signposted and accessible pathways for reporting of concerns;
- More extensive statutory powers for agencies that are charged with safeguarding;
- Legislative provisions for safeguarding, including for the practice of independent advocacy;
- Support for professionals in the area of legal competency as relevant to safeguarding adults at risk;
- Amendment of legislation that is not fully compliant with the provisions of the UNCRPD;
- A safeguarding lens to be applied to all Data Protection legislation.

Much of the potential for abuse, neglect and exploitation of vulnerable adults, especially in subtle forms, is rooted in a culture that accepts and condones certain attitudes, practices and behaviours that deprive vulnerable people of their basic human rights. Challenging and changing this culture, both within institutions and across society as a whole, is an integral part of safeguarding.

The next chapter will set out the case for national integrated legislative and policy response to safeguarding vulnerable adults and identify the main components of an appropriate legislative and policy framework.

³⁴² The concept of a National Adult Safeguarding Authority is discussed in detail in the next chapter.

/ Chapter Eleven

Developing an Integrated Safeguarding Policy Response

This chapter sets out the case for an integrated legislative and policy response to safeguarding vulnerable adults.

It identifies the current blockages to an integrated approach and outlines the core components of an integrated response. A framework for an integrated legislative and policy response is proposed for consideration by Government and other key stakeholders.

A critically important point which has been referenced regularly throughout this Discussion Paper is that, while safeguarding has been historically viewed as a health and social care issue, it is much broader. It requires a cross-departmental and inter-agency approach, as well as a whole of society approach, to address the embedded and unacceptable levels of abuse of vulnerable adults in Ireland.

It should, of course, be acknowledged that there have been positive policy developments in respect of protecting people who may be at risk as a result of their health or frailty, their requirements for social care or supports, or their living/relationship circumstances, for example, regulation of some social care services, mental health legislation, the Assisted Decision-Making (Capacity) Act 2015 and the Domestic Violence Act 2018.

The development of the Third National Strategy on Domestic, Sexual and Gender-based Violence by the Department of Justice and the proposal mooted for the creation of a Domestic, Sexual and Gender-Based Violence (DSGBV) agency should provide additional impetus for dealing with gender-based violence. However, there is a clear need for an overarching and integrated response that encompasses all aspects of abuse and exploitation of adults at risk. This chapter sets out the key components of an integrated legislative and policy framework.

Factors which impact on an integrated approach

There is a basic lack of integration and collaboration in our policy and legislative approach to safeguarding. In the health and social care policy areas, there are significant limitations to the role of HIQA, the HSE and the Mental Health Commission in responding to instances of abuse, exploitation and neglect. These limitations arise, to some extent at least, because of the following factors:

- The absence of specific safeguarding legislation;
- Limitations in legislation and subordinate regulations as it relates to health and social care services (Ireland continues to lag far behind other jurisdictions in its failure to regulate a wide range of adult social care services, including homecare, day care and adult placement, as well as independent healthcare);
- Anomalies in the Nursing Homes Support Scheme that may facilitate a delay in accessing appropriate care arrangements (this has implications for the statutory homecare scheme being currently developed);
- An approach which vests specific adult safeguarding responsibilities/services in one agency (the HSE).

In previous chapters, this paper has explored the incidence and response to safeguarding issues in other critical areas of service provision and their regulation/oversight. This has been further compounded in recent times with a shift in the configuration of policy areas that relate to services where people may be viewed as more at risk, viz.

- The Department of Children, Equality, Disability, Integration and Youth (DCEDIY) having responsibility for disability, children, (including children transitioning to adulthood) and international protection;
- The Department of Housing, Local Government and Heritage having responsibility for housing people with disabilities, homelessness, accommodation and supported living schemes;

- The Department of Justice having responsibility for areas relating to equality, gender based violence, domestic abuse, probation and prison services and the regulation of the legal profession;
- The Department of Social Protection having responsibility for social welfare payment agency arrangements and related monitoring;
- The Department of Health in its role in developing policy on adult safeguarding in the health and social care sector;
- The Department of Finance having responsibility for regulation of the financial sector.

This configuration of policy areas can give rise to a poor integration of safeguarding responses and to delays in implementing safeguarding assessments and responses.

There is also a dearth of data on adult safeguarding with no national database on issues of concern.

The sheer breadth of areas across civil society and within the service sector demonstrates the need for an overall national safeguarding regulatory authority that has a whole of Government and cross-department role in identifying, preventing and overseeing safeguarding policy and practice.

Absence of an overarching regulatory framework

At present, there is no regulatory framework for adult safeguarding. A key aspect of a regulatory framework is the assignment of responsibility for regulation and oversight to a body or bodies. A number of public bodies have responsibilities for various aspects of adult safeguarding in particular contexts, for example, HIQA regulates health and social care services, inspects services and investigates allegations involving service providers. While HIQA has a role in regulating day care and adult placement services, it currently has no role in regulating home care or investigating complaints made by individual residents in congregated settings.

There is no independent body with overarching responsibility for regulating adult safeguarding generally in terms of: receiving and investigating individual complaints; overseeing the investigation of complaints where a person is not in receipt of any care services; overseeing the investigation of complaints of various types of abuse including financial and social welfare abuse; oversight of critical incidents including deaths and matters of abuse and neglect relating to at risk adults; and carrying out statutory inspections.

Limits of jurisdiction

HSE adult safeguarding policy is limited in that it seen primarily as belonging to the health and social care domain and is not underpinned by legislation. While the HSE plays a centrally important role in adult safeguarding, and while HIQA and the Mental Health Commission have a safeguarding role in designated/approved centres and settings, many of the safeguarding issues that arise require a multi-agency response. In addition, the HSE is very restricted and has virtually no statutory powers to investigate concerns of adult abuse, neglect or exploitation outside of HSE settings. These include concerns that might arise in a community or private and voluntary nursing home settings. It is also reasonable to suggest that when there are safeguarding concerns of abuse within HSE facilities, these may present conflicts of interest.

HSE Safeguarding and Protection Teams have no right of entry to private dwellings, including nursing homes. In addition, both the Mental Health Commission and HIQA are limited in terms of their safeguarding roles and statutory powers. The likelihood is that cases where entry is prohibited by an alleged perpetrator are the ones of greatest concern and in which the victim is suffering the most severe forms of abuse or neglect. Unfortunately, many cases of abuse are perpetrated by family members and occur in people's own homes. It is for this reason that safeguarding services need to be much wider in scope than health and social care alone.

Services without a HSE contract have no legal obligation to share information and/or cooperate in safeguarding. HSE staff do not have powers such as right of access to information or to persons considered to be at risk of abuse. The majority of private sector providers cooperate on a voluntary basis with the HSE in safeguarding matters. A critical constraint is the lack of legal authority to oversee the management and assessment of safeguarding concerns within private health care facilities. This situation is compounded by the fact that, currently, there is no legal provision for the regulation of professional home care services.

Another issue arises because of the absence of clear responsibility for, and clear lines of accountability by, various sectors and services (other than health and social care) in the area of adult safeguarding.

Limits on powers to enter premises, access information and investigate concerns

HSE Safeguarding and Protection Team social workers consulted during the process of preparing this Discussion Paper referred to instances where they were unable to gain entry to the person's dwelling or to access the person in another private dwelling. This may be because access to premises is denied by a third party on the premises (usually a family member, friend or other informal carer) or because, although access to the premises can be gained, it is not possible to speak to the adult alone due to a third party's insistence on being present. In circumstances where there is concern of risk or abuse, such right of entry must be governed by clear protocols and procedures enshrined in law.

Reluctance on the part of organisations and officials to take action

There may be a reluctance on the part of staff and/or organisations to take action and/or to report suspected abuse, as they are unsure as to whether they may be in breach of privacy and data protection laws. This appears to be a particular concern amongst staff of financial institutions. It is possible that the absence of stronger statutory obligations and powers contributes to this reluctance. Relevant here is the fact that the Central Bank of Ireland's **Consumer Protection Code 2012³⁴³** has not been updated since 2015.

It may also be the case that, at times, there may be a reluctance on the part of the Gardaí to take action, particularly when the matter is inter-familial, e.g., financial abuse.

Domestic abuse

It has been widely noted and referenced in Chapter Three above that the restrictions necessitated by the Covid-19 pandemic have led to an increase in the reporting and detection of domestic and intimate partner abuse. Abuse of adults at risk that occurs within a person's own home presents particular difficulties in terms of investigation and assessment and safeguarding staff have pointed to the challenges that they face in tackling this issue. However, there is also a belief that the various legal safeguarding mechanisms that are available – such as barring orders – are inadequate in many cases. This is particularly the case where the alleged abuser is not an intimate or close family member.

Developing an integrated response to safeguarding adults at risk: Core components

It is widely acknowledged that there are major deficiencies in current provisions in Ireland for the safeguarding of adults at risk. There is a recognition that cultural attitudes in the community and in services, resource allocation and the practical mechanisms needed for the protection of vulnerable adults all require attention. However, most observers agree that – above all else – the deficiencies in the present provision are rooted in the absence of a legislative basis for adult safeguarding. These legislative deficiencies are seen as impacting on the provision of safeguarding in a number of important aspects. However, while focusing on legislative provision for safeguarding is critically important, there is a need to approach the issue on a broader basis. Figure 9.1 identifies nine key components of an integrated approach to safeguarding adults at risk.

343 <https://www.centralbank.ie/docs/default-source/regulation/consumer-protection/other-codes-of-conduct/4-gns-4-2-7-cp-code-2012.pdf>

Figure 9.1 Safeguarding adults at risk: nine key components



A rights-based approach

The absence of adequate and appropriate legislative provisions underpinning safeguarding has the effect of undermining the human rights of adults at risk. Failure to introduce comprehensive safeguarding legislation is essentially a denial of people’s right not to be subjected to coercive control, not to have their liberty arbitrarily removed and not to be exploited financially. This protection of adults at risk is at the very core of both the UNCRPD and the Assisted Decision-Making (Capacity) Act 2015. Implementing the rights of adults at risk in the context of safeguarding, therefore, requires legislative, regulatory and policy provisions.

Safeguarding legislation

Currently there is no clear obligation on the State, state agencies or organisations to prevent harm or generally to protect adults at risk. In developing a regulatory framework, it is necessary to impose a statutory obligation on state bodies and organisations providing care and support services on behalf of the State to prevent or reduce abuse in all its forms, as distinct from the current approach where the focus is primarily on the management of crises and responding to concerns reported.

There is a need to review the regulation of all services to people who might be deemed to be at risk – not just home care and not just within health and social care sectors – in order to be better safeguard people where rights abuses may occur, e.g., in Direct Provision and in homeless support services.

The need for safeguarding legislation has been identified repeatedly in recent years by various agencies (statutory and NGO). For example, HIQA, the National Safeguarding Office, Safeguarding Ireland, the Irish Association of Social Workers, Sage Advocacy, Inclusion Ireland and others have all called for safeguarding legislation.

The need for such legislation arises because of a number of factors, including, in particular,

- The need for an independent oversight body;
- The need to broaden the issue of safeguarding vulnerable adults beyond the domain of health and social care;
- The need for HSE Safeguarding and Protection Teams to have stronger rights of entry and inspection;
- The need for better intra- and inter-agency liaison and collaboration;
- The need to ensure that people who experience abuse in any form have easy access to safeguarding and to redress (where the latter is relevant);
- The need to ensure that vulnerable adults in nursing homes and in other residential care facilities are fully safeguarded and their legal and human rights protected.

The LRC has noted that the provision of adult safeguarding legislation is underpinned by international human rights obligations as well as in the context of defending the personal rights of those whose capacity is in question as set out in Article 40.3.1 of Bunreacht na hÉireann. HIQA, in its submission to the Oireachtas Select Committee on the Future of Healthcare in 2017³⁴⁴, noted as follows:

“We believe that now is the time to introduce safeguarding legislation to protect at risk adults from abuse and neglect. While national safeguarding protocols are in place following recent high-profile revelations of abuse, these do not go far enough to ensure the safety and rights of vulnerable people.”

The Joint Oireachtas Committee on Health in its Report on Adult Safeguarding³⁴⁵ recommended that there should be no unnecessary delay in implementing adult safeguarding legislation.

Adult safeguarding legislation is also clearly necessary to ensure compliance with Article 16 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD), which provides that State Parties shall take

344 <https://www.hiqa.ie/sites/default/files/2017-02/Submission-Committee-on-the-Future-of-Healthcare.pdf>
345 https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_health/reports/2017/2017-12-13_report-adult-safeguarding_en.pdf p.7.

all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects. Article 16.5 of the UNCPRD requires that effective legislation and policies are put in place “to ensure that instances of exploitation, violence and abuse are identified, investigated and, where appropriate, prosecuted.”

A National Adult Safeguarding Authority

An independent authority with overarching responsibility for safeguarding and statutory powers is clearly required. Provision was made for the establishment of a Safeguarding Authority in the Adult Safeguarding Bill 2017 which set out, amongst others, the following functions for such an Authority:

- Promote standards in the safety and quality of services provided to adults at risk;
- Undertake investigations where the authority believes on reasonable grounds that there is a risk of abuse or harm to an adult at risk;
- Receive reports from mandated persons;
- Promote education, training and public awareness regarding matters concerning adults at risk;
- Provide information to adults at risk in respect of abuse and harm that they may be experiencing;
- Supervise compliance with the duties imposed by or under the legislation;
- Provide information and guidance to service providers, organisations and bodies in the State in relation to their interaction with adults at risk, including the carrying out of risk assessments and safety statements;
- Determine if an adult needs support and assistance³⁴⁶

The proposed legislation would also empower the Authority to make provision, where appropriate, for independent advocacy to an adult at risk who is the subject of an investigation.

A National Adult Safeguarding Authority (an independent specialist body with an interagency structure) would provide overarching governance to a National Safeguarding Service, the Mental Health Commission, HIQA, the Decision Support Service and an Independent Advocacy Service provided on a statutory basis. The body would also have explicit oversight in respect of adult safeguarding responsibilities for other relevant regulatory bodies falling outside of the health and social care sector.

A National Adult Safeguarding Authority must have a statutory power to enter and inspect premises, including both nursing homes and private dwellings, where there are concerns of abuse. However, power of entry

346 This evidently raises the question of the general need for integrated social care legislation in Ireland.

must be used appropriately, proportionally and approached consistently and, therefore, legislation allowing powers of entry must be permissible only in very limited circumstances, such as where there is a reasonable concern, supported by objective evidence, of abuse, coercive control, exploitation or neglect. In addition, all other reasonable avenues of entry must have been explored and failed and the process must be overseen by the Courts, except in exceptional circumstances.

A new safeguarding regulatory authority should have at its core the overall goal of zero tolerance in our society of adult abuse, emphasised through the four key pillars of prevention, protection, prosecution and policy co-ordination. There is an opportunity to examine the development of an integrated agency within the remit of the Department of Justice as Lead Department.

Inter-agency collaboration

Collaboration between agencies can be crucial in safeguarding adults at risk. However, in the context of adult safeguarding in Ireland, many existing collaboration arrangements are not underpinned by policy or are on an informal basis and are not implemented consistently at a regional level. A lack of multiagency partnerships and protocols also exists in some cases, which makes it difficult for individual agencies to offer comprehensive person-centred solutions to at risk adults.

There are also perceived and real barriers to the exchanges and sharing of information that need to be addressed (see Chapter Eight above). For example, the **Commission on the Future of Policing in Ireland**³⁴⁷ found, in the preparation of its report, that there is currently little sharing of information between An Garda Síochána and other agencies, even where memoranda of understanding exist concerning cooperation between them. It recommended that cooperation should be underpinned by an efficient sharing of information and that transparency in information exchanges with other agencies, subject to relevant legal safeguards, would lead to better multi-agency approaches to community safety problems. It is also the case, as emphasised above, that services and regulatory bodies in sectors other than health and social care need to be more proactive in carrying out their responsibilities in respect of adult protection safeguarding.

A multi-disciplinary approach to safeguarding

While social workers generally or as part of HSE Safeguarding and Protection Teams have a crucial role in safeguarding adults at risk and in responding to allegations of abuse and exploitation, safeguarding clearly cannot just be the left within the domain of the social work profession.

The central role of a multi-disciplinary approach to meeting the long-term care and support needs of adults at risk has been well articulated in Ireland over very many years³⁴⁸The safeguarding needs of adults at risk are strongly linked to how their medical, nursing and social care needs are met. Gaps or deficiencies in any one area will almost certainly have knock-on effects in a safeguarding context.

347 Commission on the Future of Policing in Ireland, The Future of Policing in Ireland (2018), <https://assets.gov.ie/180551/8b6b5065-5720-4a24-a40c-a2b15446770c.pdf>

348 See, for example, Browne, M. (1992), Swimming against the Tide, National Council for Ageing and Older People.

Despite approaches and policies that strongly endorse a multi-disciplinary approach, current delivery systems and protocols are inadequate to deal with the complexity of ensuring that all adults at risk are fully safeguarded.

From a safeguarding perspective, inter-disciplinary working needs to be more embedded in the community care delivery system. While social workers must be leaders in safeguarding adults at risk, there is a need for greater involvement of all other relevant disciplines – GPs, PHNs, social care assistants, home helps, physiotherapists, occupational therapists, speech and language therapists, dentists, community pharmacists, dieticians, chiropodists, psychologists.

Regulation of adult community-based social care services

Since there is significant potential for abuse and exploitation of people in receipt of health and social care services in the community, there is a clear need for regulation of all adult social care services, including independent and private providers.

The safeguarding of vulnerable adults living in the community is more difficult because of the manner in which home care services are currently delivered and regulated. Currently, home care is provided by the HSE directly or is purchased from a large number of private and voluntary agencies with funding provided by the HSE. Many of these and other private agencies also provide home care privately to clients. Many clients in receipt of home care are among the most vulnerable in that there is limited statutory oversight of the care provided and an absence of nationally mandated standards.

HIQA currently monitors compliance with regulations and standards in designated centres for people with disabilities and in nursing homes. The regulations for these centres set out the fundamental requirements of a service and are enforceable through a range of measures.

There is no legislation providing for the regulation of home care services in Ireland. As far back as 2011, the Law Reform Commission recommended that HIQA should be empowered to regulate and monitor undertakings that provide professional home care (whether public sector or private sector, and whether for-profit or not-for-profit)³⁴⁹. While it is understood that HIQA is to be given powers to regulate homecare services, relevant enabling legislation has not to date been put in place.

While the HSE, in awarding a tender for homecare, must satisfy itself that an agency meets certain standards, Standards only describe best practice to be aimed at and, in this sense, are very different from statutory regulation requirements.

Over the last number of years, HIQA has advocated that the homecare sector needs a complete overhaul given the uneven distribution of homecare services and the absence of statutory provision. It is noted that the current Programme for Government has committed to

³⁴⁹ LRC 2011 Paper, Legal Aspects of professional Home Care, https://www.lawreform.ie/_fileupload/Reports/r105.htm

introducing a statutory scheme to support people to live in their own homes. Such a scheme was to be implemented in 2021 but may not now commence until 2023.

HIQA has recently published a research report, ***Regulation of Homecare***³⁵⁰ which outlined and analysed the current landscape of homecare in Ireland. The report notes that homecare services are not currently regulated to ensure their quality and safety and called for immediate reform, including the introduction of regulation and overhaul of Ireland's homecare services. The HIQA Report referred to complex conditions around home care services affected by funding, availability and geography and to the fact that the current system is unsustainable and not meeting the needs of people.

The report calls for an inclusive homecare scheme that protects everyone who receives care at home. HIQA suggests that, in order to achieve this, a needs-led, integrated homecare system is required, where age is removed as an access barrier. The HIQA report makes the important point that service users should expect the same quality of service regardless of who is providing that service. Thus, standards and regulations for homecare services should be applied to all types of providers equally – statutory, private³⁵¹ and NGO.

HIQA is currently in the process of developing National Standards for Home Support Services to drive improvements in the provision of home support services which are seen as complementing the necessary development of primary legislation and related regulations.

It is also relevant to note that people engaged with international protection services are vulnerable by reason of their status. ***The Report of the Advisory Group on the Provision of Support including Accommodation to Persons in the International Protection Process***³⁵² called for appropriate safeguards to be put in place in the international protection process to support vulnerable applicants. HIQA have now been given the function of inspecting direct provision services.

Addressing challenges of data sharing in a safeguarding context

The challenges associated with data sharing arising from GDPR and other legislation have been discussed extensively in Chapter Eight above. Data sharing is a highly complex matter and requires careful balancing in order to protect the rights of people to privacy in relation to their personal information and the rights of adults at risk of abuse and exploitation to be fully safeguarded.

As an interim measure and pending the introduction of adult safeguarding legislation, additional guidance from the Data Protection Commission specifically on data sharing in the context of adult safeguarding is urgently required in order to facilitate information sharing

³⁵⁰ <https://www.hiqa.ie/sites/default/files/2021-12/Regulation-of-Homecare-Research-Report-Long-version.pdf>

³⁵¹ It should be noted that HIQA currently has no role in monitoring compliance with national standards in private hospitals

³⁵² <https://assets.gov.ie/121976/91272c8b-00c2-4892-a484-00b270405038.pdf>

among the various organisations that encounter challenging and complex adult safeguarding issues. However, such guidance should not in any way remove the need for a more comprehensive approach to the matter.

It is essential that there are explicit procedures and protocols for the sharing of data in Adult Safeguarding legislation to embrace the provisions of the General Data Protection Regulation (GDPR) which permits disclosure of personal data for the protection of the vital interests of individuals.

A public education and awareness programme

As already stated, research commissioned by Safeguarding Ireland has found that 12% of all adults had experienced adult abuse in the previous six months and that half of all Irish adults say they have experienced the abuse of vulnerable adults either through being abused themselves or having seen somebody close to them abused.

There is now a growing appreciation that adult safeguarding can have direct relevance to a broader range of people than historically understood, including, people reliant on others for daily living, some people who have addiction problems or who are homeless.³⁵³ It can also potentially apply to people who may be at risk of having their human rights infringed through inappropriate arrangements for their care, for example, being inappropriately 'placed' in a residential care facility or not being provided with care and support commensurate with need in their own homes.

There is a clear need to acknowledge that safeguarding of adults at risk is everyone's business. It is also necessary to recognise that safeguarding involves proactive support (including emotional, social and end-of-life support) for people who are vulnerable as well as protection measures. This point is particularly pertinent in the context of Covid-19 in that it can be reasonably suggested that people resident in nursing homes were not well supported, for example, by not being able to see loved ones.

As a society, we need to fully take on board the lessons from Leas Cross (2005) and Áras Attracta (2014) and from the more recent 'Grace' and 'Brandon' cases. As with gender-based violence, there is a need for society to become more culturally, emotionally and mentally attuned to the nature, prevalence and pervasiveness throughout society of vulnerable adult abuse. Clearly, adults who are vulnerable to harm and abuse in Ireland require the same level of public awareness (as well as legislative protection) that is afforded to children.

It is likely that much of the abuse of vulnerable adults that takes place goes unreported, as indicated in a RED C National Poll referred to earlier in the Discussion Paper.

³⁵³ See, for example, Adult Support and Protection (Scotland) Act 2007 Code of Practice <https://www.gov.scot/publications/adult-support-protection-scotland-act-2007-code-practice-2/documents/>

Legal provision for the practice of independent advocacy

It is widely accepted that the provision of independent advocacy is an essential part of an effective safeguarding framework. However, the absence of a legislative remit for independent advocacy other than under the Mental Health Act 2001 results in an advocacy environment that is somewhat unclear. The Citizens Information Act 2007 provides for the establishment by the Citizens Information Board of a Personal Advocacy Service (PAS), but the service has not been established as the relevant section of the Act has not been commenced. The National Advocacy Service for People with Disabilities (NAS) has been established by the Citizens Information Board on a non-statutory basis.

The lack of statutory powers for advocacy are considered a barrier that can prevent advocacy services from accessing or acting on behalf of people with disabilities. While provisions of the Assisted Decision-Making (Capacity) Act 2015 and proposals of the Adult Safeguarding Bill 2017 give context to the provision of independent advocacy, there is still evidence that the right to independent advocacy is being denied to adults at risk. Some nursing homes are still not facilitating access to an independent advocate and anecdotal evidence from advocacy personnel indicates that, sometimes, nursing home staff may side with relatives to exclude an independent advocate and that an at risk adult's General Practitioner will often side with family members or not speak out, for a variety of reasons.³⁵⁴

While much of the consideration given to the concept of independent advocacy has, rightly, focused on aspects of assisted decision-making and capacity, it is equally clear that advocacy can have a large and important role in minimising abuse, empowering vulnerable adults and in identifying and dealing with instances of abuse.

An overarching national safeguarding framework

The work of Safeguarding Ireland has resulted in greater awareness of the need for an overarching safeguarding framework. The Law Reform Commission 2019 Issues Paper, ***A Regulatory Framework for Adult Safeguarding***, explored comprehensively the various dimensions of a regulatory framework and identified a wide range of related issues and questions that needed to be addressed. Many of these issues and questions will, no doubt, be addressed in the LRC Report on the matter to be published later in 2022.

The need for an overarching safeguarding framework in Ireland also arises because of the implications of an ageing population. There has been a focus on the impact that an ageing population will have on the public finances in Ireland.³⁵⁵ However, there is an equally important need to focus attention on the implications of an ageing population for safeguarding as longevity is likely to result in greater frailty and

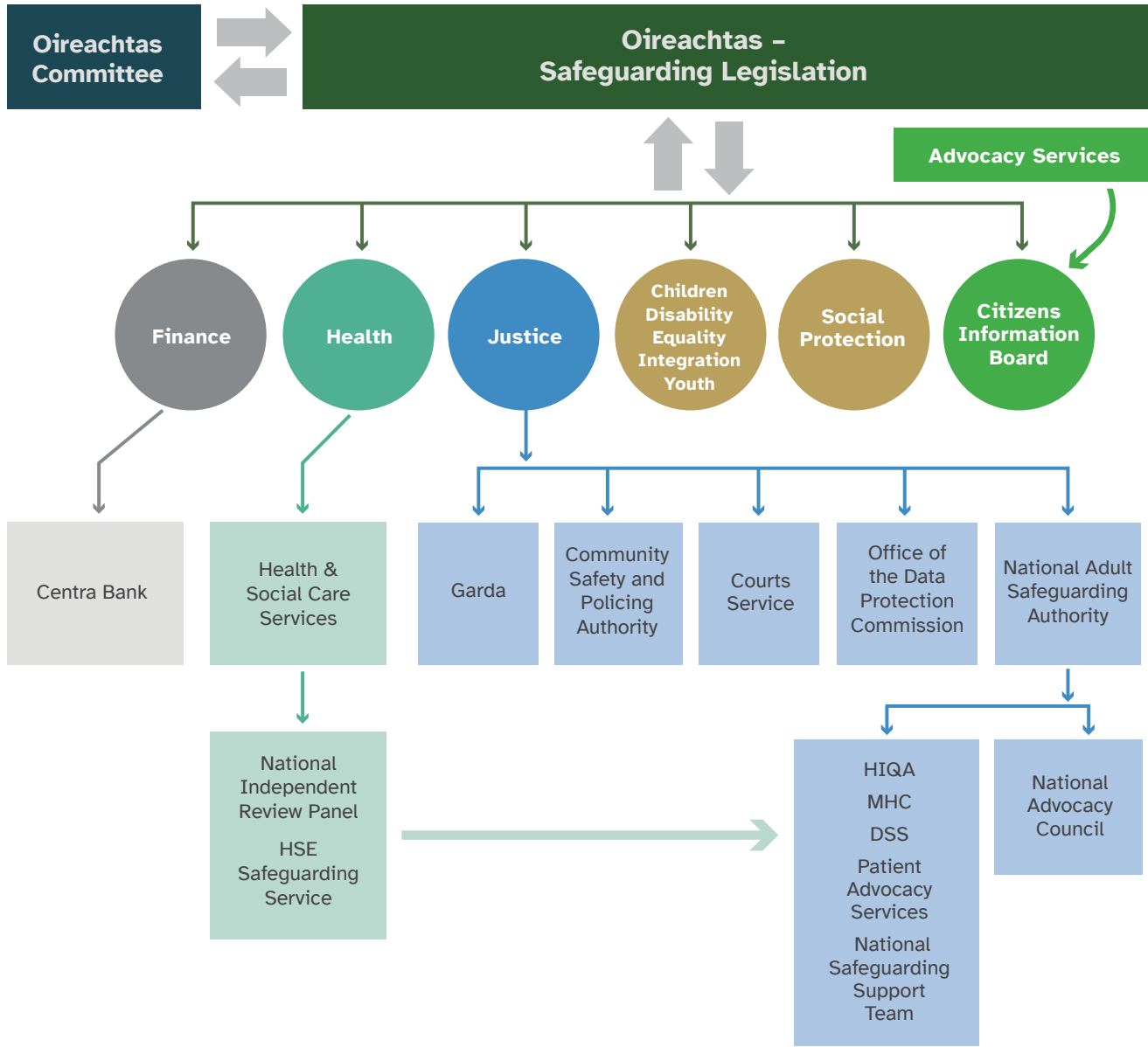
³⁵⁴ Browne, M. (2018) Independent Advocacy in Ireland – Current Context and Future Challenge safeguarding Ireland, <https://www.safeguardingireland.org/wp-content/uploads/2018/10/Advocacy-Scoping-Documents-Final-310818.pdf>

³⁵⁵ <https://www.gov.ie/en/publication/6ba73-population-ageing-and-the-public-finances-in-ireland/>

associated vulnerability and higher numbers of people with reduced decision-making capacity (e.g., as a result of dementia).

An overall national framework is required in order to create a context within which the legislative basis, the development and coordination of safeguarding initiatives can be effectively realised. A possible structure for a national framework is outlined in Figure 11.2 below.

Figure 11.2: Integrated National Safeguarding Framework



There is a clear need for an overarching safeguarding structure which will engage all appropriate government departments such as Justice, Social Protection and Health, agencies of state such as the Office of the Ombudsman, Mental Health Commission, Decision Support Service, HSE, HIQA, the Central Bank, as well as inter-sectoral entities such as An Garda Síochána, Safeguarding Ireland, financial institutions and independent advocacy providers.

Figure 11.2 above sets out the main components of such a framework. Its main components are:

1. Safeguarding legislation
2. Oversight by an Oireachtas Committee
3. A National Adult Safeguarding Authority
4. The involvement of Government Departments
 - Justice
 - Finance/Department of Public Expenditure and Reform.
 - Health
 - Social Protection
 - Children, Equality, Disability, Integration & Youth Affairs
 - Housing, Local Government and Heritage
5. Participation by key statutory agencies
 - National Safeguarding Office & Teams
 - Decision Support Service
 - HSE Health & Social Care Services
 - Mental Health Commission
 - HIQA
 - Citizens Information Board
 - Courts Service
 - Data Protection Commissioner
 - Central Bank/Financial Services Regulator
 - Irish Human Rights and Equality Commission
 - An Garda Síochána
 - The Housing Agency
6. Organisations providing independent advocacy services
7. Public interest representative roles at key levels, including senior management teams
8. A National Council for Independent Advocacy

The Assisted Decision-Making (Capacity) Act 2015 is central to the safeguarding agenda relating to adults at risk. This needs to be complemented by specific safeguarding legislation and the establishment of a National Adult Safeguarding Authority, the latter an independent agency within the remit of the Department of Justice as Lead Department. Relevant statutory bodies (the Decision Support Service, HIQA and the Mental Health Commission) would have a statutory obligation to report and interact with the National Adult Safeguarding Authority on safeguarding issues (as part of the interagency collaboration in relation to safeguarding).³⁵⁶

356 In relation to their main statutory function HIQA and the Mental Health Commission will be within the remit of the Department of Health and the Decision Support Service will be within the remit of the Department of Children, Equality, Disability, Integration & Youth Affairs.

All of the above will be necessary in order to implement the Assisted Decision-Making (Capacity) Act 2015 in a manner which delivers on what is intended by the legislation in respect of safeguarding adults at risk and what is required under the UN Convention on the Rights of Persons with Disabilities (UNCRPD).

Overview and Conclusion

This chapter has discussed the many weaknesses, blockages and deficiencies that seriously detract from the provision of effective safeguarding to vulnerable and at risk adults in Ireland. While it could be argued that some of these flaws might be corrected simply through the implementation of improved procedures and practices, it is clear that the creation of an adequate legislative foundation is crucial if Ireland is to have a fit-for-purpose safeguarding capability. The need for such a legislative foundation is further emphasised by the requirements of the Assisted Decision-Making (Capacity) Act 2015 and the compliance requirements of the UNCRPD.

The fragmented nature of the allocation of responsibilities for safeguarding between different state agencies and departments; the limits of powers and jurisdiction; the present emphasis on health and care settings alone; and the gaps in existing provision for safeguarding vulnerable adults in a number of areas, highlights the real possibility and danger that some vulnerable adults - who are at risk and/or potentially experiencing abuse - will not be provided with an effective and timely safeguarding response and are at risk of 'falling between the cracks' in the system.

It is recognised that many safeguarding concerns that arise annually are reported to and dealt with by the HSE Safeguarding and Protection Teams. However, the dearth of safeguarding and protection data generally and the multi-faceted nature of abuse raises critical questions about the actual proportion of all safeguarding issues are being referred to SPTs.

It is highly likely that the HSE SPTs will continue into the future, and under any new safeguarding legislative and policy framework, to play a crucial and prominent role in detecting risk and abuse, and in putting safeguarding plans in place for vulnerable adults. There is a very strong argument that Safeguarding and Protection Teams should be independent of the HSE.

It will, however, be important that any new safeguarding authority be empowered to adequately monitor and review the performance of the HSE SPTs, oversee compliance with statutory duties and standards, and ensure effective levels of inter-agency collaboration in the safeguarding arena.

Consideration will need to be given to the design and implementation of the most effective and appropriate arrangements for communications and interaction between the HSE, Safeguarding and Protection Teams and any new authority. There would appear to be a logical argument for transfer of the role of the National Safeguarding Office to within the structure of a new authority, thereby giving recognition to the reality of the extent of

vulnerable adult abuse across many aspects of society and across the remits of many agencies.

The clear need for multi-disciplinary and multi-agency approaches to safeguarding and the evidence that such collaboration, information-sharing and linked-up actions are frequently underdeveloped - both within and between agencies - highlights the importance of establishing a high-level authority that can enable, encourage, monitor, review and enforce the highest standards of cooperative practice.

The uncertainties that persist regarding access to, and the sharing of, data create barriers to effective safeguarding practice and is seen to contribute to levels of caution and reluctance regarding the taking of action, collaboration and safeguarding in general. Robust safeguarding legislation, clarification of other legislative provisions and the presence of an over-arching safeguarding framework and national authority is needed if these weaknesses are to be overcome.

There remains a lack of awareness amongst the general public, within institutions and agencies, and even within the ranks of health and social care professionals, as to what constitutes abuse of vulnerable adults. A culture that is dismissive of certain forms of abuse and that trivialises others, and that also plays down the human rights of many vulnerable adults, persists in Ireland. There is a need for an effective attack on this culture. The fragmented and specialised remits of various agencies, as noted earlier, limits their potential in this regard. There is a need for a national body that that can address the issue in a comprehensive and all-encompassing manner.

As noted in this and earlier chapters, the provision of access to independent advocacy will be essential for many people who are vulnerable and at risk of abuse. In addition to its importance with regard to safeguarding matters, advocacy is also an essential component in terms of decision-making. Its importance needs to be further provided for and emphasised in safeguarding legislation.

There will need for clear lines of demarcation and communication between any new agencies to be established within the remit of the Department of Justice as Lead Department. In particular, any new statutory agency with responsibility for domestic, sexual and gender-based violence must be integrated with a broader overall National Adult Safeguarding Authority.

The provision of a sound legislative basis for safeguarding and the creation of an overarching framework for its implementation will provide a strong signal regarding the importance of safeguarding, the unacceptability of abuse and the responsibilities involved for all concerned.

An overarching national safeguarding framework will point more clearly to the pathways for reporting and acting on situations and instances of suspected and/or observed abuse.

An overall national framework would create a context within which the legislative basis and the development and coordination of safeguarding initiatives can be effectively realised.

/ Chapter Twelve

Overview and Conclusion

This Discussion Paper has set out a range of factors relating to safeguarding adults at risk. The Paper is envisaged as complementing the important work of the Law Reform Commission in developing proposals for *A Regulatory Framework for Adult Safeguarding*.

The current safeguarding regulatory framework in Ireland has been described and its significant shortcomings identified. The challenges in implementing an integrated safeguarding approach arising from difficulties associated with data sharing and collaboration between agencies and professionals have been outlined.

The Paper has discussed the nature and extent of abuse of adults at risk in Ireland and identified a range of matters relating directly or indirectly to abuse and exploitation. Different forms of abuse of adults at risk have been described and analysed – financial abuse, coercive control, abuse in nursing home settings, self-neglect.

The critical role of independent advocacy in safeguarding adults at risk has been described in the Paper. The potential of the general social support infrastructure (both formal and informal) in safeguarding adults at risk has been explored and the main components of a national integrated safeguarding policy response have been identified.

Key points arising from the analysis

- The level of reported abuse of adults at risk is very significant as shown by annual statistics from the National Safeguarding Office – this point takes on a new dimension when the fact that a considerable amount of abuse goes unreported is taken into account.
- There is some strong anecdotal evidence about adults at risk being afraid to make a complaint about potential abuse within their household or residential care facility because of fear of repercussions.
- Research shows that one in eight people had taken no action in relation to abuse experienced and that a sizeable proportion of people did not have an informed understanding of what safeguarding means.
- The model of long-term care that exists in Ireland, with its inherent bias towards nursing home care and lack of meaningful choice, results in a situation where adults at risk are not being properly safeguarded – this reality came into sharp focus with Covid-19 when nursing home residents were put at very much increased risk by virtue of the fact of being in a congregated setting.
- There is research evidence and strong case evidence that residents in nursing homes are sometimes abused by staff, either by neglect, deprivation of liberty, coercive control or by not having their will and preferences respected.
- Despite the strong emphasis in public and policy discourse on people's legal and human rights and on respecting people's will and preference, there continue to be situations where adults at risk are 'put into' a nursing home against their will and are thus effectively deprived of their liberty.
- Early intervention and the implementation of effective safeguarding and protection plans is difficult due to a lack of services and resources such as home supports. In some instances, there were relatively few social workers available to carry out these roles or their caseloads were so high that waiting lists were in operation.

- Older adults at risk are vulnerable to financial abuse as a result of people (usually relatives) deliberately taking their money or encouraging and facilitating them to transfer money and property to relatives or to put money into a joint account.
- There is strong research and case evidence that people are reluctant to engage in forward planning or to put in place an Enduring Power of Attorney and an Advance Healthcare Directive or use the 'Think Ahead' framework – this can leave people at high risk of exploitation and vulnerable if they lack decision-making capacity.
- Because there is a significant public misunderstanding about the role of 'next-of-kin', it may be the case that relatives believe that they can make decisions for people whose decision-making capacity is reduced and act accordingly – this practice may not be identified by professionals as abuse and exploitation, particularly when it refers to disposal or transfer of assets or decisions on place of care.
- There are strong indications that many forms of abuse are considered 'trivial' and acceptable, and have become normalised by society, despite the fact that they involve infringements of the human and legal rights of at risk adults and are exploitative.
- Policy efforts addressing the abuse of adults at risk may tend to focus on more extreme forms of violence, sometimes at the expense of attending to everyday abuse and exploitation – this needs to be changed.
- As a society, we may have conflicting values relating to safeguarding adults at risk – on the one hand, we want nobody to be the victim of abuse and exploitation while, on the other, we may not see this as part of our responsibility as citizens.

Adult safeguarding regulatory framework

There are a number of basic shortcomings in the current regulatory framework for adult safeguarding. Centrally important is the fact that there is no uniform framework for regulating safeguarding across all settings/contexts. Other areas where there are important regulatory shortcomings are:

- Absence of regulation of Home Care Services
- Limited form of protection afforded by current regulation of Nursing Homes
- No regulatory body with responsibility for receiving complaints of all types of abuse – physical, psychological, sexual, emotional, financial abuse, neglect as well as breaches of people's legal and human rights and a failure to respect at risk adults' will and preferences
- No regulatory body with responsibility for, and powers to, investigate individual cases of abuse reported in residential care settings

- No overall framework to facilitate inter-agency co-operation and collaboration in identifying and responding to abuse of adults at risk
- No dedicated statutory provision for safeguarding, either in legislation or through a National Adult Safeguarding Authority
- No statutory provision for the practice of independent advocacy
- Restrictive scope of the Domestic Violence Act 2018 (confined to people in intimate relationships)
- No statutory provision for dealing with self-neglect by adults at risk.

Safeguarding adults at risk can be a complex and multi-faceted process. Risk can arise in multiple settings ranging from institutional residential facilities through to private dwellings and in the general community. At present, a number of public bodies have responsibility for various aspects of adult safeguarding. However, the absence of a single regulatory authority limits the effectiveness and scope of safeguarding provision, not only within service settings but also within the wider community.

There is a clear need for fundamental changes to the existing safeguarding legislative and policy infrastructure. Such a framework is required to provide legislative clarity and certainty and which would remove challenges to effective action by safeguarding personnel.

The regulatory framework will need to make provision for ensuring that:

1. The powers necessary to set and enforce standards in all relevant areas of adult safeguarding are in place;
2. There is a widespread and universal rights-based and proactive approach to the safeguarding tasks involved;
3. All relevant bodies are authorised and held accountable under a statutory duty to safeguard at risk adults and that their performance is monitored and assessed;
4. Collaboration between relevant bodies is not only maximised, but that it is a mandated duty.

The establishment of a dedicated regulatory authority will allow for overseeing the investigation of complaints, the monitoring of the performance of individual agencies and bodies with regard to their safeguarding duties, the ensuring of collaboration and information sharing and the promotion of the rights of adults at risk.

It will also be important that any regulatory authority that is established will have the power to oblige non-state organisations and bodies to take all steps necessary in order to protect adults at risk. This will be especially crucial in the case of financial institutions.

Effective inter-agency collaboration cannot be simply dependent on the interest and commitment of individual leaders and champions within organisations. It must be seen as an essential element, structured and supported by regulatory provisions. A cross-cutting, whole-of-government approach is clearly needed if adults at risk are to be effectively safeguarded.

Challenging the prevailing culture relating to abuse of adults at risk

While safeguarding regulation and enforcement is highly important, a singular focus on this aspect of safeguarding alone will not be sufficient and may, in fact, divert attention from the need to tackle the culture and attitudes that deny at risk adults their basic rights as citizens and which can result in abuse and coercive control in one form or another. The challenging of this culture of acceptance, both within institutions and services and across the wider community, will demand an ongoing programme of effective awareness raising, information and education. Legislative clarity will, hopefully, also emphasise and reinforce the message that vulnerable adults have human and legal rights and that abuse and denial of these rights will not be tolerated.

Need for an overarching safeguarding structure

There is a clear need for an overarching safeguarding structure which will engage all appropriate government departments and state agencies such as the Office of the Ombudsman, Mental Health Commission, Decision Support Service, HSE and HIQA as well as inter-sectoral entities such as An Garda Síochána, Safeguarding Ireland, financial institutions, and independent advocacy providers.

The components of such a structure have been identified in the Discussion Paper as:

- Safeguarding legislation
- Oversight by an Oireachtas Committee
- A National Adult Safeguarding Authority
- The involvement of five Government Departments
 - Justice
 - Health
 - Children, Equality, Disability, Integration & Youth Affairs
 - Social Protection
 - Housing
 - Finance
 - Children, Equality, Disability, Integration & Youth Affairs

- Participation by key statutory agencies
 - National Safeguarding Office & Teams
 - Decision Support Service
 - HSE Health & Social Care Services
 - Mental Health Commission
 - Citizens Information Board
 - Courts Service
 - Data Protection Commissioner
 - Central Bank/Financial Services Regulator
 - An Garda Síochána
- Organisations providing independent advocacy services
- Public interest representative roles at key levels, including senior management teams
- A National Council for Independent Advocacy

The Assisted Decision-Making (Capacity) Act 2015 is an integral part of the safeguarding adults at risk agenda. This will be complemented by adult safeguarding legislation and the establishment of a National Adult Safeguarding Authority, the latter, an independent agency within the remit of the Department of Justice as Lead Department. Relevant statutory bodies (the Decision Support Service, HIQA, the Mental Health Commission) will have a statutory obligation to report to and interact with the National Adult safeguarding Authority on safeguarding issues, as part of the interagency collaboration required in relation to safeguarding adults at risk.³⁵⁷

It is suggested that all of the above components will be required in order to implement the Assisted Decision-Making (Capacity) Act 2015 in a manner which delivers on what is intended by the legislation and what is required under the UN Convention on the Rights of Persons with Disabilities (UNCRPD) in relation to safeguarding adults at risk.

Need for innovative thinking about safeguarding adults at risk

We need to develop a new vision of what we want in terms of safeguarding our adults at risk population, individually and collectively. Society, as a whole, requires new thinking and an attitudinal shift if we are to deliver the safeguarding and protection that adults at risk have a right to, deserve and should expect.

³⁵⁷ In relation to their main statutory function, HIQA and the Mental Health Commission will be within the remit of the Department of Health and the Decision Support Service will be within the remit of the Department of Children, Equality, Disability, Integration & Youth Affairs.

Responses are required at the societal level in terms of awareness and at political level in terms of challenging embedded social and cultural norms about what constitutes abuse and exploitation and what should be done to prevent it and to address it proactively when it occurs. This is integral to creating a safer society for at risk adults.

There is a need for a much clearer understanding of people's rights, will and preferences irrespective of their decision-making capacity. Pending the full commencement of the Assisted Decision-Making (Capacity) Act 2015, in cases where people do not have decision-making capacity, current legal protections need to be adhered to despite their limitations. For people who do have decision-making capacity, their consent is always required on all matters affecting them, including, in particular, managing their finances and where they are cared for.

In Ireland, we now need to have a serious conversation about how to better safeguard adults at risk, both individually and collectively. This conversation needs to take place at societal level, at policy level and at the political level. The ethic of social solidarity and justice for all citizens demands no less. The Covid-19 experience of deaths of people in nursing homes and denial of basic human rights provides an additional impetus (if such were needed) for radical action in the context of safeguarding those most at risk. It is a stark reminder that new societal values relating to the delivery of health and social care in later years for an ageing population are imperative. Fundamentally, we need to address the issue of 'misrecognition' when it comes to the abuse and exploitation of adults at risk.

While there has to date been a tendency to view adult safeguarding as predominantly a 'health/social care' issue and to assume that health and social care agencies should carry primary responsibility for protecting adults at risk, there is a need to recognise that adult abuse can occur in many other sectors of daily living and that there is, therefore, a need for safeguarding mandates, responsibilities and mechanisms across all sectors that come into contact with or provide services to adults at risk, including, *inter alia*, financial institutions, housing, An Garda Síochána and local government.

There has been much discussion about the rights of adults at risk to participate as fully as possible in the decisions that affect them. There will need to be stronger acceptance throughout society of the fact that the realisation of human rights can only, in many cases, be effective if coupled with the supports and protections necessary to facilitate the exercise of those rights.

The full establishment and implementation of a safeguarding regulatory framework will be required to effect a move from aspiration to practice.

Looking to the future

In developing a regulatory framework, it is necessary to impose a statutory obligation on state bodies and organisations to prevent or reduce abuse in all its forms and not to be focused on the management of crises/acute responses as is currently the case.

Empowerment and safeguarding of at risk adults require both legislative, regulatory and policy provisions. The absence of adequate and appropriate legislative foundations weakens effective actions at the implementation levels, allows for confusion and over-caution in safeguarding response decisions and results in loopholes for people who wish to exploit others or who hope to avoid responsibility for their negligent approach to safeguarding.

Some of the issues raised in this Discussion Paper are clearly more central than others but all contribute to a situation where adults at risk are not well safeguarded in Ireland at present. There is inadequate acknowledgement by society in general that safeguarding adults at risk is everybody's business.

Safeguarding means putting measures in place to uphold rights by supporting health and well-being and reducing the risk of harm. It involves families, services and professionals working together to prevent adult abuse, neglect, or coercive control. It also involves neighbourhoods and local communities.

Finally, in considering the matter of safeguarding adults at risk and upholding their basic human and legal rights not to be subjected to abuse and exploitation, it needs to be acknowledged that the society we live in at present is deeply flawed in that it appears incapable of providing safe and humane care and support and offers such limited options for its most at risk and vulnerable members. The critical question that must be addressed is what values underpin our policy choices and whether these values are commensurate with an integrated safeguarding approach which puts people's human and legal rights at the very centre.

/ Appendix

Abuse of Adults at Risk: Eleven Indicative Case Scenarios

As part of the methodology involved in preparing this report, an analysis was carried out of case material provided to Safeguarding Ireland by a number of agencies and actors involved in areas relating to safeguarding adults at risk. These included health and social care, and financial and income support agencies and institutions. The Appendix contains 11 case scenarios.

Case material was also received that has not been included in the Appendix as there were concerns regarding any risk that individuals could be identified. It should be noted that the material excluded from the Appendix has also significantly informed the research.

While some changes have been made in order to preserve the privacy of individuals and the anonymity of all involved (clients and professionals) – names of people, places and institutions have been changed – the case scenarios remain true to the real situations and actions involved.

Some of the case scenarios include the views of the personnel involved, regarding the adequacy and/or shortcomings of legislative provisions as applied to the safeguarding situations that were encountered.

Case Scenario 1: Áine

Áine is 64 years old and has been resident in a private nursing home for 10 years. Following a road traffic accident, Áine sustained a brain injury which leaves her reliant on carers for all activities of daily life. Her communication is severely restricted and she has minimal family or social support.

Notification from Private Nursing Home

The nursing home contacted the Safeguarding and Protection Team (SPT) to advise that the Health Information and Quality Authority (HIQA) had instructed them to refer an allegation of physical abuse to the SPT. Following an unannounced inspection by HIQA, it emerged that unexplained bruising to Áine's arm had not been reported to her GP. The GP visited following the HIQA inspection and determined that the injury could have been non-accidental. The Person in Charge requested the support of the SPT in the investigation and management of the concern. The social worker agreed to meet the Person in Charge and go through the allegation in some detail. The nursing home management were open and receptive to a safeguarding intervention.

Assessment Phase

In the course of the assessment, it emerged that the nursing home had been reliant on a bank of temporary staff, some of whom were not fully conversant with patient care plans and, in particular, the use of

full body hoists for patients like Áine, who require assistance of two carers for all transfers. The Person in Charge, on reviewing the rota and on interviewing care staff, established that Áine's care plan had not been followed in all instances and that this appeared to be the most reasonable explanation for the bruising sustained. It was evident that members of the care team had not always used the hoist equipment as recommended in Áine's Care Plan.

Outcome

The SPT recommended that the nursing home consider hiring an Occupational Therapist on a sessional basis to review care plans, the use of aids such as hoists and to assist staff training on repositioning techniques, etc. In addition, the use of body maps was instituted for instances when an incident of bruising was noted, along with a recommendation that all occurrences of unexplained bruising be immediately notified to the GP.

Limitations of existing legislation

Were the nursing home not receptive to support from the SPT, it would have been difficult for the SPT to gain access to what is, essentially, a private facility (*powers of entry*). It is unclear if the nursing home involved would have notified this allegation to the SPT were it not for the instruction from HIQA (*mandatory reporting*). This nursing home was, in this instance, receptive to safeguarding support but in the event that they were not there could have been a very different outcome for Áine and for other residents who cannot readily communicate their needs.

Case Scenario 2: Gerry

Concern

A referral was received from a housing association in relation to Gerry, a 46-year old man with mild intellectual disability (ID).

Concern was raised that Gerry was being coercively controlled by a person who had moved into his property. This person had a previous history of high involvement in anti-social behaviour and was known to Gardaí.

Concern was raised that Gerry was possibly afraid of this person and unable to get him to leave.

Intervention

The SPT liaised with Community Gardaí regarding the concerns raised.

Gardaí, the SPT and the housing association met with Gerry and alleged person causing concern regarding the matters raised. The person causing concern did not engage with this process and was verbally abusive towards Gardaí.

The SPT liaised with Gerry's GP who deemed that Gerry had capacity to make decisions.

The SPT met with Gerry to discuss the concerns raised, to get his wishes and to discuss a possible safety plan, including working with the housing association and Gardaí to: (a) notify the person allegedly engaging in coercive control that he would have to vacate the property, (b) changing the locks on the doors and (c) arranging for the Gardaí to be called should things escalate.

Limitations of existing legislation

In this case it became apparent that there is a lack of a legislative basis for dealing with domestic violence cases for non-intimate partners which would have been very useful in this case.

Case Scenario 3: Kerry

Kerry is a 20 year-old person with a mild ID and autism. She is attending a local learning support service and has begun to withdraw from them. Staff are shown, by other students, details that Kerry is putting up on Facebook about her boyfriend. The tutor meets with Kerry who tells the tutor that the boyfriend is in Africa and they have a great relationship. He is planning to visit and she is sending him money to help buy his tickets. She also told the tutor that she is sending naked photos to him and he sometimes gets cross if she doesn't do it straight away. He also gets cross if she is not nice to his friends who call to see her when her mother is out at work. This is why she has been missing classes in the college as she has to be there to meet them.

She is unwilling to make a complaint to Gardaí as she believes that this man is her boyfriend. She does not want to tell her mother or other family members.

Options

- Currently, the sexual abuse could be reported under the Withholding Information legislation – however, she may decline to attend a Sexual Assault Treatment Unit (SATU) assessment or to give a statement;
- Training on sexual health could be recommended and counselling to help explore options;
- Consideration of Ward of Court application or options to be available under the Assisted Decision-Making (Capacity) Act 2015 once the latter is commenced;
- Consideration on how to limit social media might be considered but very difficult to monitor so more education around safe use of social media could be mandated.

Case Scenario 4: Eileen

The SPT received a referral in respect to a person at risk in the community. Eileen is an 82- year old woman residing with her two siblings (John and Paula). Eileen is being cared for by her 81- year old sibling (Paula). The concerns reported were in respect to neglect and psychological abuse. The reporter alleged that Eileen has advanced dementia and her care needs are being neglected. It was alleged that Eileen is being denied medical treatment and support by her carer. Concerns were also relayed in respect of the carer's (Paula) own health and ability to care for Eileen. Only limited information could be collated from the Public Health Nurse (PHN) or GP at the time of the referral. Family were not known to services. There had been one previous safeguarding report in 2019 in respect to carer (sister) refusing medical assessment and intervention on behalf of Eileen and being unable to meet her care needs. Family are very isolated in the community with no contact from relatives or professionals.

Paula initially refused entry to the home by the safeguarding social workers. Paula eventually agreed for workers to complete a home visit. During this home visit, Eileen's presentation and behaviour was of concern (limited communication, agitated, fidgeting) and she was unable to engage with social workers. Eileen's hair was observed to be extremely matted with a large mark on her face which reporter alleges to be skin cancer. There were discrepancies in the information provided by the sibling Paula in respect to Eileen's health and level of care required. Paula advised that Eileen has advanced dementia – however, no formal diagnosis had been made. Paula disclosed concerning information regarding Eileen's presentation and behaviour including confusion, pacing, agitation, difficult sleep patterns, unable to communicate, fearful of water, refusing personal care, incontinence issues. However, she later retracted these concerns and advised that she is managing Eileen's care well. Paula refused to have Eileen medically assessed, stating she does not believe in medication/treatment for dementia Paula (carer) refused all community services such as home carer support. Paula presented as very low in her mood, suffering grief and loss (a sister passing away) and reporting she is unwell herself – however, she will not seek medical attention.

The family are financially independent with Eileen and Paula having a number of properties. Eileen is unable to manage her own finances and Paula has no access to Eileen's finances. Paula stated that she does not require access to Eileen's finances to order to support her.

The SPT are unable to determine Eileen's medical and health needs at this time. Eileen is not in a position to attend a medical assessment herself and her carer also not willing to support Eileen in obtaining a medical assessment. Community services, GP/Consultant Geriatrician, are limited in their capacity to complete home visits.

There are concerns in respect to Paula's ability to meet Eileen's t needs due to Eileen's high level of care needs and concerns regarding her presentation and behaviour. Paula is currently refusing all medical

intervention on behalf of Eileen and community supports. Paula refuses to allow other relatives entry or to have contact with Eileen and is reluctant to agree to ongoing social work intervention.

The only option available to the SPT is an emergency Ward of Court order which may result in Eileen's immediate removal from the home. Since she has not left her home in years, she may have to be restrained and sedated for this removal to occur. Consideration to removing her sister (carer) under the Domestic Violence legislation may also be considered but without medical information would be very difficult to secure.

Need for Safeguarding Legislation

Safeguarding Vulnerable Adults at Risk of Abuse legislation would support intervention in respect to the above person. Eileen has a right to medical assessment and treatment, dignity and respect in regards to her care and well-being, and a right to reside in an environment conducive to meeting her needs.

Appropriate safeguarding legislation would underpin social work intervention in respect to the following:

- Allow ongoing entry into the home for continued assessment and intervention to reduce the impact of harm in respect to allegations of neglect;
- Ensure that Eileen has access to medical and health services in the community, specifically mandating professionals to conduct medical assessments of persons at risk in the community;
- Provide for carers/family members to be mandated to follow through with treatment and care plans in respect of the person at risk where the person lacks capacity to ensure that an intervention plan is implemented;
- Ensuring that the person's basic right to be fully safeguarded in all situations is upheld;
- Access to Eileen's funds may allow for private care to allow her to stay in her home rather than move to a care home.

Case Scenario 5: Joseph

Joseph is 40 years old and has an intellectual disability. He lives independently with support from a HSE-funded service which he attends on an *ad hoc* basis.

Joseph's mother has died in the recent past. She was his only close living relative as his father died when Joseph was young and Joseph has no siblings. He does have some first cousins who call from time-to-time and who ensure that he is included in family occasions.

Joseph has been left a significant amount of money following the death of his mother and this has been deposited in his bank account.

Joseph is lonely and neighbours have reported to the Local Authority (LA) that there has been a lot of “anti-social” behaviour around Joseph’s flat in recent months and a lot of “late night activity” with people coming and going. As a result of ongoing complaints, the LA tenancy officer has called and Joseph has been told his tenancy is at risk.

An anonymous referral is made to the safeguarding social worker which alleges that Joseph is also appearing in a dishevelled state. The social worker calls to Joseph and, while he acknowledges the issues with neighbours and “money management issues”, he reports that everything is fine. He is happy to receive support but in a very limited way. Over a period of time, the social worker gains Joseph’s trust and he consents to her linking with the other services that Joseph is engaged with.

The social worker calls a case conference and invites Joseph and all of the services who have contact with him to attend. There is an open discussion with Joseph and a plan is developed to safeguard Joseph.

Joseph is supported and he begins to attend his day service regularly. He also begins to address rent arrears and agrees to a budgeting plan.

The issues with his “friends” persist, however. The Council threatens to evict Joseph and Gardaí have intelligence that drugs are now being dealt from the apartment.

Eventually, Joseph is rushed to hospital on Sunday morning with serious head injuries following an assault at his own house.

Limitations of existing legislation

In this case, the sharing of appropriate information was very important so that a full picture of what is going on for Joseph can be established and each agency is not working with a “silo” mentality.

However, there is no obligation on state services to attend a case conference and the sharing of information can be problematic. A legislative basis for this to happen would ensure that the right people are in attendance and share the appropriate information as necessary and in a timely fashion.

The absence of legislation to specifically exclude or bar someone known to be a cause of a safeguarding concern from Joseph’s house is a gap here. Potentially, if legislation enabled the social worker to seek a ban or exclusion order against a third party (such as Joseph’s ‘friends’) from his home, it could have been an important tool in safeguarding Joseph.

Case Scenario 6: Seamus

Seamus is 87 years old and lives with his adult daughter Sally in a rural setting. He is a widower and has three other adult children whom he rarely sees. Seamus was a farmer and a number of years ago he transferred ownership of the farm to his daughter. Seamus retained ownership of his home which he continues to share with his daughter. Seamus is not known to primary care services and has not been seen in the community for many years.

Context of referral

Seamus was admitted to hospital following a respiratory infection. While an inpatient, he discloses the following information to the medical social worker:

1. He has not had access to his pension for over 5 years, his daughter Sally is agent and in receipt of Carer’s Allowance.
2. Sally does not allow his other adult children to visit; this has been further compounded by the recent pandemic and public health advice regarding the ‘cocooning of older adults’.
3. Sally does not like people to intrude on their lives, she is described as ‘mistrustful and suspicious’.
4. Sally contacts the hospital to advise that no other family members should visit and states that she is the ‘Next of Kin’ and should be consulted on all matters. Sally issues solicitor’s letter to hospital instructing that a power of attorney is in place naming her as her father’s representative.

In addition to the above disclosure, Seamus’s non-resident daughter contacts the hospital alleging that her sister Sally delayed seeking medical treatment for their father as she is very ‘reclusive and controlling’.

Initial intervention:

Seamus consents to referral to SPT who arrange to meet Seamus in hospital. Following meeting with Seamus to establish his will and preference, the following plan is agreed:

1. Seamus feels that in order to have a relationship with his other children he will need to move to nursing home care. He is reassured by the safeguarding social worker that she will follow up with him on discharge and assist him with arranging a return home should he change his mind regarding nursing home placement.
2. Seamus gives consent for the safeguarding social worker to address concerns with his daughter; he declines consent for social worker to contact the Department of Social Protection on his behalf.

Following meeting with Sally, the safeguarding social worker establishes that Sally’s relationship with her other siblings has broken down entirely. Sally presents as very controlling with respect to her father, she does not acknowledge his rights to determine where he lives and threatens to initiate legal action against the HSE for detaining her father in a ‘nursing home against his will’.

Following a two-week period in the nursing home, Seamus makes the decision to return home to the care of his daughter. The safeguarding social worker initiates contact with Sally and explains that she will be assisting Seamus with a return home.

A Safeguarding plan is devised in line with Seamus’s will and preference which details the following:

1. That Sally will provide Seamus with his pension card and return any monies owing to him;
2. That there will be no further restrictions on other family members visiting Seamus – to this end a visiting rota will be instigated;
3. That home help will be provided on a daily basis to assist Seamus with personal care and monitor home situation, reporting any concerns immediately to the safeguarding social worker;
4. That an Occupational Therapist (OT) will assess Seamus’ home prior to discharge and that Sally will co-operate fully with any recommendations in line with her responsibilities under DSP carers allowance scheme;
5. That the safeguarding social worker will continue to visit Seamus on discharge and ensure that Seamus has the opportunity to express any concerns with respect to his home situation so that any such concerns can be addressed in a timely manner;
6. With Seamus’s consent, the safeguarding social worker will continue to engage with non-resident adult children to ensure efficacy of the safeguarding plan.

The above case illustrates how coercive control tactics can be used in non-intimate relationships to extort monies and exploit relationships of trust. Even if it were legally possible, it is unlikely that Seamus would have consented for the HSE to initiate an order on his behalf. Seamus had an ambivalent relationship with his daughter Sally -he recognised that, while she was controlling, there were times when they got on well and enjoyed each other’s company. Seamus showed insight into Sally’s difficulties, he explained that the attachment relationship which Sally had with her mother had been critical in how she went on to manage all of her adult relationships.

Seamus did not feel in fear of Sally and knew that without her continued support, albeit conditional, he would not be able to live in his own home. The role of the safeguarding social worker in this case was focused on building a supportive and trusting relationship with Seamus that would allow him sufficient time to make an informed decision about where he wished to live. Once Seamus had made the decision to return home, the social work intervention moved towards planning for how this could be done safely, ensuring that Sally’s controlling tactics could be curtailed. Sally continued to retain control of Seamus’s finances and, at that time, he was clear that he did not wish to further challenge this arrangement.

For Seamus, the fact he was living at home and could enjoy unrestricted visits from his children, grandchildren and neighbours was the most important outcome.

Case Scenario 7: Tom

Tom is approximately 62 years old, living in a very rural area. He is the youngest of three siblings who have always lived at home in very withdrawn circumstances. Following the death of their parents, the older two siblings have taken over the caring role. It is thought that Tom was never formally assessed but from collateral information provided by referrer it is probable that Tom has an undiagnosed learning disability.

Context of referral

Neighbour phones local SPT advising that Tom has been calling to their home looking for food. Tom appears unkempt and confused. Neighbours concerned that he may be locked in the house at night.

Initial response to referral

Background information sought from referrer. Query as to whether neighbour will be in a position to facilitate Safeguarding Social Worker meeting with Tom in the local Health Centre. The neighbour does not think Tom would be agreeable to this appointment as he fears his older brother.

Background checks carried out on a ‘need to know basis’ and in the absence of Tom’s consent:

1. Safeguarding Social Worker contacts local PHN who advised that neither Tom nor his family are currently known to the nursing service;
2. Gardaí advise that they are aware of Tom’s circumstances but report that the family are very private and sometimes in dispute with neighbours over land issues;
3. GP reports that while Tom is registered with him he has not seen Tom in over 10 years;
4. GP reports that from local knowledge Tom may have attended a ‘special school in his youth’;
5. Contact was made with HSE Disability Office who confirmed that Tom was a pupil in a Special School in the late 1960’s – on the basis of this information, it may be assumed that Tom has a mild learning disability.

Initial action taken

The GP agrees to carry out routine home visit to Tom to review his medical status and request Tom’s consent regarding a referral to SPT.

Following a routine visit, the GP reports the following to Safeguarding Social Worker:

1. Tom and his two older siblings living in squalid and substandard accommodation;
2. Tom appears to be malnourished and fearful in the presence of his older brother;
3. GP agrees to effect hospital admission for Tom to review ulcerated leg;
4. Tom is agreeable to a referral to an SPT social worker.

In advance of admission to hospital, the SPT liaises with the medical social work team and gives background of case. Tom discloses the following concerns to safeguarding social worker:

- He does not have access to his disability payment;
- He does not have access to regular cooked meals;
- Tom alleges that both he and his sister have been subjected to physical, psychological and financial abuse by his brother.

Tom does not want to report complaints to Gardaí and wishes to return home (the home is jointly owned by all three siblings). Tom may consider the HSE making an application for a Safety Order on his behalf if it means he can return home.

Tom has a positive relationship with his sister who tries her best to support and provide meals etc., but she is limited in this regard as her brother also controls her finances.

Tom consents to Safeguarding social work staff meeting with his brother to address the concerns. Garda assistance is sought for this meeting. During this meeting, Tom’s brother acknowledges that he has been physically abusive towards his siblings and had taken their money to feed his alcohol dependency. Tom’s sibling agrees to consider residential detox. Safeguarding social worker advises of HSE’s intention to initiate application to District Court for a Safety Order.

Outcome of Safeguarding Intervention

1. Tom will return home in line with his stated will and preference but in advance of this a thorough clean-up of the home is planned;
2. Tom reports a positive and caring relationship with his sister who appears to have mental health difficulties for which she has not sought treatment; GP refers her to local mental health team who become involved;

3. Tom’s brother avails of residential detox before returning to the family home;
4. With Tom’s consent, the HSE initiates an application for a Safety Order; Protection Order granted in lieu of full hearing;
5. Tom returns home with regular home help and meals on wheels in place;
6. Tom begins to attend disability day service and options available for occasional residential respite;
7. The home situation is now subject to regular monitoring by a safeguarding social worker.

If Tom’s GP had not gained access or had declined to visit Tom at home, this outcome may have been very different. The safeguarding team could have sought the assistance of the Garda in gaining access to Tom but this too could have proven difficult if Tom, because of fear of reprisal from his brother, had declined social work assessment. In this latter instance, legislation permitting ‘power of entry’ for the purpose of assessment could have proved beneficial.

Case Scenario 8: Georgina

Georgina is 35. She has an intellectual disability. The mental capacity of Georgina is unknown but her family would describe her as being unable to understand anything or to communicate her wishes. Georgina is cared for by her family on a full-time basis.

A report was made to the safeguarding social worker that Georgina is being abused by her family. She has no access to her own money and is physically assaulted as a way of controlling her behaviour. When the safeguarding social worker calls, the family are open in admitting that Georgina does not get her money and they do use physical force.

The social worker meets Georgina on a number of occasions and, while it is obvious that she has an intellectual disability, she is able to communicate and remembers the social worker from visit to visit.

A safeguarding plan is agreed with Georgina to include:

- Georgina to be assessed for a placement at a day centre;
- Georgina to be offered regular respite care at a residential centre;
- Georgina to be assessed for independent living or supported living;
- Georgina to have access to her disability allowance.

The assault matters were referred to An Garda Síochána.

The plan started well and Georgina was brought for her initial respite care stay. However, she was removed early. Cooperation with the family began to deteriorate and they refused to engage with any other parts of the plan. They refused to answer phone calls and they refused social workers’ access to the house and to allow them to see Georgina.

While a number of months were spent trying to engage the family again, it was eventually necessary to apply for Wardship in order for Georgina's rights to be vindicated and to ensure her ongoing safeguarding.

In this case, legislative provision to prevent Georgina being removed from the respite care centre would have been important. Between that event and her eventually having to be made a Ward of Court, a substantial period of time elapsed when Georgina was not being safeguarded. The only current option would be to refuse discharge from the respite care centre and to refer the matter to the High Court, as was done in the AC Case³⁵⁸.

Also, it would be important to include regulatory provision that a third party cannot block a planned assessment in the first place (as the parents did in this case).

Finally, the fact that social workers were blocked from being able to access Georgina in her own home led to heightened concerns for her welfare. A legislative power to prevent such behaviour would ensure social workers get direct access to the client as necessary and would cut out the issue often faced of someone else "gate-keeping" access to the client.

Case Scenario 9: Self-neglect case

Concerns

The Safeguarding and Protection Team received a referral in respect to 69-year old woman due to the following concerns:

- Allegations of financial abuse;
- Self-neglect;
- Lack of food in home;
- Unkempt appearance;
- Environmental concerns;
- Significant amounts of rubbish in the property;
- No electricity in the home; and
- Allegations of substance abuse.

The woman lived with two adult sons and was also supported by her two daughters. The family have long standing issues of neglect and environmental concerns. This woman suffered a stroke as SPT referral was received. However, she was discharged from hospital after a number of weeks with no rehabilitation goals, follow-up or advice for family on how to support her.

GP and Geriatrician have no contact with the person due to their restricted capacity to complete home visits despite repeated requests from the SPT that there were concerns about increasing physical frailty and her ability to make decisions.

³⁵⁸ This case refers to a woman who was being "detained" by Cork University Hospital (CUH) against her wish (allegedly) and against the wishes of her adult children. See Supreme Court decision in the AC case <https://www.casemine.com/judgement/uk/5df-c6a614653d042431b0cbc> which has been discussed in Chapter Nine of this Paper.

Intervention

- It was assessed that there were significant concerns in regard to self-neglect;
- There was no evidence in respect to the allegations of substance abuse in the home;
- There was no evidence to suggest that the person did not have capacity to make decisions; however, due to the pattern and history, she was assessed as vulnerable in respect to the self-neglect;
- Following her stroke, her cognition appeared to deteriorate and there was evidence of fluctuating mood and memory – the GP and Consultant Geriatrician were requested by SPT to review same;
- There was no evidence of financial abuse. The woman stated that she had nominated her daughter to collect her pension when she could not and was happy with this arrangement;
- The family were extremely reluctant to have SPT involvement and were very wary of any such involvement;
- The SPT attended the home but were not allowed inside on a number of home visits initially – gradually, the SPT built a rapport with the family and engagement increased;
- A letter was sent to GP/Consultant Geriatrician due to concerns for the person's health, particularly over concerns person was malnourished;
- Geriatrician appointment scheduled; however, she missed a number of appointments and SPT supported family rescheduling and exploring barriers;
- On the day of a rescheduled appointment to see the Geriatrician, the social worker called to house to ensure that the client would attend appointment and had a taxi arranged. However, the person was semi-conscious in the bed so the social worker rang ambulance who brought her to hospital.

Specific actions taken

- Emergency services were contacted on several occasions by the social worker during home visits, due to the person's health deteriorating, concerns about malnourishment and a visibly worsening pressure sore. However, she was assessed to be stable by paramedics and she refused to attend hospital on those occasions.
- Consultation occurred with the Principal Social Worker in seeking legal advice regarding the concerns and consideration of a Ward of Court application without the support of medical reports.
- The person refused community supports but agreed to address concerns in respect of the environment – a skip was organised to help with clearing the rubbish.

- Support was given in respect to budgeting and ensuring electricity was topped up consistently in the home.
- SPT liaised with GP recommending a Geriatrician assessment due to self-neglect and impact on health – GP confirmed that the person had capacity to make decisions.
- SPT liaised with PHN in respect to the person's care needs and the PHN conducted weekly home visits.
- The client reluctantly agreed to a Home Care Package and a Meals-on-Wheels service;
- A referral was made to OT who conducted assessment and completed their intervention;
- The SPT made representations in respect of the person accessing basic essentials via the Community Welfare Officer and the Society of Saint Vincent de Paul;
- Consultation occurred with the Principal Social Worker in seeking legal advice regarding the concerns and consideration for Ward of Court and applying without support of medical reports.

Challenges in dealing with case

Many of the professionals involved in the case had long term knowledge of this case and family. The social worker was met with repeated comments of “you won’t make any changes there”, “that’s just how those people live”, “they don’t know any other way”, “I’m not going there we tried years ago and they said no so what’s the point now”. Even the charities that the SPT requested support from were reluctant to help on the basis that the family had got so much in the past.

However, the experience of the social worker was that spending the time building up a relationship and delivering on practical resources like getting the electricity turned back on, began the process of building trust. After the woman’s passing, the social worker was warmly thanked by the family for her help and she was able, with their consent, to support them in going to their own GP to get referrals to mental health services and other support services to maintain the positive changes they had made.

Limitations of existing legislation

In this case, it would have been beneficial for specific legislation relating to extreme self-neglect concerns. This legislation could explore accessing the home and person to complete risk assessments in a timely manner and ensure there is a shared responsibility in addressing and supporting such people. In particular, making it mandated for a GP/Consultant to conduct home visits in these cases where there are concerns regarding their increasing frailty or physical condition and decision-making capacity.

Case Scenario 10: Financial institution

A frail older customer with some physical/sensory disabilities requested that a family member be added to their account to support them with their finances. The customer had a full-time carer who needed to be paid in cash and getting to the bank/ATM machine to withdraw this and carrying out day to day activities, i.e., shopping, paying bills, etc. was now proving difficult.

After discussing other reasonable adjustments to support the customer to bank independently, the customer decided to add the family member to their account, mainly due to the carer requiring weekly cash payments and support needed with day to day living needs. The request was carried out and the family member was added to the account as a third party.

Once the third party was added, the profile of the account changed. The customer’s pension had previously been enough to cover care costs and household/living costs and the balance on accounts had previously been healthy. Once the third party was added, withdrawals increased and the balance was being drained. Suspicions were raised when funds were being looked for from a deposit account to supplement what was advised by the third party as an increase in the cost of care.

Investigations established that the customer was not aware of the additional withdrawals and the funds could not be accounted for. The third party refused to engage and the customer did not want the relative to be in trouble. With consent, a safeguarding and protection referral was carried out to discuss how to safeguard the customer and still ensure her needs, both personally and financially, were being met.

The main challenge here was that, due to her mobility and sensory difficulties, support with her finances was required – mainly as a result of the carer’s need to be paid cash but also to support with daily living expenses. However, the customer’s support system was small and she was now reliant on the family member who was also the alleged abuser.

Outcome

The third party was removed from the customer’s account and a new card and pin ordered for the main account, as previous ones were known by the family member. A full understanding of the customer’s everyday banking needs was established; where possible bills were set up by direct debit thus reducing the reliance on cash; a separate account was then set up with a set amount of funds transferred over to cover costs such as the care costs, shopping etc. A card was ordered on this new account that the customer then entrusted with the carer to take her wages out and purchase shopping. It was still not ideal that the card had to be given to the carer. However, the amount of cash in the account was limited. The accounts continued to be monitored to ensure they were in line with what was established as the norm for the customer. Regular check-ins with the customer were carried out to ensure she was still happy and that her needs were being met.

Case Scenario 11: Financial institution

A daughter was added as a joint account holder to her mother's account. Funds in the account are all derived from the mother's income. This arrangement had been in place for a number of years and activity had always just been carried out by the mother who at one stage moved to long-term residential care. The financial institution was advised by the daughter that her mother did not want to be in long term care, but it was required for safety reasons as she had been diagnosed with dementia and needed support.

The daughter then started to manage the account; nursing home costs were paid and funds were being withdrawn weekly and given to her mother for required personal items. The mother did not have a card on the account; all activity was carried out by the daughter. There was no concern over the amounts being withdrawn.

The challenge:

The woman (mother) presented at the financial institution with another family member and advised that she wanted a card on her account. She advised that her daughter had sole access to her money and if she wanted to buy something she had to ask her daughter for the money, which she was not happy with.

She had no concerns about the activity on the account and confirmed all of this was in order; she was happy with her daughter helping her with her finances and confirmed she needed help; she just did not want to have to ask for money every time she decided that she wanted to buy something. Following the meeting, a card was then ordered for the mother.

The daughter then called and said her mother was at risk of financial abuse from other family members; that she had dementia and that she should not be given a card. The daughter advised that she – the daughter – withdraws what money her mother needs and gives it to her. She then confirmed that if her mother had a card, she would give money to these other family members. Whilst it was confirmed she would have always done that in the past, the daughter confirmed she can now no longer afford to do it as she has to ensure that she has funds to cover her cost of care.

The Outcome

The outcome of the meeting with her mother was explained to the daughter, as were the rights her mother had regarding access to her own funds. It was agreed to hold a meeting with them both along with the support of an advocate so that it could be established how best to support her mother to have access to her own funds, while also addressing the safeguarding concerns that the daughter had. The main issue for the financial institution was that, despite the assistance of the advocate, the woman would change her mind; agree with her daughter

around not needing a card; confirm that she was satisfied how everything was operating; and would ask for the card to be cancelled, but that she would then present again in branch with family members advising that she is not happy having to ask her daughter for money and the family member would confirm that the daughter is controlling their mother's finances.

The financial institution continues to presume capacity and endeavours to support the woman and ensure that she has access to her own finances when needed. Due diligence is always carried out due to the financial abuse concerns.

However, the card issue is still not resolved and to date there is no active card. The financial institution continues trying to manage the account with conflicting stories from different sides of the family.



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