ADULT SAFEGUARDING
LEGISLATION IN
NORTHERN IRELAND

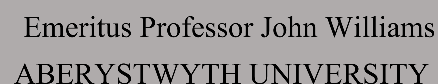
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Table of Contents

Part 1: The current context 3
Overview 3
Human Rights 4
The current context in Northern Ireland. 6
Part 2: Elements of effective safeguarding legislation. 9
Definitions and scope. 9
Adult at risk: 9
Abuse 10
Neglect 12
Self-harm or self-neglect (“self-harm/neglect”) 13
Overarching principles 16
Other issues relating to principles. 18
Duties 20
To make enquiries 20
To cooperate 22
To share information 23
Duty of candour 24
Advocacy 25
Powers 28
Entry 28
To speak to the older person in private 31
Further powers available in Scotland under the ASPA 2007 32
Statutory Safeguarding Adults Boards 36
Mental Capacity 38
Link to adult social/heath care 39
Safeguards 40
Summary of arguments opposing safeguarding legislation 41
Summary of key policy issues 43
Appendix 1: Legislation checklist 48
Appendix 2: Care Act 2014: What constitutes abuse and neglect? 49

Appendix 3: Non-exhaustive list of categories of abuse – Social Services and Well-being (Wales) Act 2014 statutory guidance.....51
Appendix 4: Key adult safeguarding principles – Care Act 2014 Guidance.....52

Part 1: The current context

Overview

Northern Ireland is the only one of the four nations of the United Kingdom not to have placed adult safeguarding on a statutory basis. Scotland was the first to introduce adult safeguarding law. The Adult Support and Protection (Scotland) Act (ASPA 2007) is the max model as it contains extensive powers to intervene to protect and safeguard adults at risk. Unlike Scotland, England and Wales did not introduce separate safeguarding legislation, but included it in the legislation reforming social care. In England this is the Care Act 2014 (CA 2014) and in Wales it is the Social Services and Well-being (Wales) Act 2014 (SSWA 2014). During the discussions leading up to the legislation in England and Wales there was recognition of the need for adult safeguarding legislation. The Law Commission for England and Wales in its report *Adult Social Care* when making the case for adult safeguarding legislation, rejected the argument that general community care assessments could identify abuse or neglect. It said,

> … that the community care assessment duty, which is the main legal vehicle for investigations, was not framed primarily with adult protection cases in mind and is often an unsatisfactory mechanism for dealing with them. Therefore, we proposed that the statute should clarify the existing legal position and establish a duty on local authorities to make enquiries and take appropriate action in adult protection cases. Action could include service provision, monitoring or the use of existing compulsory powers.[1]

Until the 2014 legislation, England and Wales relied, like Northern Ireland, on guidance.[2] Separate reviews of the statutory guidance in England and in Wales concluded that such an approach was no longer appropriate.[3]

The CA 2014 adopted a minimalist approach to adult safeguarding. There was reluctance by the Westminster government to include powers for social workers or others to intervene; emphasising what they referred to as the 'right to live in isolation'. Wales was more adventurous, although not by very much. In certain circumstances the Welsh legislation allows a power of entry.

In developing a law Northern Ireland faces three models:

i. *Scottish model: Maximum powers of intervention, balanced by safeguards to ensure human rights compliance and proportionality.*
ii. *English model: A minimalist approach with only limited duties (duty to make enquiries and joint working).*
iii. *Welsh model: The English model plus limited powers of entry.*

It is open to Northern Ireland to adapt these models to fit in with its own policy objectives and to enhance or improve them.

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[1] Law Commission, "Adult Social Care" (London, 2011) vol Law Com 326.

[2] Department of Health, "No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse"; National Assembly for Wales, "In Safe Hands" (2000).

[3] Magill J, Yeates V and Longley M, "Review of In Safe Hands" (Welsh Institute for Health and Social Care University of Glamorgan, 2010); Department of Health, "Safeguarding Adults: Report on the Review of 'No Secrets'." (London., 2009).

Human Rights

The principal argument in favour of a statutory framework for adult safeguarding is the duty on public authorities under s.6 Human Rights Act 1998 to act in a way compatible with the European Convention on Human Rights. Although an approach based on guidance is better than nothing, it lacks the certainty of a legal duty on the State to ensure adults at risk are safe from abuse and neglect. This extends to preventing violation or rights, rather than only being reactive.

In A v UK[4], the European Court of Human Rights said vulnerable individuals requires state protection in the form of deterrence against breaches of their personal integrity. The European Court has said the state must protect rights even though the abuse happens in private space, such as the person's home or a privately run care home. If the State is aware of a vulnerable person, it has an enhanced duty to intervene and protect.

Several human rights are engaged, the major ones being:

Convention Right	Relevance to adult safeguarding
Article 2: Everyone's right to life shall be protected by law.	*Abuse and neglect endanger life. Failure by the State (via public authorities) to protect where it is aware of a risk to life is a breach of the Convention.*
Article 3: No one shall be subjected to torture or to inhuman or degrading treatment or punishment.	*Abuse and neglect are by definition inhuman and/or degrading.*
Article 5: Everyone has the right to liberty and security of person.	*Using unlawful restraint and locked rooms violate this right if there is no lawful justification. Such behaviour should be prohibited in adult safeguarding legislation.*
Article 6: In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law.	*This has wider application than ensuring that those accused of a crime get a fair trial. It includes the rights of victims of elder abuse to access justice in its various forms. This presupposes that when agencies identify elder abuse, they have a legal duty to respond.*
Article 8: Everyone has the right to respect for his private and family life, his home and his correspondence.	*This is a wide-ranging right that embraces amongst other things dignity, the right to a safe environment, autonomy, and respect.*

Points to be emphasised – human rights:

i. *Human rights belong to everybody.*

[4] A. v. The United Kingdom (100/1997/884/1096)

ii. *Under the Human Rights Act 1998 and the CA 2014 the Convention binds many private providers of care who have a duty to act in a way that is compatible with the Convention.*
iii. *The State has a positive duty to prevent violations of human rights.*
iv. *When the State knows of a person who is vulnerable is at risk, it has an enhanced duty to protect.*
v. *The State must be able to show that it has systems in place to protect the human rights of vulnerable people. These processes must be robust and the only guarantee of this is if they are enshrined in law. Policy and guidance have a role to play, but the key question is who has the legal duty to ensure the protection of the rights of older people at risk?*

The current context in Northern Ireland.

Unlike the other three parts of the United Kingdom, Northern Ireland does not have adult safeguarding legislation. Being different within a devolved constitutional structure is not a failing. Devolution offers potential for different approaches to devolved matters. However, devolution also provides a dynamic and allows each of the four nations to learn from each other. Adult safeguarding is one such area. Across the United Kingdom we have an asymmetrical approach to safeguarding. The three nations with legislation adopt different approaches. In England and in Wales adult safeguarding legislation is relatively new, whereas Scotland legislated in 2007. It was not until the Law Commission for England and Wales recommended that adult safeguarding should be put on a statutory basis that the two nations were spurred into action.

Can Northern Ireland continue its current position and rely not on legislation but on guidance? The short answer is no it cannot. Why not? As seen above adult safeguarding is a human rights issue. Public authorities in Northern Ireland are bound by the Human Rights Act 1998 to act in a way compatible with the European Convention of Human Rights. It is debatable whether a guidance-based approach can deliver such compatibility; it lacks the necessary legal traction to make the rights enforceable. Two major reports have identified the shortcomings of the current position in Northern Ireland, the *Cherry Tree House Review*[5] and *Home Truths.*[6]

The Cherry Tree Review identified many weaknesses in how concerns and complaints about the care of older residents were handled. The Review team noted,

> All of [the family members and others] whom we met, stated that they had not received information explaining how to make a complaint when the relative was first admitted to Cherry Tree House nor did they know how to progress a complaint. In addition, they did not understand the different roles of the Trust, RQIA, the Patient Client Council and the N.I. Ombudsman or indeed the various procedures to be followed.[7]

In some instances, family members felt that they were being passed round different public authorities and that nobody was willing to take responsibility. There was a very lax approach to investigations. Families were not interviewed neither were care staff who could have contributed to an investigation. In addition, there was a feeling that there was an over-reliance on reports made by the management of Cherry Tree. One relative said the trust and the RQIA were 'asking management [of Cherry Tree] to investigate themselves and write a report.'[8] Some basic failings were identified by the Review team:

- Minutes of vulnerable adult strategy meetings did not identify those to be interviewed during the investigation;
- RQIA in some cases did not follow up issues raised in complaints in its inspections.

The Review made recommendations to improve the complaints procedures and to ensure that investigators spoke to the complainant and interviewed staff.[9]

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[5] Regulation and Quality Improvement Authority, "Independent Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House, Carrickfergus" (Belfast, 2014), https://www.rqia.org.uk/RQIA/files/1f/1fc36cdd-154f-47a6-bd5d-366dcea2f3bf.pdf.

[6] Commissioner for Older People Northern Ireland, "Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home" (Belfast, 2018), www.copni.org.

[7] Regulation and Quality Improvement Authority, n 5, para 3.6.

[8] Regulation and Quality Improvement Authority, n 5, para 3.6.

[9] Regulation and Quality Improvement Authority, n 5, para 3.7

The Cherry Tree Review findings identify a fragmented system where responsibility was dissipated to the point where it became unattributable to a single authority. Also, failing to follow through concerns and complaints led to serious harm not being properly investigated. The findings of the Cherry Tree Review provide a compelling case for legislation that clarifies legal responsibility and accountability for ensuring that concerns and complaints are followed up.

The disturbing findings of the Cherry Tree Review were sadly to reappear in the Commissioner's *Home Truths Report into Dunmurry Care Home*. The Report found many violations of the human rights of Dunmurry residents.[10] Concerns and complaints by relatives often failed to get beyond the walls of Dunmurry. There was confusion over what was an internal 'quality monitoring' incident and what was safeguarding. The lack of a clear threshold and definitions, plus the absence of a central body with responsibility for safeguarding led to abuse and neglect going unchallenged.

In his report the Commissioner recommended that,

> (A)n Adult Safeguarding Bill for Northern Ireland should be introduced without delay. Older People in Northern Ireland must enjoy the same rights and protections as their counterparts in other parts of the United Kingdom. It remains arguable that a policy based approach may not be Human Rights compatible as it does not guarantee an appropriate level of protection.[11]

In 2014 the Commissioner published *Protecting our Older People in Northern Ireland: A Call for Adult Safeguarding Legislation*[12] which made the case for adult safeguarding legislation. The Report identifies the main ingredients of safeguarding legislation, namely definitions, duties, powers, and oversight. It recognised that,

> There needs to be a balance between protection of older people from abuse or harm, as well as prevention, and specific legislation underpinned by human rights principles. It is recognised that legislation on its own is not a solution but it is a crucial part of improving protection for older people at risk of harm or abuse.[13]

Adult safeguarding legislation will not on its own end elder abuse and neglect; suitably trained practitioners, adequate resources, and improved services all have a part to play. However, the success of these will always be inhibited by the lack of clarity of legal responsibility. Child protection would no longer function without the legislative framework. Article 66(1)(b) Children (Northern Ireland) Order 1995 says that where an authority 'has reasonable cause to suspect that a child who lives, or is found, in the authority's area is suffering, or is likely to suffer, significant harm' it must make, or cause to be made inquiries. Adults at risk are entitled to similar protection.

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[10] Commissioner for Older People Northern Ireland, n 6, pp 19-24.

[11] Commissioner for Older People Northern Ireland, n 6, p 153.

[12] Commissioner for Older People Northern Ireland, "Protecting Our Older People in Northern Ireland A Call for Adult Safeguarding Legislation" (2014), https://www.safeguardingireland.org/wp-content/uploads/2018/10/final-protecting-our-older-people-_-a-call-for-adult-safeguarding-legislation.pdf

[13] Commissioner for Older People Northern Ireland, n 12, p 39.

What is available in Northern Ireland? In 2015 the Department for Health, Social Services and Public Safety and the Department of Justice published a policy, *Adult Safeguarding: Prevention and Protection in Partnership.*[14] One of the stated aims of the Policy is to

> …establish clear guidance for reporting concerns that an adult is, or may be, at risk of being harmed or in need of protection and how these will be responded to…[15]

In *Home Truths* the Commissioner recognised that the Policy had much to commend it, but there were weaknesses. The threshold for a care provider to report a concern was vague and, sometimes, serious risks and suspected criminal activity were not reported. A Policy that allows this to happen is unfit for purpose. Legislation is essential.

Legislation in Northern Ireland will be supported by other legislation such as the Mental Capacity (Northern Ireland) Act 2016 (when fully in force). Codes or guidance issued under each Act should refer to the importance of the capacity legislation in safeguarding cases. The powers in the Mental Capacity Act 2016 allow decisions to be made in safeguarding cases. Safeguarding legislation benefits those without capacity and those who have the capacity to consent or refuse.

There is much debate on the need for a criminal offence of elder abuse. This needs careful consideration and some prosecutors feel that it may hinder rather than promote safeguarding. Although discussion in Northern Ireland will no doubt take place, any proposal to criminalise it should be included in criminal legislation.

This report outlines a context for discussions on how legislation might develop basing it on the experience of England, Wales, and Scotland. It is not intended to be prescriptive. On the contrary there is considerable scope for Northern Ireland to follow the lead of the other three nations and develop its own approach.

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[14] Department of Social Services and Public Safety and Department of Justice, "Adult Safeguarding: Prevention and Protection in Partnership" (Belfast, 2015), https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf.

[15] Department of Social Services and Public Safety and Department of Justice, n 14, para 3.

Part 2: Elements of effective safeguarding legislation.

Definitions and scope.

To ensure that adult safeguarding legislation is proportionate, clear definitions are important. Definitions trigger the exercise of powers and duties in legislation; those definitions must provide practitioners with some certainty, although as in all such cases the ultimate decision depends on a practitioner's professional judgement. However, adult safeguarding law provides a framework for decision making. Several key definitions must be in legislation whether based on the Scottish approach or the English or Welsh approaches. Definitions provide safeguards and help ensure that the legislation is proportionate.

Adult at risk:

The Welsh legislation and the Scottish legislation adopt the term 'adult at risk', although with different wording. The English legislation does not use the term, although it adopts a similar definition to Wales. Using the term is helpful as it provides certainty and helps move discussion beyond the term 'vulnerable adult'. Although not in the CA 2014, practitioners in England use the term.

England and Wales

Wales and England adopt a similar definition. The components of the definitions are that the person:

> (a) has needs for care and support (whether or not the authority is meeting any of those needs),
>
> (b) is experiencing, or is at risk of, abuse or neglect, and
>
> (c) because of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.
>
> *s. 42 Care Act and s.126(1) Social Services and Well-being (Wales) Act 2014*

Many criticise this definition because the inability to protect himself or herself against the abuse or neglect in (c) must result from the need for care and support under (a) rather than the abuse or neglect under (b). What this does is to exclude many victims of domestic abuse (which may include many older people) as it may be the abuse or neglect that renders them incapable of protecting themselves; they may not have needs for care and support. The Health and Social Care Committee of the National Assembly for Wales in its report on the draft Bill highlighted the fact that it limits the definition to those in need of care and support.[16] Some argued before the Committee that this should not be a precondition; the important element is that they cannot protect themselves and this makes them vulnerable. The unspoken rationale for the definition is that this limits the number of people who will fall within the safeguarding process and thus save money. An alternative approach would be to change the wording and to continue to include the need for care and support, but link the inability to protect self to the abuse or neglect; this would recognise that the need for care and support may not be driving the inability to protect.

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[16] National Assembly for Wales Health and Social Care Committee, "Social Services and Well-Being (Wales) Bill: Stage 1 Committee Report" (Cardiff, 2013), http://www.assembly.wales/Laid Documents/CR-LD9418 - Health and Social Care Committee Stage 1 Committee Report, Social Services and Well-being (Wales)-18072013-248230/cr-ld9418-e-English.pdf viewed 3 August 2016, pp 38-41.

Scotland

Section 3(1) ASPA 2007 'adults at risk' means adults who:

(a) are unable to safeguard their own well-being, property, or other interests,

(b) are at risk of harm, and

(c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

For the purposes of (b), an adult is 'at risk of harm' if another person's conduct is causing (or is likely to cause) them to be harmed, or they are engaging (or are likely to engage) in conduct which causes (or is likely to cause) self-harm.[17] Note that the ASPA 2007 refers to 'harm' and not abuse.

This inclusive approach links to the person's vulnerability rather than to a need for care and support. It is also interesting as it includes self-harm.

Policy issues relating to the definition of 'adults at risk.

i. *All three definitions recognise the importance of including people at risk of harm and those who have experienced or are experiencing it. Adult safeguarding law should be preventative as well as responsive.*
ii. *In drafting legislation in Northern Ireland, a decision will have to be made on the definition of 'adults at risk'. The Wales and England definition is restrictive and excludes those who do not have needs for care and support. This may exclude some older people being abused or neglected. The Scottish definition is more inclusive, although still excludes some older people being abused or neglected – or at risk of it.*

Abuse

Each of the three nations adopts a different definition of abuse. There are also different approaches to self-neglect.

England

In the Parliamentary debates on the Care Bill there was discussion about the detailed definition of abuse. The outcome was that 'abuse' is an ordinary word not requiring a definition.

Financial abuse is specifically mentioned; it *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.

Note that this is not an exhaustive list.

Whereas the CA 2014 avoids a precise definition for the above reason, the statutory Guidance is less inhibited.[18] It emphasises that exploitation is a common theme and lists those types of abuse and neglect where it is present (see Appendix 2). A crucial point is that although a

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[17] s.3(2)(a) & (b) Adult Support and Protection (Scotland) Act 2007
[18] See Department of Health, "Care and Support Statutory Guidance" 375, https:// https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance s

person experiences one of more of the forms of abuse and neglect listed in the Guidance, they do not always come within adult safeguarding under the 2014 Act. They must satisfy the criteria for being an 'adult at risk' (see above), including the need for care and support which makes them unable to protect themselves. This excludes many people who are, in the non-legal sense, at risk. Safeguarding teams report turning away victims of domestic abuse for this reason. Northern Ireland can adopt a more inclusive definition, although there may be significant political resistance to this on grounds of cost.

Wales

As discussed, adult at risk in the SSWA 2014 is similar to the CA 2014 definition. In assessing a situation, the Guidance requires that regard be had to the following,

- frailty or vulnerability of the adult at risk;
- extent of abuse or neglect;
- length of time and frequency of the occurrence;
- impact on the individual;
- risk of repeated or escalating acts involving this or other adults at risk.[19]

Section 197(1) SSWA 2014 defines abuse as,

> "abuse" means physical, sexual, psychological, emotional, or financial abuse (and includes abuse taking place in any setting, whether in a private dwelling, an institution or any other place), and "financial abuse" includes:
> having money or other property stolen;
> being defrauded;
> being put under pressure in relation to money or other property;
> having money or other property misused.

Scotland

Unlike England and Wales, Scotland's ASPA 2007 does not use the term 'abuse' but refers to 'harm' as defined in s.53(1);

> "harm" *includes* all harmful conduct and, in particular, includes—
> (a) conduct which causes physical harm,
> (b) conduct which causes psychological harm (for example: by causing fear, alarm or distress),
> (c) unlawful conduct which appropriates or adversely affects property, rights or interests (for example: theft, fraud, embezzlement or extortion),
> (d) conduct which causes self-harm (see below).

This list is not exhaustive. The ASPA 2007 Code says that the harm can be accidental, intentional, because of self-neglect, neglect by a carer, and attempted suicide.[20] Harm is a much wider concept than abuse as used in the English and Welsh legislation, particularly the specific reference to accidental harm.

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[19] Welsh Government, "Social Services and Well-Being (Wales) Act 2014 Working Together to Safeguard People Volume I – Introduction and Overview Guidance on Safeguarding", http://gov.wales/docs/phhs/publications/160404part7guidevol1en.pdf., para 25

[20] Scottish Government, "Adult Support and Protection (Scotland) Act 200: Code o of Practice7" (2014), https://www.pkc.gov.uk/media/25785/ASAP-Scottish-Government-Code-Of-Practice/pdf/Adult_Support_And_Protection_-_Scottish_Govenment_Code_Of_Practice.pdf?m=636099846743570000 viewed 16 March 2020.

Policy issues relating to the definition of abuse/harm

i. *The choice for Northern Ireland is the extent to which it wishes to define what the legislation should include – a general definition that relies on the assumption that 'it will be recognised when seen', or a more detailed definition? England and Wales provide examples of each. Whatever the approach, a list (long or short) must not be exhaustive. It is impossible to predict the totality of abuse.*

ii. *The definitions of abuse/harm in the other three nations are not freestanding and are to be read in the context of the definition of adults at risk. For example, domestic abuse does not automatically engage safeguarding procedures. Persuading the Government to adopt a broader definition will be difficult; they will argue it would impose a considerable commitment on Health and Social Care Trusts. However, not doing so means an older person who is vulnerable because of the abuse rather than need is excluded. This has implications for older people who experience domestic abuse.*

iii. *Northern Ireland could adopt the Scottish idea of harm rather than abuse. This is a wider concept.*

Neglect

All three nations refer to neglect in their legislation. Neglect presupposes a duty to care. All practitioners (statutory, independent, or voluntary sector) working with older people have a legal duty of care. For unpaid carers (family, friends) it is more difficult. The key question is whether they assumed a caring role? If so, they have a responsibility not to neglect the person for whom they are caring.

England

The CA 2014 does not define neglect; however, the Guidance refers to neglect and acts of omission. Not doing something you have an obligation to do is neglect. It gives several examples (again, not exhaustive).

> Neglect and acts of omission include:
>
> - ignoring medical emotional or physical care needs
> - failure to provide access to appropriate health, care, and support or educational services
> - the withholding of the necessities of life, such as medication, adequate nutrition, and heating.[21]

Wales

Section 197(1) SSWA 2014 defines neglect:

> "neglect" ("*esgeulustod*") means a failure to meet a person's basic physical, emotional, social, or psychological needs, which is likely to result in an impairment of the person's well-being (for example, an impairment of the person's health …)

As with abuse, practitioners must have regard to,

- frailty or vulnerability of the adult at risk;
- extent of abuse or neglect;

[21] Department of Health, "Care and Support Statutory Guidance", https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1., para 14.17.

- length of time and frequency of the occurrence;
- impact on the individual;
- risk of repeated or escalating acts involving this or other adults at risk.[22]

Examples of neglect in the Guidance are,

> Failure to access medical care or services, negligence in the face of risk-taking, failure to give prescribed medication, failure to assist in personal hygiene or the provision of food, shelter, clothing; emotional neglect.[23]

Scotland

The APSA 2007 does not use the word abuse but refers to harm. The definition of adults at risk of harm in s.3 ASPA 2007 refers to where 'another person's *conduct* is causing (or is likely to cause) the adult to be harmed…' Section 53 defines conduct as including 'neglect and other failures to act'. The Code reaffirms this. It states,

> (H)arm means all harm including self-harm and neglect.[24]

The Code emphasises the need for training of safeguarding practitioners in recognising neglect.

Policy issues relating to the definition of neglect:

i. *As with the definition of abuse/harm, the decision is whether to adopt the England and Wales approach of specific reference to it in the definition, or the Scottish approach of incorporating it under the term 'conduct' and not going into any detail of what it includes. Not including neglect in the definition of abuse/harm and incorporating it indirectly risks it being forgotten or treated as not as bad as, for example, physical abuse. If Northern Ireland adopted the Scottish definition of abuse, it could easily be adapted to include specific reference to neglect on the face of the legislation.*
ii. *Legislation or codes or guidance may provide examples of neglect, but these are not an exhaustive definition.*

Self-harm or self-neglect ("self-harm/neglect")

Whether self-harm/neglect is a safeguarding matter is contentious. Should choice of lifestyle be subject to public authority legal powers? The argument against inclusion is that they are exercising their right to a private life under art. 8 European Convention on Human Rights. Self-harm has come to public attention because of media coverage of hoarding, but it is much wider than this and includes neglecting health and personal care. In some instances, public health or housing authorities may use their legal powers and duties to intervene; similarly the Northern Ireland Fire and Rescue Service may have powers that could be helpful. However, this does not cover all cases. Again, there is variation across the three nations whether self-harm should fall within adult safeguarding legislation. Another argument against is that self-harm/neglect is a social care matter and addressed by assessments and providing services. The CA 2014 and the SSWA 2014 include general duties on local authority including a well-being duty; in England it is a duty to promote, in Wales a duty to 'seek to promote'. This is important when responding to a person who is self-neglecting; difficulty in engaging people

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[22] Welsh Government, "Social Services and Well-Being (Wales) Act 2014 Working Together to Safeguard People Volume I – Introduction and Overview Guidance on Safeguarding", n 19., para 25
[23] Welsh Government, "Social Services and Well-Being (Wales) Act 2014 Working Together to Safeguard People Volume I – Introduction and Overview Guidance on Safeguarding", n 19. para 1.26.
[24] Scottish Government, "Adult Support and Protection (Scotland) Act 200: Code o of Practice7", n 20. p. 8

does not displace the duty, although authorities cannot impose social care services on a person with capacity.

England

Although the CA 2014 does not refer to self-harm/neglect, it features in the Guidance. The original guidance adopted the approach that self-harm/neglect came within safeguarding. This was subsequently toned down because of the heavy demand it placed on safeguarding teams. Updated Guidance says that self-neglect 'may not' prompt an enquiry; assessments should be made on a case-by-case basis. A decision whether it is a safeguarding matter depends upon the person's ability to protect themselves by controlling their own behaviour. There may come a point when they can no longer do this without support.[25]

Wales

The SSWA 2014 and its Guidance does not refer to self-harm/neglect. This is an odd omission. The National Assembly Health and Social Care Committee in its report on the Bill, whilst asking government to consider the Scottish definitions, had reservations about including self-harm/neglect. It reported,

> As drafted, the Bill does not contain a reference to self-harm. While we recognise that the Scottish Act offers an alternative definition, we have reservations about its inclusion of adults engaging or likely to engage in self-harm, as we question the impact this may have on the rights of an adult to make choices about how to live their lives. However, we acknowledge that this power may rarely be used in practice.[26]

It is likely that discussion on legislation in Northern Ireland will encounter this argument.

Scotland

As seen above, s.53 ASPA 2007 harm includes 'conduct which causes self-harm'. 'Adult at risk of harm' as defined in s.3(2)(b) includes a person 'engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.' The Code provides no guidance on what self-harm means.

Policy issues relating to self-harm/neglect

i. *Should the legislation refer to self-harm or self-neglect? Harm has the advantage of being a wider and more inclusive concept.*
ii. *Northern Ireland faces three models.*
    a. *incorporate self-harm/neglect in legislation (Scotland);*
    b. *leave it to the code or guidance to introduce it (England); or*
    c. *make no reference to it (Wales).*
iii. *Option (c) may create the impression that self-harm/neglect is never a safeguarding matter. Practice in Wales suggests that cases are referred to safeguarding, although practitioners are unsure whether this is correct. Option (a) may create the impression that self-harm/neglect is routinely safeguarding. This may meet with opposition based on the autonomy and freedom to live in isolation argument. Scotland avoids this risk by incorporating safeguards against a disproportionate or inappropriate use of powers. Option (b) provides some guidance on the use of safeguarding, but its absence from the legislation may lead to the impression that it is unimportant.*

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[25] Department of Health, "Care and Support Statutory Guidance", n 18., paras 14.18 and 14.41.
[26] National Assembly for Wales Health and Social Care Committee, n 16., p 40-41

iv. *How far is Northern Ireland prepared to go in addressing self-harm/neglect? A response to the autonomy argument is to include safeguards, and checks and balances against misuse in the legislation.*

Overarching principles

Powers of intervention are intrusive and engage human rights; overarching principles are necessary to prevent misuse. Should such principles be on the face of the legislation, or in accompanying codes or guidance? An example of the former is the Mental Capacity Act (Northern Ireland) 2016. Sections 1 and 2 outline principles applicable when assessing capacity and best interests. The advantage of having them on the face of the legislation is that they become unambiguously a legal requirement rather than good practice or general guidance. They are enforceable. Decisions made under the Act must be compliant with the principles and in any court, practitioners will need to evidence that they have applied them. How practitioners apply or interpret the principles in an individual case is a matter of professional judgement, but judgements must take full account of the principles. The legal impact of principles in codes or guidance depend upon the status of those documents. If Northern Ireland were to decide on including principles it is necessary to decide their legal status.

England

The CA 2014 does not include statutory principles. There is however a 'general duty' in s.1(1) to promote well-being which is defined in s.1(2)(c) as including protection from abuse and neglect. General duties, that is duties owed to the public in general, are difficult for individuals to enforce. The Guidance identifies six key principles that underpin adult safeguarding work. They are,

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability[27]

(See Appendix 4 for full details)

The Guidance emphasises the need to make safeguarding personal; adult safeguarding exists to protect individuals.[28] It is made under the CA 2014, so has the status of statutory guidance. Local authorities must act under the Guidance 'unless they can demonstrate legally sound reasons for not doing so.'[29] It does not have the same legal status as legislation but is similar.

Wales

The SSWA 2014 does not include statutory principles as such. Like the CA 2014, it includes overarching duties, including a duty to 'seek to promote' the well-being of people needing care and support. Section 2(2) includes protection from abuse and neglect as one of the elements of well-being. Another overarching general duty requires anybody exercising functions under the Act to comply with the following:

- as far as is reasonably practicable, ascertain and have regard to the individual's views, wishes and feelings,
- have regard to the importance of promoting and respecting the dignity of the individual,
- have regard to the characteristics, culture, and beliefs of the individual (including, for example, language), and

[27] Department of Health, "Care and Support Statutory Guidance", n 21., para 14.13.
[28] Department of Health, "Care and Support Statutory Guidance", n 10, para 14.14.
[29] Department of Health, "Care and Support Statutory Guidance", n 10, p 3.

- have regard to the importance of providing appropriate support to enable the individual to participate in decisions that affect him or her to the extent that is appropriate in the circumstances, particularly where the individual's ability to communicate is limited for any reason.

In addition, they must 'have regard' to—

- the importance of beginning with the presumption that the older person is best placed to judge the older person's well-being, and
- the importance of promoting the older person's independence where possible.

The SSWA 2014 is innovative in that includes an overarching duty have 'due regard to United Nations Principles for Older Persons'.[30] The Principles are,

- Independence
- Participation
- Care
- Self-fulfilment
- Dignity

This duty is like that under s.2(3) Commissioner for Older People Act (Northern Ireland) 2011 except that it refers to 'due' regard rather than 'regard'. The idea of a 'due regard' duty is uncertain. Social Care Wales are in the process of publishing guidance on the due regard duty. It states that the duty must be performed 'in substance, with rigour and with an open mind.' This means that it is not just a tick box exercise, it takes account of all relevant evidence, and includes considering different options. It is good practice to keep a record of how the duty was performed. Although the SSWA 2014 includes social care as well as safeguarding, including the UN Principles in bespoke safeguardinglegislation deserves consideration. This may be in addition to principles in the legislation, code, or guidance.

Scotland

The ASPA 2007 is dedicated to adult safeguarding. Section 1 states,

> The general principle on intervention in an adult's affairs is that a person may intervene, or authorise an intervention, only if satisfied that the intervention—
> (a) will provide benefit to the adult which could not reasonably be provided without intervening in the adult's affairs, and
> (b) is, of the range of options likely to fulfil the object of the intervention, the least restrictive to the adult's freedom.

Section 2 requires a public body or office-holder performing a function under the Act in relation to an adult must, if relevant, 'have regard to',

> (a) the general principle on intervention in an adult's affairs (see s.1),
> (b) the adult's ascertainable wishes and feelings (past and present),
> (c) any views of—
> (i) the adult's nearest relative,
> (ii) any primary carer, guardian, or attorney of the adult, and
> (iii) any other person who has an interest in the adult's well-being or property,
> which are known to the public body or office-holder,
> (d) the importance of—

[30] s.7(1) SSWA 2014 and General Assembly resolution 46/91 of 16 December 1991, "United Nations Principles for Older Persons", http://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx.

(i) the adult participating as fully as possible in the performance of the function, and
(ii) providing the adult with such information and support as is necessary to enable the adult to so participate,

(e) the importance of ensuring that the adult is not, without justification, treated less favourably than the way in which any other adult (not being an adult at risk) might be treated in a comparable situation, and

(f) the adult's abilities, background and characteristics (including the adult's age, sex, sexual orientation, religious persuasion, racial origin, ethnic group and cultural and linguistic heritage).

Note that the s.2 duty is to 'have regard' and not 'due regard'. This is a less demanding requirement.

Sections 1 and 2 are reproduced in full as they provide a basis for drafting statutory principles in any Northern Ireland legislation.

Other issues relating to principles.

Legislation must include a commitment to preventative work. Waiting until abuse or harm happen before intervention becomes possible is unacceptable. All three nations refer to a person experiencing abuse or neglect or being at risk of it. This raises the general point of integrating safeguarding into general social care. In England and Wales, the safeguarding provision are included in general social care legislation whereas in Scotland there is bespoke safeguarding legislation. Both approaches require close working between safeguarding teams and social care or health teams. Practitioners must be alert to the signs of abuse and neglect and be aware of the importance of sharing concerns they may have; this may avoid a case escalating. However, referring an adult to safeguarding does not mean it is solely the responsibility of that team. Social and health care remain important and may be a part of action identified by safeguarding. The expression 'safeguarding is everybody's concern' sums this up.

All three nations recognise the need for intervention to be proportionate. Although this is a general legal duty under human rights law, it needs spelling out in safeguarding legislation and codes or guidance.

The autonomy versus protection argument must be considered in context. Autonomy is not absolute; the European Convention on Human Rights recognises this. Also, when and adult is consenting or refusing, practitioners must satisfy themselves the person is acting of their own free will, and had the opportunity of making an informed decision. This applies to safeguarding as much as it does to consent to health and social care.

Policy issues relating to principles

i. *Should Northern Ireland safeguarding legislation include principles that apply to public authorities and practitioners?*
ii. *If so, should such principles be included in:*
    a. *The legislation;*
    b. *any code or guidance;*
    c. *the legislation and guidance?*
iii. *If they are in the legislation, should they impose an absolute duty to apply, a due regard duty, or a have regard duty?*
iv. *In addition to statutory principles, should Northern Ireland consider incorporating the United Nations Principles for Older People? If so, should it be a due regard or*

have regard duty? It would be difficult to make it an absolute duty given the general nation of the Principles. (Note that any legislation will have wider application than older people. However, including the Principles helps address ageism and also helps develop an approach that may benefit other groups).

Duties

To make enquiries

A significant weakness in the Northern Ireland safeguarding procedures is the inability to identify a public authority with responsibility for ensuring that safeguarding concerns are addressed. *Home Truths*[31] identified this as a key failure. Responsibility is fragmented, confusing, and allows the buck to be passed. Concerns travelled between the HSC Trusts, RQIA, and the PSNI, assuming they got beyond the care home. The bare minimum for safeguarding legislation is identifying a single authority with legal responsibility for ensuring safeguarding happens, and a threshold for referring concerns to that responsible body. Again, *Home Truths* identified instances where legitimate safeguarding concerns were 'reclassified' as internal to the home resulting in them not being properly investigated. A key theme of the approach by three nations is the imposition of clear duties on nominated public bodies to make enquiries and identifying thresholds for such intervention.

England and Wales

The approach in the CA 2014 and the SSWA 2014 is similar. As noted above, s.42 CA 2014 defines adult at risk (although it does not use that term) and this acts as a trigger for a duty to make enquiries. The first part of the section states,

> This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) … [the definition of adult at risk follows]

What does the section do? This is found in s.42(2).

> The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

Section 126 SSWA 2014 contains slightly different wording, but the duty is identical other than providing a power to make regulations saying that the outcome of the enquiries should be included in the care and support plan.

Several points need to be noted:

- The duty is based on having a 'reasonable cause to suspect'. It is not a balance of probability let alone beyond all reasonable doubt. The Welsh Guidance provides some assistance. Certainty is not required. There must be information available that would satisfy an objective observer that the facts underlying the concern may exist. It is necessary to summarise the information underlying the assessment, explain why they consider objectively that it meets the threshold for intervention, and prepare a brief statement of the risks for the adult if nothing is done.[32] If this threshold is chosen in Northern Ireland, all those working in social and health care must be made aware of it. They should share concerns; robust evidence is not required.
- The duty is to make 'enquiries'. It is not a duty to investigate, although the need for an investigation may be an outcome of the enquiries. Enquiries are information gathering and not full-scale investigations.

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[31] Commissioner for Older People Northern Ireland, n 6.

[32] Welsh Government, n 8, para 84. This Guidance provides detailed information on the conduct of enquiries and their outcomes. In any Northern Ireland legislation, much of the detail could be included in a code or guidance.

- The local authority may make the enquiries or ask another person or organisation to do so. This may be another public authority (if within their statutory remit), or a third sector organisation. However, the responsibility for making the enquiries and follow up action remains with the local authority.
- The duty applies to adults at risk physically present in the local authority area; the niceties of 'ordinary residence' do not apply.
- The adult at risk may refuse to be involved in any enquiry, but this does not relieve the local authority of the duty although does compromise their ability to do so. Again, practitioners must ensure it is an informed decision and freely made. If the person lacks capacity to make the decision to consent to involvement, the provisions of the Mental Capacity Act 2005 will apply.
- Normally enquires should be completed with seven days, although an extension is possible. They should be proportionate.
- Advocacy and support may be necessary.
- The outcome an enquiry is a report identifying whether the person is an adult at risk, and if so, an action plan should be put in place. The plan should link into any social care plan for the adult at risk.

Scotland

Section 4 of the ASPA 2007 includes a duty to make inquires.

> A council must make inquiries[33] about a person's well-being, property or financial affairs if it knows or believes—
> (a) that the person is an adult at risk, and
> (b) that it might need to intervene (by performing functions under this Part or otherwise) in order to protect the person's well-being, property or financial affairs.

The use of 'knows or believes' as the threshold does not provide a lot of legal precision. 'Know' could suggest a high level of satisfaction is required; 'believe' begs the question as to the nature of belief, in particular whether it is a reasonable belief. 'Reasonable cause to suspect' provides greater legal traction.

The Code refers to the good practice of ensuring frontline staff in public bodies who may be the first point of contact for the older person, are aware of this duty and refer concerns to safeguarding.[34] Unlike England and Wales, the inquiries can only be undertaken by council social workers, but if there is a need for further investigation or intervention, consulting or working in partnership with other agencies is permitted.[35] The outcome of the inquiry may involve a need to intervene using the powers under the Act, other legislation (e.g. Mental Health (Care and Treatment) (Scotland) Act 2003), or non-statutory interventions.[36] The Code makes similar provision to those in England and Wales where the person refuses to cooperate.[37]

Policy issues relating to a duty to make enquiries

(i) *Including a duty imposed on a single public authority to make enquiries is an essential component and avoids concerns being lost in a melee of buck passing. The most obvious candidate in Northern Ireland are the Health and Social Care Trusts.*

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[33] The ASPA 2007 refers to 'inquiries' rather than 'enquiries' as used in England and in Wales.
[34] Scottish Government, n 9, para 6.7
[35] Scottish Government, n 9, para 6.6
[36] Scottish Government, n 9, para 13.
[37] Scottish Government, n 9, para 6.10-12

They are uniquely placed to undertake the responsibility. They should have primary responsibility for adult safeguarding; they will be the route into adult safeguarding.

(ii) *The threshold for triggering this duty should not be too demanding. Early intervention may prevent things worsening; it may also identify that there is no cause for concern, or that there is a social care or health care need that has thus far gone unnoticed.*

(iii) *The single body identified could be solely responsible for undertaking the enquiries, although recognising the importance of collaboration. Alternatively, it could have the power to ask other to undertake the enquiry.*

(iv) *It is essential that if the adult is at risk that an action plan is devised and monitored. This action plan must link in with any care plan.*

(v) *A refusal on the part of the suspected adult at risk does not relieve the authority of its duty but restricts their ability to undertake the enquiries.*

(vi) *Normally enquiries should take seven days, with the possibility of one extension. It is not an investigation; it is a fact-finding exercise.*

To cooperate

A common concern identified in adult safeguarding is the failure of public authorities and other to cooperate. This may range from an unwillingness to attend case conferences and failing to share information, to blame shifting. A legal duty to cooperate may help to overcome some of these problems, although the diverse cultures of organisations can still be a problem. All three nations include duties to cooperate.

England and Wales

The CA 2014 and SSWA 2014 impose duties to cooperate with 'relevant partners'. Under s.6(7) CA 2014 there is a general duty to cooperate with partners in relation to care and support and safeguarding. Relevant partners include other local authorities, NHS bodies, Department for Work and Pensions, police, the Prison Service, and Probation Service. The duty is reciprocal, although partners cannot be asked to do something beyond their statutory remit. It also has a duty to cooperate with any other person or body it considers appropriate. These could include GPs and the Fire and Rescue Service. In these cases, the duty is not reciprocal. Section 7 allows the local authority to request cooperation from a relevant partner in relation to an individual case, subject to it being compatible with the partner's duties and does not have an adverse effect their ability to perform their functions. If the partner refuses to cooperate under s.7, it must provide a written reason for not doing so.

In Wales relevant partners have a duty to report to the local authority if they have reasonable cause to suspect that an adult at risk is in their area. They must also share information as part of their safeguarding responsibilities, including enquiries. A relevant partner must comply with a request to undertake an enquiry unless it is beyond their statutory remit.[38]

Scotland

The duty to cooperate is in s.5 ASPA 2007. Interestingly, it includes in the list of bodies to whom the duty applies the Care Inspectorate Scotland – the Scottish equivalent of RQIA. The duty is to cooperate with the council undertaking a s.4 inquiry, and with each other if it is likely to assist the inquiry. *Home Truths* demonstrates the need for RQIA to be subject to this duty. It is a gap in the English and the Welsh legislation.

[38] s.128 -30 SSWA 2014

Policy issues in relation to the duty to cooperate

i. *Legislation should include a duty on relevant public bodies to cooperate in adult safeguarding at a strategic and policy development level, and in individual cases.*
ii. *Who should be included in the list of relevant bodies? HSCTs should have a duty to cooperate with each other. The PSNI must also be included as should the Probation Board for Northern Ireland. There is a firm case for including RQIA. Public bodies involved in housing, education (legislation would include younger vulnerable adults who may be in education), environment and public health. The Fire and Rescue Service and GPs are other possibilities, although the latter may he more difficult given their legal status. Should COPNI be on the list?*
iii. *A list of relevant bodies may distinguish between those where the duty will be reciprocal (frontline adult safeguarding services) and those where the duty is not reciprocal.*
iv. *The registration system should ensure private providers of social care have an obligation to cooperate in safeguarding enquiries.*
v. *Legislation should make it clear that those who are required to cooperate cannot be made to do something beyond their legal powers. However, if they have a reciprocal duty, then they should if requested provide a written reason for not complying with a request from a HSCT.*

To share information

Cooperation presupposes the sharing of information. Failure to do so is a key finding in many enquiries into adult safeguarding. Misunderstanding of the General Data Protection Regulation and the Data Protection Act 2018, along with confidentiality make some practitioners, public authorities and private providers unwilling to share essential information. As noted above, safeguarding is every body's concern. Practitioner should not assume that others will report incidents. Nothing is too trivial to be reported; what appears relatively unimportant may alongside other information identify an adult safeguarding issue.

England

The CA 2014 Guidance identifies sharing information as essential to providing an effective response where there are emerging concerns about an adult. Information sharing arrangements should be in place setting out the processes and principles. It makes it clear that,

> (N)o professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. If a professional has concerns about the adult's welfare and believes they are suffering or likely to suffer abuse or neglect, then they should share the information with the local authority and, or, the police if they believe or suspect that a crime has been committed.[39]

Detailed guidance on information sharing and confidentiality is in paras. 14.180-195 of the Guidance.

Wales

Section 128 SSWA 2014 a 'relevant partner' of a local authority must inform it if they think a person in its area is an adult at risk (or where the person is in another local authority's area, to inform that other authority).

[39] Department of Health, "Care and Support Statutory Guidance", n 7, para 14.43.2.

The Guidance reminds practitioners they must share information in accordance with data protection laws and confidentiality, but these cannot be used routinely as a reason for not sharing. In exceptional circumstances information can be shared without consent if there is a statutory duty to do so, or the practitioner deems it to be in the public interest.[40] Information shared should be necessary and proportionate.

Scotland

As part of the duty to cooperate under s.5 ASPA 2007, where a public body or office-holder becomes aware that an adult is at risk and action needs to be taken to protect them, they must report the matter to the council in the area where that person is. Under s.10 a council officer may require a person holding health, financial or other records on an adult whom they knows or believe to be an adult at risk, to produce the records.

Chapter 10 of the ASPA 2007 Code discusses information sharing and gives similar guidance to England and Wales.

Policy issues in relation to sharing of information

1. *The approaches in England, Wales, and Scotland emphasise the importance of sharing information. However, much of the detail is contained in the codes and guidance. There is a case for saying that a duty on practitioners and public bodies to share information when necessary, subject to data protection laws and confidentiality, should be in the legislation. This would concentrate minds and help to break down the culture of non-sharing. The duty should be qualified by the need for a lawful justification for sharing. Such justifications may be in legislation (for example, the criminal law), or the common law on the duty of confidentiality. The latter duty is not absolute; there may be a compelling public interest in sharing.*
2. *Some jurisdictions go as far as mandatory reporting and impose it on all practitioners, and in some instances on members of the public. This is controversial.*
3. *Consent should be the primary justification for sharing information. However, any code or guidance accompanying the legislation should spell out when sharing without consent is permissible and expected.*
4. *Where the adult lacks relevant mental capacity, mental capacity legislation should be followed.*
5. *Training programme introducing legislation should include a module on information sharing and its importance.*

Duty of candour

Linked to information sharing is the duty of candour. In his investigation into Dunmurry, the Commissioner was frustrated by a lack of certainty that there was full disclosure of evidence. One of the recommendations was that Northern Ireland should introduce an individual duty of candour for all personnel and organisations involved in delivering care.[41] A duty of candour features in the legislation for the English, Welsh, and Scottish regulatory bodies.

Policy issues relating to a duty of candour

1. *Adult safeguarding legislation provides an opportunity to implement the Home Truths recommendation on duty of candour.*

[40] Welsh Government, n 8, para 28.
[41] Commissioner for Older People Northern Ireland, n 6, Rec 57.

Advocacy

Independent advocacy is an important part of safeguarding. A right to advocacy in adult safeguarding would help ensure that the individual is at the centre of decision making and their voice is heard in social care, health and the criminal justice system. It is also an effective way of protecting the human rights of the person. One difficulty is identifying who should be eligible for advocacy and when.

England

Where a local authority is making an enquiry under s.42 SSWA 2014 (or where a Safeguarding Adults Board is carrying out a review of a case involving a living person) the authority must, if it considers that the older person would be disadvantaged by the absence of independent advocacy, arrange for somebody independent of the authority to represent and support the older person. This independent advocate will help the person to be involved. A person is not appropriate to act as an independent advocate, if the adult at risk has capacity and does not consent to them doing so. If the adult at risk lacks capacity, the authority must be satisfied that appointing the person is in their best interest.

The duty to appoint an independent advocate does not apply if the authority is satisfied that there is somebody who is appropriate to represent and support the older person and who is not providing care or treatment for the older person in a professional capacity or paid capacity. This may be a family member or friend. Anecdotal evidence suggests that authorities may be too willing to use this to avoid funding an independent advocate. Relatives and friends are unlikely to have advocacy training and may not understand the role, or be reluctant to challenge. Also, they may be implicated in the allegations of abuse or neglect or have divided loyalties.

Wales

There was reluctance by Welsh Government to include a right to advocacy in the SSWA 2014; fears of a blank cheque dominated government thinking. It was political pressure from the Health and Social Care Committee, and the Assembly that eventually forced the Government to include it in the Act. Regrettably, it has not been implemented as intended. The SSWA 2014 includes a power to make regulations on advocacy; this would have placed advocacy on a sound legal basis. This has not happened. Instead, Government opted to include advocacy in a Code of Practice.[42] The Government's justification is that advocacy is pervasive throughout the Act – it is the 'golden thread'. Opinions differ on this approach!

The Code identifies two principal themes for advocacy. The first is to speak up for individuals not being heard and help them express their views and make informed decisions and contributions. Safeguarding is one of the functions under the SSWA 2014 where local authorities 'must consider individuals' needs for advocacy and support.' The duty is to consider advocacy and not provide it in all safeguarding cases. The Code says that the need for advocacy may be heightened when there is an adult at risk and there is a s.126 enquiry, action under s.127 (Adult Protection and Support Orders), and s.128 (the duty to report adults at risk). The second theme is to safeguard individuals at risk:

> Local authorities must arrange for an independent professional advocate, … when a person can only overcome the barrier(s) to participate fully in

[42] Welsh Government, "Social Services and Well-Being (Wales) Act 2014 Part 10 Code of Practice (Advocacy)" (Cardiff, 2015), https://gov.wales/sites/default/files/publications/2019-05/part-10-code-of-practice-advocacy.pdf.

> the assessment, care and support planning, review and safeguarding processes with assistance from an appropriate individual, but there is no appropriate individual available.[43]

An appropriate individual may be a family member, friend, or somebody from a wider social network. Under the Code, if appropriate individuals can ensure the person's involvement in the safeguarding process they can act as advocate unless,

- The adult at risk does not want that person to support them
- The person may be unlikely to be able or available to support the person
- That person is implicated in the safeguarding process (a suspected perpetrator, for example).[44]

As with the CA 2014, the use of non-professional advocates gives rise to issue of ability and impartiality.

Scotland

Section 6 ASPA 2007 says councils 'must have regard to the importance of the provision of appropriate services (including, in particular, independent advocacy services)' to an adult where it is necessary to intervene following a s.4 inquiry. The advocate must be independent of any authority providing services to the older person. This is a very weak duty. To 'have regard' to the importance of does not have as much legal traction as a duty to provide or even a duty to consider. The Code does not add a great deal to s.6 ASPA 2007.

Policy issues in relation to the provision of advocacy

i. *Provision of statutory independent advocacy across England, Wales, and Scotland is less than fulsome. There is concern over the cost of funding independent advocacy. There is also a touching belief in the ability and willingness of family and friends to advocate, besides any conflict of interests they may have. Similarly, many believe that health and social care practitioners can act as effective advocates. This is not the case as they are conflicted by their duties to their employers. For Northern Ireland, the choice is whether they want to follow any of the three existing models or be more radical. A more radical approach involves a statutory presumption of advocacy which is rebuttable. If the older person refuses advocacy, that will normally displace the presumption. However, the older person may refuse because of coercion or control. Rebutting the presumption in these cases will reaffirm the power of the abuser. The duty should continue. Obviously, if access is difficult, and the adult refuses to cooperate, advocacy will be difficult. Nevertheless, an independent advocate may still make an important contribution to decision making. Specialist training for such cases is necessary.*
ii. *Advocates must be independent of any public authority involved in providing services to the older person. The third sector should provide the service.*
iii. *Independent advocacy services must be funded by the public authority having responsibility for making enquiries.*
iv. *Eligibility criteria should identify who is eligible and the circumstances giving rise to the duty.*

[43] Welsh Government, "Social Services and Well-Being (Wales) Act 2014 Part 10 Code of Practice (Advocacy)", n 30. para 47.
[44] Welsh Government, "Social Services and Well-Being (Wales) Act 2014 Part 10 Code of Practice (Advocacy)", n 30,para 61.

v. A duty to provide advocacy services and the eligibility criteria should appear in the legislation or in delegated legislation. Details can be included in a code or guidance made under the legislation.

Powers

Entry

Inability to access a person who may be an adult at risk frustrates many safeguarding enquiries, but including powers of entry in the CA 2014 and the SSWA 2014 proved controversial.[45] Entry may be impossible because the person objects, or somebody is 'objecting on their behalf'. The right to a private life and home life are important and a power to enter a person's home without permission intrudes into those rights. However, these rights are not absolute and there may be circumstances where it is necessary to override them to protect a person. Research has shown that most times social care and health care practitioners can get access using their professional skills. This may still leave some adults at risk in danger, especially where coercive or controlling behaviour is present. The perpetrator will refuse to allow entry. It is here that England, Wales, and Scotland's approaches diverge.

England

The CA 2014 does not include powers of entry. A consultation exercise by the Department of Health leading to the Care Bill involve a survey of attitudes towards powers. The results are worth noting as attitudes in Northern Ireland may be the same. In response to whether it should include entry powers in the Bill the survey revealed the following:

Type of respondent	In favour	Against	Undecided or not stated
Individual	18%	77%	5%
Health	90%	0%	10%
Local authority (including SABs)	72%	12%	16%
Other (third sector/police)	60%	23%	17%

Breakdown by type of respondent.[46]

The conclusion reached by the Westminster Government was that,

> Based on the views expressed, and the qualitative evidence provided by respondents, we have concluded that the responses to the consultation did not provide a compelling case to legislate for a new power of entry. Therefore we will not be adding a safeguarding power of entry to the Care and Support Bill.[47]

It claimed it was influenced by the strength of feeling against the idea by the public and also the unintended consequences highlighted by some respondents.

[45] For and account of the debates in Westminster, see Manthorpe J, Martineau S, Norrie C and Stevens M, "Parliamentary Arguments on Powers of Access – the Care Bill Debates" (2016) 18 J. Adult Prot. 318, http://www.emeraldinsight.com/doi/abs/10.1108/JAP-04-2016-0008; Stevens M, Martineau S, Manthorpe J and Norrie C, "Social Workers' Power of Entry in Adult Safeguarding Concerns: Debates over Autonomy, Privacy and Protection" (2017) 19 J. Adult Prot. 312.

[46] Department of Health, "Government Response to the Safeguarding Power of Entry Consultation" (London, 2013), www.nationalarchives.gov.uk/doc/open-government-licence/ viewed 8 October 2018.

[47] Department of Health, "Government Response to the Safeguarding Power of Entry Consultation", n 34, para 33.

Wales

The SSWA 2014 includes a power to apply for an Adult Protection and Support Order (APSO). An APSO provides a power of entry and the right to speak to the older person in private. There are no powers of removal. In evidence to the Health and Social Care Committee of the National Assembly, Age Cymru welcomed the power of entry, but felt it did not go far enough.

> We believe that powers of intervention should include a power of access and assessment and an injunction order: the aim of which would be to reduce the risk posed to the adult at risk by the perpetrator in the most supportive and least restrictive means possible.[48]

Welsh Government's response recognised powers involved a balance between autonomy and protection. In a letter to the Committee the Deputy Minister said,

> … I am clear that in keeping with the general principles of this Bill, the wishes of an adult at risk with capacity must be key to any support given. There are also equally strong arguments in relation to not overriding individuals' human rights. Should it be clear following the use of an Order that an adult is in need of further support, it would be the role of Social Services (and their partners) to persuade and negotiate with the person to accept appropriate assistance and support, even those who are reluctant.[49]

Powers of persuasion, negotiation, and offers of support play an important part. But the 'what if' scenarios must be catered for; what if none of those work? Does the authority just leave the person to it? The police may be reluctant to use any powers they have because of a lack of sufficient evidence to, for example, arrest the perpetrator. Use of mental health or mental capacity legislation may be inappropriate.

The main provisions of the APSO are as follows:

An application for an APSO must be made by an 'authorised officer' to a justice of the peace. The justice of the peace must be satisfied that ⟹	i. *the Authorised Officer has reasonable cause to suspect that a person is an adult at risk;* ii. *it is necessary for the Authorised Officer to gain access to the person to assess whether they are an adult at risk and to decide on what action should be taken;* iii. *making an order is necessary to fulfil the purposes of an APSO; and* iv. *exercising the power of entry will not result in the person being at greater risk of abuse or neglect. (s.127(4) SSWA 2014*
The purposes of an APSO are ⟹	i. *To enable the Authorised Officer and any other person accompanying the officer to speak in private with a person suspected of being an adult at risk.* ii. *To enable the Authorised Officer to find out whether that person is making decisions freely.*

[48] National Assembly for Wales Health and Social Care Committee, n 5, para 248.
[49] National Assembly for Wales Health and Social Care Committee, n 5, para 258.

	iii. *To enable the Authorised Officer to assess whether the person is an adult at risk, and to decide what, if any, action should be taken. s.127(2) SSWA 2014*
What premises can be entered under an APSO? ⟹	*'Premises' include* i. *domestic premises – a house, flat or similar;* ii. *residential care homes;* iii. *nursing homes;* iv. *hospitals, or* v. *any other buildings, structures, mobile homes or caravans in which the person is living.*[50]
Conditions may be attached to an APSO. ⟹	*Conditions may include:* i. *Restricting the time at which the power may be exercised.* ii. *Providing for another specified person to accompany the authorised person. (e.g. a mental capacity or mental health practitioner, somebody to assist with communication, or an advocate).*
Police involvement. ⟹	*When giving effect to the APSO the authorised person may be accompanied by a police constable. The role of the constable is not confined to gaining entry; they are there to enable all the purposes of the APSO to be fulfilled, in particular to ensure that the authorised person can speak to the adult in private.*

An authorised officer must be trained, not involved in the older person's case, and act in a semi-autonomous capacity.

APSOs have been used rarely because of the difficulty for the Authorised Officer and the justice of the peace to be satisfied that an order will not place the person at greater risk. The lack of additional powers means that in the worst-case scenario the Authorised Officer will leave the older person alone with an enraged perpetrator. This tentative approach to statutory powers achieves little and when used could add to the risk to the older person. Whereas there are some helpful ideas (e.g. right to talk to the older person in private) APSOs fails to recognise that the power to enter is only meaningful if backed up by further powers.

Scotland

Section 7 ASPA 2007 enables a council officer to enter any place when undertaking s.4 inquiries; this is known as a 'visit'. This is a wide-ranging power which does not normally require a warrant. However, the council may apply to the sheriff for a warrant to enter where the council officer has been refused entry or cannot enter, or reasonably expects that to be the case. A warrant may also be granted if the sheriff is satisfied that trying to enter without one would defeat the object of the visit.[51] There is provision for urgent orders; in such cases an application is made to a justice of the peace rather than the sheriff.

[50] Welsh Government, "Social Services and Well-Being (Wales) Act 2014: Working Together to Safeguard People - Volume 4 Adult Protection and Support Orders", http://gov.wales/docs/dhss/publications/160909safeguarden.pdf, para 1.13.

[51] See s.36(2) ASPA 2007.

The visit allows the council to decide whether the adult is at risk of harm, and whether action needs to be taken.[52] The council must have regard to the principles noted above, in particular whether this is the least restrictive action necessary to benefit the older person. It must consider whether services should be provided for the older person such as advocacy.

The list of 'premises' that may be entered includes,

- the adult's rented or owner-occupied accommodation;
- the home of relatives, friends or others with whom the person resides;
- supported or sheltered accommodation staffed by paid carers;
- temporary or homeless accommodation;
- a care home or other residential accommodation.
- a day centre;
- a place of education, employment or other activity;
- 'respite' residential accommodation; or
- a hospital or other medical facility.[53]

As with the Welsh APSO Guidance, including care homes is welcome. It is also appropriate that it includes places where the older person may only spend part of their time there, such as day centres.

Policy issues relating to powers of entry.

i. *Nothing must replace the ability of practitioners to use their skills of achieving access to an older person. Consent and agreement are the least intrusive ways of achieving access. The existence of powers may assist in getting agreement.*
ii. *Does Northern Ireland want to include a power of entry or, like England, does it consider such powers to be draconian and a violation of the right to autonomy? If powers are to be included, would they be based on the narrow Welsh model or the Scottish model? The latter has much to commend itself, the former very little. A power of entry must be backed up by further powers to ensure the safety of the older person following the visit. It cannot be a freestanding power.*
iii. *If powers of entry are included in the Northern Ireland legislation, should they be exercisable only with court approval, or should there be an automatic right of entry with the backup of a warrant if difficulties are encountered?*
iv. *Criteria must be identified on the face of the legislation for the exercise of a power of entry.*

To speak to the older person in private

Coercive or controlling behaviour is a disturbing feature of abuse and neglect but was not recognised until recently. The Serious Crimes Act 2015 and the Domestic Abuse (Scotland) Act 2018 have criminalised it in England, Wales, and Scotland. Similar legislation is anticipated in the Northern Ireland Assembly. These are welcome developments. However, coercive or controlling behaviour must be seen in a broader context that the criminal law. It features in most if not all abusive relationships. A consequence of it is the unwillingness of the perpetrator to allow the older person to be seen or spoken to in private. Perpetrators are ever present thus denying the older person the opportunity to speak freely. The inability to see and speak to the older person in private frustrates many enquiries; it is often wrongly concluded that the older person is exercising autonomy.

[52] Scottish Government, n 9 para 7.5.
[53] Scottish Government, n 9, para 7.13-14.

England

The CA 2014 does not include a power to see the older person in private. The Guidance makes one reference to private meetings. An older person being supported by an independent advocate should 'where practicable' meet the meet the advocate in private.[54]

Wales

One of the purposes of an APSO is to allow the authorised officer to speak to the older person in private and identify whether they are making decisions freely. If the perpetrator still refuses to allow access to the older person, the police constable may assist.

Scotland

Under s.8 ASPA 2007 the council officer and anybody else accompanying him or her may interview the older person in private. Similarly, under s.9 a health professional accompanying the officer may carry out a medical examination in private. Again, the older person may refuse an interview or examination. The older person may refuse to answer questions in which the council may apply to the sheriff for an assessment order under s.11 ASPA 2007. Interviews and medical examinations may be in private.[55]

Policy issues relating to speaking to the older person in private

i. *Being able to speak to the older person in private is essential if coercive and controlling behaviour is to be recognised and addressed. England and Wales do not address this satisfactorily. England ignores it and Wales tacks it onto the APSO. Scotland includes it as part of its statutory powers.*
ii. *A power to speak to the older person alone when enquiries are being made under Northern Ireland legislation would be useful. It would be subject to the older person agreeing to answer questions, but it would allow removal of the perpetrator on a temporary basis if necessary. It is not perfect, but would enable practitioners to separate perpetrator and victim.*

Further powers available in Scotland under the ASPA 2007

At this point reference to England and Wales is pointless as neither includes any of the following powers in their legislation. Practitioners may rely on civil law procedures or police powers under the Police and Criminal Evidence Act 1984.

Section 10 ASPA 2007 gives councils power to examine records A council officer may require anybody holding health (physical or mental), financial or other records about somebody whom the officer knows or believes to be an adult at risk, to give the records or copies to the officer. A request must be in writing. The records may be inspected by the officer and any other person considered appropriate; health records can only be inspected by a health professional.

ASPA 2007 introduced three Protection Orders. These are outlined in the table below.

ASPA 2007 Section	Protection Order	Comment

[54] Department of Health, "Care and Support Statutory Guidance", n 7, para 7.39.
[55] s.8 – 11 APSA 2007.

11	Assessment orders	*A council may apply to the sheriff for an assessment order authorising a council officer to take a person from premises visited under a s.7 order. This is to allow a council officer, or nominee, to interview the person in private, and for a health professional to conduct a private medical examination.* *The purpose of the order is to enable the council to decide whether the person is an adult at risk, and if so whether it needs to do anything to protect them from harm. The order is valid for seven days. The sheriff must be satisfied:* *(a) that the council has reasonable cause to suspect that the person for whom the order is sought is an adult at risk who is being, or is likely to be,* ***seriously*** *harmed,* *(b) the assessment order is required to discover whether they are an adult at risk being, or likely to be,* ***seriously*** *harmed, and* *(c) as to the availability and suitability of the place at which the person is to be interviewed and examined.* *An order is only available if during a s.7 visit it is not practicable to interview them under s.8 or medically examine them under s.9. An example is where there is a lack of privacy.* *Note the reference to 'seriously harmed' rather than 'harmed'.*
14	Removal orders	*A council may apply to the sheriff for a removal order authorising* *(a) a council officer, or nominee, to move a person to a specified place within 72 hours of the order being made, and* *(b) the council to take such reasonable steps as it thinks fit for protecting the moved person from harm.* *The order expires 7 days (or such shorter period stated in the order) after the day the person is moved.* *The sheriff must be satisfied—* *(a) that the person is an adult at risk who is likely to be* ***seriously*** *harmed if not moved to another place, and* *(b) as to the availability and suitability of the place to which the adult at risk is to be moved.* *An order may allow for a named person to have contact with the adult at risk; conditions may be placed on the contact. Representations to the sheriff may be made by the council, the adult at risk, the person wishing to have contact and any other person interested in the adult's welfare.* *Under s.16 ASPA 2007 the council officer has the right to enter the premises to give effect to the order.* *The sheriff may vary or recall the order on the application of the adult at risk, a person having an interest in the well-being or property of the adult, or the council. (s.17 ASPA 2007).*

		The council must take reasonable steps to protect the property of the adult following their removal. (s.18 ASPA 2007). *Note the reference to 'seriously harmed' rather than 'harmed'.*
19	Banning orders.	*The sheriff has the power to make a banning order if satisfied:* *(a) that an adult at risk is, or is likely to be,* ***seriously*** *harmed by another person,* *(b) that the adult's well-being or property would be safeguarded better by banning the other person from a place occupied by the adult than it would be by moving the adult.* *The effect of the order is to ban the person from a specified place and possibly from the vicinity. It also allows for the person to be ejected and to prevent them from removing items. Provision may be made to protect the banned person's property during the ban. Conditions may be included.* *Representations can be made to the sheriff by the applicant, adult at risk, the subject of the proposed banning order or anybody having an interest in the adult's well-being or property.* *The maximum duration of a banning order is six months, although a shorter time may be included in the order, or it may be recalled or varied by the sheriff.* *An interim banning order may be made pending the decision on the full order (s.21 ASPA 2007).* *A power of arrest may be attached to an order or temporary order. The police must be notified of the inclusion of the power, normally by the applicant. This also applies where the order is varied or recalled. Provisions apply relating to the arrest and police duties after the arrest.* *Who may apply for a banning order? The adult who would be safeguarded by the order and any other person entitled to occupy the property (e.g. relative). The council may also apply if it is satisfied that,* *(a) the criteria for making an order have been met,* *(b) nobody else is likely to apply for a banning order, and* *(c) no other proceedings to eject or ban the person from the place are before a court (e.g. under domestic abuse legislation).* *Note: banning orders engage property rights and rights of occupation. Any such provision in Northern Ireland legislation must recognise the (unwarranted) respect the law has for property rights in such cases.* *Note the reference to 'seriously harmed' rather than 'harmed'.*

Protection orders are highly intrusive. Section 35 ASPA 2007 provides that the consent of the adult at risk to a protection order is normally required before the sheriff can make an

order. Normally, nothing can be done without the consent of the adult. However, the sheriff can ignore a refusal if the adult has been 'unduly pressurised to refuse'. Before ignoring a refusal, the sheriff must be satisfied there are no steps that could be taken with consent that would provide protection. Strangely the Act gives an example of 'unduly pressurised'. Section 35(4) says that the adult is unduly pressurised if it appears,

> (a) that harm which the order or action is intended to prevent is being, or is likely to be, inflicted by a person in whom the adult at risk has confidence and trust, and
> (b) that the adult at risk would consent if the adult did not have confidence and trust in that person.

This is a benign definition as confidence and trust are invariably absent in coercive and controlling behaviour. However, s.35(5) makes it clear, albeit obscurely, that this is just an example and the more typical form of coercion is relevant.[56]

Policy issues relating to Protection Orders

i. *Including protection orders in Northern Ireland legislation may be controversial. Their inclusion would distinguish Northern Ireland from England and Wales and bring it into line with Scotland. If included, adequate safeguards are essential. The need for consent, other than in case of being unduly pressurised, is a key safeguard. Whether the Scottish model of undue pressure could be updated and brought more into line with current thinking on coercive or controlling behaviour is worthy of consideration.*
ii. *It is debatable whether the existence of protection orders has led to a rush of applications to the sheriff for orders. Much of the research (limited though it is) suggests that is not the case. Indeed, the existence of the power can lead to compliance and enables preventative and supportive work to be put in place.*
iii. *It is essential to be robust in the response to the argument that these powers are anti human rights. They are not if the criteria are clear, there are adequate safeguards, and the general principles in legislation are complied with. Decisions must satisfy the proportionality and least restrictive intervention tests.*
iv. *What level of court will be able to make protection orders?*
v. *Fast track provision must be made for urgent cases*
vi. *In the case of banning orders, the rights of the person banned must be taken account of.*

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[56]The Code clarifies this. See Scottish Government, n 9, para 44

Statutory Safeguarding Adults Boards

Safeguarding adults boards have an overarching responsibility in relation to safeguarding. Under the s.43 Care Act 2014 each local authority must establish a Safeguarding Adults Board for its area. Boards have three core duties:

- develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute;
- publish an annual report on how effective their work has been;
- commission safeguarding adults' reviews for cases meeting the criteria.

Membership must include the local authority, the clinical commissioning group for the area, and the chief officer of police. Others may be added to the list of membership.

In Wales s.134 SSWA 2014 provides for local Safeguarding Boards. The position is more complicated in Wales as part of the philosophy under the Act was to have a cradle to grave approach to social care. A Safeguarding Board for children and a separate one for adults must be established. There is a residual power that would lead to the merger of the two types of Board. The Bill anticipated unified boards, but under pressure they were made optional. Part of the concern was that safeguarding children and safeguarding adults are different, even though they share a common goal. Membership of the Adult Safeguarding Boards includes the local authority, the local Health Board, NHS Trusts, and the chief officer of police. Matters are complicated by the fact that local government, health boards, and the police do not share a common geographical footprint.

The objects of Safeguarding Boards are found in s.135 SSWA 2014; they are to,

> Protect adults within its area who—
> (i) have needs for care and support (whether or not a local authority is meeting any of those needs), and
> (ii) are experiencing, or are at risk of, abuse or neglect, and
> (iii) to prevent those adults within its area mentioned in paragraph (i) from becoming at risk of abuse or neglect.

A Safeguarding Board must seek to achieve its objectives by co-ordinating and ensuring the effectiveness of what is done by each person or body represented on the Board.

An additional feature of the SSWA 2014 is the National Independent Safeguarding Board. The duties of the National Board are to provide support and advice to local Safeguarding Boards, to report on the effectiveness of safeguarding in Wales, and to make recommendations to government.

Section 42 ASPA 2007 establishes multi-agency Adult Protection Committees in each council area to monitors and review what is happening locally to safeguard adults. Senior staff from the agencies involved in protecting adults who may be at risk are members. As with England and Wales, it includes the council, the NHS and the police. Their duties include,

- reviewing adult protection practices
- improving cooperation
- improving skills and knowledge
- providing information and advice
- promoting good communication

- Each committee must present a report to the Scottish Ministers every two years. [57]

Boards in England have the statutory responsibility for conducting Safeguarding Adult Reviews. Under s.44 CA 2014 Safeguarding Adult Board must arrange a Safeguarding Adult Review when an adult in their area dies or has experienced serious abuse or neglect as result of abuse or neglect and there is concern that partener agencies could have worked together more effectively. The Review is not about apportioning blame, but to see what lessons can be learned on how agencies and professionals can better work together. Other objectives include,

- how effective are the safeguarding procedures
- learning and good practice issues
- how to improve local inter-agency practice
- service improvement or development needs for one or more service or agency.

Provision for Practice Reviews for adults in Wales are included in regulations.[58] A Practice Review must be carried out by the Board if the adult has,

- died, or
- sustained potentially life threatening injury, or
- sustained serious and permanent impairment of health or development.

The objectives of a Review are similar to those under the CA 2014. Guidance on conducting Adult Pratice Reviews has been published by Welsh Government.[59]

In Scotland reviews are referred to as Significant Case Reviews. The Scotthish Government has developed an interim national framework for Adult Protection Committees for conducting reviews.[60]

Policy issues in relation to adult practice reviews

i. *Statutory Adult Safeguarding Boards should be established in each HSCT area.*
ii. *Northern Ireland should consider whether a National Safeguarding Board is necessary.*
iii. *Legislation should include provision for statutory safeguarding boards to review cases involving the death or serious harm of an adult at risk. Reviews should not focus on apportioning blame, but rather on identifying lessons that can be learnt in particular in relation to joint working.*

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[57] Helpful guidance on Adult Protection Committees is produced by Scottish Government. See Scottish Government, "Guidance for Adult Protection Committees" (Edinburgh , 2008), https://www.webarchive.org.uk/wayback/archive/20170701074158/http://www.gov.scot/Publications/2009/01/06115617/0 viewed 28 March 2020.

[58] The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015 Wales Statutory Instruments2015 No. 1466, r 4 (W. 160)

[59] Welsh Government, "Working Together to Safeguard People: Vol 3 Adult Practice Reviesws" (Cardiff, 2016), https://gov.wales/sites/default/files/publications/2019-05/working-together-to-safeguard-people-volume-3-adult-practice-reviews.pdf.

[60] Scottish Government, "Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review" (Edinburgh, 2019), https://www.gov.scot/publications/interim-national-framework-adult-protection-committees-conducting-significant-case-review/pages/2/.

Mental Capacity

England and Wales share mental capacity legislation – the Mental Capacity Act 2005. The CA 2014 Guidance reminds safeguarding practitioners that they should work in line with the Mental Capacity Act 2005.[61] In Wales the Guidance requires that a report arising out of an enquiry should include a statement whether a mental capacity or a mental health assessment has been carried out. Authorised officers involved in APSOs must have a 'clear understanding' of the Mental Capacity Act 2005. It may be necessary for the mental capacity expert to accompany an authorised officer using the APSO power. If a capacity assessment is anticipated, a condition specifying the time of the visit can be included in the APSO to maximise the chance of the adult being able to decide for themselves.[62]

The Scottish Code in discussing consent requires practitioners to consider mental capacity. If there is doubt about the older person's capacity, some or all the following may be considered.

- does the adult understand the nature of what is being asked and why?
- is the adult capable of expressing his or her wishes/choices?
- does the adult have an awareness of the risks/benefits involved?
- can the adult be made aware of his/her right to refuse to answer questions as well as the possible consequences of doing so?[63]

One of the purposes of a medical examination under s.9 ASPA 2007 is to assess the older person's capacity.[64] Where no guardian or attorney for a person who lacks relevant capacity has been appointed, practitioners should consider whether to use the Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Care and Treatment) (Scotland) Act 2003.[65]

Advocacy features in all three pieces of legislation. As seen, 6 ASPA 2007 requires the council to have regard to the need for advocacy. In England and Wales, the Mental Capacity Act 2005 introduces Independent Mental Capacity Advocates (IMCAs). IMCAs support and represent the person lacking relevant capacity and are there to ensure that the Mental Capacity Act 2005 is followed. The 'no other appropriate person' to advocate provision applies. IMCAs may be useful in adult safeguarding during enquiries, police investigations and general support in ensuring that decisions are made lawfully.[66]

Section 86 Mental Capacity (Northern Ireland) Act 2016 places a duty on Health and Social Care Trusts to make sure that IMCAs are available within their area. IMCAs will be independent of the decision maker. They will be involved in a best interests decision. The Northern Ireland Act goes into greater detail regarding IMCAs. When the legislation is fully brought into force, safeguarding practitioners will, as in England, Wales, and Scotland need to be aware of the legislation and its relationship with safeguarding legislation.

Policy issues relating to mental capacity

i. *The interrelationship between safeguarding and mental capacity legislation should be emphasised in the statutory and the code or guidance.*

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[61] Department of Health, "Care and Support Statutory Guidance", n 7, para 14.18.
[62] Welsh Government, "Social Services and Well-Being (Wales) Act 2014 Working Together to Safeguard People Volume I – Introduction and Overview Guidance on Safeguarding", n 8. paras 42, 50, and 72.
[63] Scottish Government, n 9, paras 8.13-14.
[64] Scottish Government, n 9, para 9.3.
[65] Scottish Government, n 9, para 9.5.
[66] On the use of IMCAs in adult safeguarding see Williams J, Wydall S and Clarke A, "Protecting Older Victims of Abuse Who Lack Capacity: The Role of the Independent Mental Capacity Advocate" (2013) 2 Elder Law J. 167.

Link to adult social/heath care

Adult safeguarding legislation must be closely linked with social and health care law. Referrals to safeguarding may come from health or social care practitioners. It is essential that all practitioners are aware of safeguarding and are able to identify concerns and know what they should do with them. Safeguarding teams must not be isolated. The results of enquiries by safeguarding must feed back into social care and health care. As noted above, safeguarding is everybody's business.

In England and in Wales safeguarding law is included in general social care law. In Scotland it is a separate piece of legislation. Which is the better approach is a matter of debate. As Northern Ireland does not have plans for a comprehensive reform of social care, it seems that it will be a freestanding piece of legislation. If it is, the link with other areas of health and social care must be spelt out.

Regard must be had to including housing, environment, education and public health bodies. They have a role to play.

Policy issues in relation to social care or health care legislation

i. *Despite being in separate Northern Ireland legislation, adult safeguarding and social or health care are an integral part of safeguarding and the promotion of well-being.*

Safeguards

As discussed, ensuring compliance with the Human Rights Act 1998 and the European Convention on Human Rights requires adequate safeguards, preferably in the legislation. The above analysis has identified what these are, and they include:

- Clear definitions of the key concepts
- Including statutory principles
- A due regard duty to the UN Principles
- A least restrictive intervention approach to the use of powers
- A clear threshold for intervention
- Involvement of the adult at risk
- The importance of consent
- Awareness of coercive or controlling behaviour
- A commitment to sharing information so that decisions are made on the best evidence
- Linking safeguarding with health and social care
- In appropriate cases the use of courts

Summary of arguments opposing safeguarding legislation

The following is a summary of the arguments presented in opposition to legislation in England, Wales, and Scotland.

Argument against	Counter argument
Powers of intervention undermine personal autonomy – the so called right to 'live in isolation'.	To concentrate on autonomy ignores the following: 1. Autonomy is not an absolute right. Under art.8(2) ECHR it can be interfered with if three conditions are met. It must be in accordance with the law (safeguarding legislation would satisfy this); the aim of the intervention must be legitimate under art. 8(2) – this includes public safety, protection of health or morals, prevention of crime, or protection of the rights of others; it must be necessary and proportionate – safeguards against abuse in legislation would ensure proportionality. 2. The right to autonomy must be balanced against the right under art.2 to have life protected and the art.3 right not to be subjected to inhuman or degrading treatment. Art 8 also includes the right to dignity – abuse and neglect are undignified. Inaction because of a lack of statutory powers may result in denying the older person justice. 3. Coercive or controlling behaviour is often present in abuse and neglect cases. It undermines the autonomy of the older person; they are not exercising free choice. 4. Has the older person been given sufficient information to enable them to make an informed choice? For example, are they aware of what support may be available if they engage with safeguarding and maybe criminal investigations?
The Westminster government opposed giving social workers powers of access, etc.	Evidence from Scotland suggests that giving practitioners powers does not mean they use them. The existence of powers often results in the abuser granting access and being more cooperative when it is pointed out that powers exist.[67]
Provision is already available under existing legislation.	For people who lack mental capacity some protection may be available under the Mental Capacity (Northern Ireland) Act 2016. Other legislation that may be used if often designed for different purposes and does not contain the necessary safeguards. People may be shoehorned into legislation simply because no alternative powers are available.

[67] Mackay K, "The Scottish Adult Support and Protection Legal Framework" (2008) 10 J. Adult Prot. 25.

Resources.	How resource intensive will proper preventative practice be? Good safeguarding procedures will protect people and lead to earlier intervention. How much did Cherry Tree and Dunmurry cost?
Existing complaints procedures already perform the role of safeguarding.	Cherry Tree and Home Truth's clearly identify this is not the case.[68]
Do social care practitioners want powers?	The survey carried out on the Care Bill in England suggests that public authorities and practitioner would find powers helpful, but are aware of the need to exercise them with caution.
Is access to adults at risk a problem?	Research suggest that in most cases practitioners can gain access.[69] But that will still leave many adults at risk without protection.
Data protection and confidentiality prevent/restrict sharing of information.	This is a red herring. The Data Protection Act 2018, the General Data Protection Regulation, and the law on confidentiality allow sharing (sometimes with consent) if certain conditions are complied with.
Relatives and practitioners can be effective advocates – statutory advocacy is unnecessary.	1. Relatives may have their own agenda and there is no guarantee that they will have the adult's best interests at heart. 2. Practitioners may be conflicted and have responsibilities towards their employers. 3. Advocates must be trained. The amateur advocate can sometimes do more damage, even if they are well intentioned.
The existence of powers of entry may make matters worse – abuse may escalate because of the intervention.	1. The alternative is that the adult remains in the abusive environment without the opportunity to assess the risk this poses to them. 2. The powers must go beyond entry and assessment. It must give the authority power to put in place appropriate measures to ensure the safety of the adult as in the Scottish model. The lack of follow up powers is the major weakness of the Welsh model.
People would be afraid to have contact with the system and seek help when needed.	A public information campaign is necessary to ensure that the public understand that elder abuse happens and that we all have a role to play in preventing it. For practitioners who report, greater protection is needed. See Rec 47 *Home Truths*.

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[68] Older People's Commissioner for Northern Ireland, "Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home" (Belfast, 2018), www.copni.org.

[69] Norrie C, Manthorpe J, Martineau S and Stevens M, "The Potential Uses and Abuses of a Power of Entry for Social Workers in England: A Re-Analysis of Responses to a Government Consultation" (2016) 18 J. Adult Prot. 256, http://www.emeraldinsight.com/doi/10.1108/JAP-04-2016-0009 viewed 26 April 2017.

Summary of key policy issues

In developing a law Northern Ireland has three models to consider:

i. Scottish model: Maximum powers of intervention, balanced by safeguards to ensure human rights compliance and proportionality.
ii. English model: A minimalist approach with only limited duties (duty to make enquiries and joint working).
iii. Welsh model: The English model plus limited powers of entry.

It is open to Northern Ireland to adapt these models to fit in with its own policy objectives and to enhance or improve them.

Human rights:

i. Human rights belong to everybody
ii. Under the Human Rights Act 1998 and the CA 2014 the Convention binds many private providers of care who have a duty to act in a way that is compatible with the Convention.
iii. The State has a positive duty to prevent violations of human rights.
iv. When the State knows of a person who is vulnerable is at risk, it has an enhanced duty to protect.
v. The State must be able to show that it has systems in place to protect the human rights of vulnerable people. Those processes must be robust and the only guarantee of this is if they are enshrined in law. Policy and guidance have a role to play, but the key question is who has the legal duty to ensure the protection of the rights of older people at risk?

Definition of 'adults at risk.

i. All three definitions recognise the importance of including people at risk of harm and those who have experienced or are experiencing it. Adult safeguarding law should be preventative and reactive.
ii. In drafting legislation in Northern Ireland, a decision will have to be made on the definition of 'adults at risk'. The Wales and England definition is restrictive and excludes those who do not have needs for care and support. This may exclude some older people being abused or neglected. The Scottish definition is more inclusive, although still excludes some older people being abused or neglected – or at risk of it.

Definition of abuse/harm.

i. The choice for Northern Ireland is the extent to which it wishes to define what the legislation should include – a general definition that relies on the assumption it will be recognised when seen, or a more detailed definition? England and Wales provide examples of each. Whatever the approach, any list (long or short) must not be exhaustive. It is impossible to predict the totality of abuse.
ii. The definitions of abuse/harm in the other three nations are not freestanding and are to be read in the context of the definition of adults at risk. For example, domestic abuse does not automatically engage safeguarding procedures. Persuading the Government to adopt a broader definition will be difficult; they will argue it would impose a considerable commitment on Health and Social Care Trusts. However, not doing so means an older person who is vulnerable because of the abuse rather than need is excluded. This has implications for older people who experience domestic abuse.
iii. Northern Ireland could adopt the Scottish idea of harm rather than abuse. This is a wider concept.

Definition of neglect:

i. As with the definition of abuse/harm, the decision is whether to adopt the England and Wales approach of specific reference to it in the definition, or the Scottish approach of incorporating it under the term 'conduct' and not going into any detail of what it includes. Not including neglect in the definition of abuse/harm and incorporating it indirectly risks it being forgotten or treated as not as bad as, for example, physical abuse. If Northern Ireland adopted the Scottish definition of abuse, it could easily be adapted to include specific reference to neglect on the face of the legislation.
ii. Legislation or accompanying codes or guidance may provide examples of neglect, but these are not an exhaustive definition.

Self-harm/neglect

i. Should the legislation refer to self-harm or self-neglect? Harm has the advantage of being a wider and more inclusive concept.
ii. Northern Ireland faces three models.
    a. incorporate self-harm/neglect in legislation (Scotland);
    b. leave it to the code or guidance to introduce it (England); or
    c. make no reference to it (Wales).
iii. Option (c) may create the impression that self-harm/neglect is never a safeguarding matter. Practice in Wales suggests that cases are referred to safeguarding, although practitioners are unsure whether this is correct. Option (a) may create the impression that self-harm/neglect is routinely safeguarding. This may meet with opposition based on the autonomy and freedom to isolate argument. Scotland avoid this risk by incorporating safeguards against a disproportionate or inappropriate use of powers (see below). Option (b) provides some guidance on the use of safeguarding, but its absence from the legislation may lead to the impression that it is unimportant.
iv. How far is Northern Ireland prepare to go in addressing self-harm/neglect? A response to the autonomy argument is to include safeguards, and checks and balances against misuse in the legislation.

Principles

i. Should Northern Ireland safeguarding legislation include principles that apply to public authorities and practitioners?
ii. If so, should such principles by included in:
    a. The legislation;
    b. A code or guidance;
    c. Legislation and guidance?
iii. If they are in the legislation, should they impose an absolute duty to apply, a due regard duty, or a have regard duty?
iv. In addition to statutory principles, should Northern Ireland consider incorporating the United Nations Principles for Older People? Is so, should it be a due regard or have regard duty? It would be difficult to make it an absolute duty given the general nation of the Principles. (Note that legislation will have wider application than older people. However, including the Principles helps address ageism and also helps develop an approach that may benefit other groups).

Duty to make enquiries

i. Including a duty imposed on a single public authority to make enquiries is an essential component and avoids concerns being lost in a melee of buck passing. The most obvious candidate in Northern Ireland are the Health and Social Care Trusts. They

are uniquely placed to undertake the responsibility. They should have primary responsibility for adult safeguarding; they will be the route into adult safeguarding.

ii. The threshold for triggering this duty should not be too demanding. Early intervention may prevent things worsening; it may also identify that there is no cause for concern, or that there is a social care or health care need that has thus far gone unnoticed.

iii. The single body identified could be solely responsible for undertaking the enquiries, although recognising the importance of collaboration. Alternatively, it could have the power to ask other to undertake the enquiry.

iv. It is essential that if the adult is at risk that an action plan is devised and monitored. This action plan must link in with any care plan.

v. A refusal on the part of the suspected adult at risk does not relieve the authority of its duty but restricts their ability to undertake the enquiries.

vi. Normally enquiries should take seven days, with the possibility of one extension. It is not an investigation; it is a fact-finding exercise.

Duty to cooperate

i. Legislation should include a duty on relevant public bodies to cooperate in adult safeguarding at a strategic and policy development level, and in individual cases.

ii. Who should be included in the list of relevant bodies? HSCTs should have a duty to cooperate with each other. The PSNI must also be included as should the Probation Board for Northern Ireland. There is a firm case for including RQIA. Public bodies involved in housing, education (legislation would include younger vulnerable adults who may be in education), environment and public health. The Fire and Rescue Service and GPs are other possibilities, although the latter may he more difficult given their legal status. Should COPNI be on the list?

iii. Any list of relevant bodies may distinguish between those where the duty will be reciprocal (frontline adult safeguarding services) and those where the duty is not reciprocal.

iv. The registration system should ensure private providers of social care have an obligation to cooperate in safeguarding enquiries.

v. Legislation should make it clear that those who are required to cooperate cannot be made to do something beyond their legal powers. However, if they have a reciprocal duty, then they should if requested provide a written reason for not complying with a request from a HSCT.

Sharing of information

i. The approaches in England, Wales, and Scotland emphasise the importance of sharing information. However, much of the detail is contained in the codes and guidance. There is a case for saying that a duty on practitioners and public bodies to share information when necessary, subject to data protection laws and confidentiality, should be in the legislation. This would concentrate minds and help to break down the culture of non-sharing. The duty should be qualified by the need for a lawful justification for sharing. Such justifications may be in legislation (for example, the criminal law), or the common law on the duty of confidentiality. The latter duty is not absolute; there may be a compelling public interest in sharing.

ii. Some jurisdictions go as far as mandatory reporting and impose it on all practitioners, and in some instances on members of the public. This is controversial.

iii. Consent should be the primary justification for sharing information. However, any code or guidance accompanying the legislation should spell out when sharing without consent is permissible and expected.

iv. Where the adult lacks relevant mental capacity, mental capacity legislation should be followed.
v. Training programme introducing legislation should include a module on information sharing and its importance.

Duty of candour

i. Adult safeguarding legislation provides an opportunity to implement the Home Truths recommendation on duty of candour.

Advocacy

i. Provision of statutory independent advocacy across England, Wales, and Scotland is less than fulsome. There is concern over the cost of funding independent advocacy. There is also a touching belief in the ability and willingness of family and friends to advocate, besides any conflict of interests they may have. Similarly, many believe that health and social care practitioners can act as effective advocates. This is not the case as they are conflicted their duties to their employers. For Northern Ireland, the choice is whether they want to follow any of the three existing models or be more radical. A more radical approach involves a statutory presumption of advocacy which is rebuttable. If the older person refuses advocacy, that will normally displace the presumption. However, the older person may refuse because of coercion or control. Rebutting the presumption in these cases will reaffirm the power of the abuser. The duty should continue. Obviously, if access is difficult, and the adult refuses to cooperate, advocacy will be difficult. Nevertheless, an independent advocate may still make an important contribution to decision making. Specialist training for such cases is necessary.
ii. Advocates must be independent of any public authority involved in providing services to the older person. The third sector should provide the service.
iii. Independent advocacy services must be funded by the public authority having responsibility for making enquiries.
iv. Eligibility criteria should identify who is eligible and the circumstances giving rise to the duty.
v. A duty to provide advocacy services and the eligibility criteria should appear in the legislation or in delegated legislation. Details can be included in a code or guidance made under the legislation.

Powers of entry.

i. Nothing must replace the ability of practitioners to use their skills of achieving entry to an older person. Consent and agreement are the least intrusive ways of achieving access. The existence of powers may assist in getting agreement.
ii. Does Northern Ireland want to include a power of entry or, like England, does it consider such powers to be draconian and a violation of the right to autonomy? If powers are to be included, would they be based on the narrow Welsh model or the Scottish model? The latter has much to commend itself, the former very little. Power of entry must be backed up by further powers to ensure the safety of the older person following the visit. It cannot be a freestanding power.
iii. If powers of entry are included in the Northern Ireland legislation, should they be exercisable only with court approval, or should there be an automatic right of entry with the backup of a warrant if difficulties are encountered?
iv. Criteria must be identified on the face of the legislation for the exercise of a power of entry.

Speaking to the older person in private

i. Being able to speak to the older person in private is essential if coercive and controlling behaviour is to be recognised and addressed. England and Wales do not address this satisfactorily. England ignores it and Wales tacks it onto the APSO. Scotland includes it as part of its statutory powers.
ii. A power to speak to the older person alone when enquiries are being made under Northern Ireland legislation would be useful. It would be subject to the older person agreeing to answer questions, but it would allow removal of the perpetrator on a temporary basis if necessary. It is not perfect, but would enable practitioners to separate perpetrator and victim.

Protection Orders

i. Including protection orders in Northern Ireland legislation may be controversial. Their inclusion would distinguish Northern Ireland from England and Wales and bring it into line with Scotland. If included, adequate safeguards are essential. The need for consent, other than in case of being unduly pressurised, is a key safeguard. Whether the Scottish model of undue pressure could be updated and brought more into line with current thinking on coercive or controlling behaviour is worthy of consideration.
ii. It is debatable whether the existence of protection orders has led to a rush of applications to the sheriff for orders. Much of the research (limited though it is) suggests that is not the case. Indeed, the existence of the power can lead to compliance and enables preventative and supportive work to be put in place.
iii. It is essential to be robust in the response to the argument that these powers are anti human rights. They are not if the criteria are clear, there are adequate safeguards, and the general principles in legislation are complied with. Decisions must satisfy the proportionality and least restrictive intervention tests.
iv. What level of court will be able to make protection orders.
v. Fast track provision must be made for urgent cases
vi. In the case of banning orders, the rights of the person banned must be taken account of.

Adult safeguarding boards and adult practice reviews

i. Statutory Adult Safeguarding Boards should be established in each HSCT area.
ii. Northern Ireland should consider whether a National Safeguarding Board is necessary.
iii. Legislation should include provision for statutory safeguarding boards to review cases involving the death or serious harm of an adult at risk. Reviews should not focus on apportioning blame, but rather on identifying lessons that can be learnt in particular in relation to joint working.

Policy issues relating to mental capacity

i. The interrelationship between safeguarding and mental capacity legislation should be emphasised in the statutory and the code or guidance.

Policy issues in relation to social care or health care legislation

i. Despite being in separate Northern Ireland legislation, adult safeguarding and social or health care are an integral part of safeguarding and the promotion of well-being.

Appendix 1: Legislation checklist

	To be included in Northern Ireland legislation?	Northern Ireland Yes/No
1.	Statutory principles	
2.	Due regard duty - UN Principles for Older Persons	
3.	Duty to cooperate	
4.	Personal autonomy and decision making	
5.	Definition – harm/abuse	
6.	Definition – neglect	
7.	Definition – self-harm/neglect	
8.	Definition – financial abuse	
9.	Duty to make enquiries	
10	Duty to provide advocacy including IMCA	
11	Duty to share information	
12	Duty to report concerns	
13	Duty of candour	
14	Power of entry	
15	Power to speak to the adult at risk in private	
16	Assessment orders	
17	Removal orders	
18	Banning orders	
19	Warrants	
20	Powers of arrest	
21	Consent of the adult at risk	
22	Adults who lack capacity	
23	Coercive or controlling behaviour	
24	Local statutory Adult Safeguarding Boards	
25	National Safeguarding Board	
26	Adult safegaurding reviews	

Appendix 2: Care Act 2014: What constitutes abuse and neglect?[70]

Physical abuse including:

- assault
- hitting
- slapping
- pushing
- misuse of medication
- restraint
- inappropriate physical sanctions

Domestic violence including:

- psychological
- physical
- sexual
- financial
- emotional abuse
- so called ‘honour’ based violence

Sexual abuse including:

- rape
- indecent exposure
- sexual harassment
- inappropriate looking or touching
- sexual teasing or innuendo
- sexual photography
- subjection to pornography or witnessing sexual acts
- indecent exposure
- sexual assault
- sexual acts to which the adult has not consented or was pressured into consenting

Psychological abuse including:

- emotional abuse
- threats of harm or abandonment
- deprivation of contact
- humiliation
- blaming
- controlling
- intimidation
- coercion
- harassment
- verbal abuse
- cyber bullying
- isolation
- unreasonable and unjustified withdrawal of services or supportive networks

[70] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1, para 14.17

Financial or material abuse including:

- theft
- fraud
- internet scamming
- coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions
- the misuse or misappropriation of property, possessions or benefits

Modern slavery encompasses:

- slavery
- human trafficking
- forced labour and domestic servitude.
- traffickers and slave masters using whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment

Discriminatory abuse including forms of:

- harassment
- slurs or similar treatment:
  - because of race
  - gender and gender identity
  - age
  - disability
  - sexual orientation
  - religion

Organisational abuse

- Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to ongoing ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

Neglect and acts of omission including:

- ignoring medical
- emotional or physical care needs
- failure to provide access to appropriate health, care and support or educational services
- the withholding of the necessities of life, such as medication, adequate nutrition and heating

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Appendix 3: Non-exhaustive list of categories of abuse – Social Services and Well-being (Wales) Act 2014 statutory guidance.[71]

The following is a non-exhaustive list of examples for each of the categories of abuse and neglect:

- physical abuse - hitting, slapping, over or misuse of medication, undue restraint, or inappropriate sanctions;
- sexual abuse - rape and sexual assault or sexual acts to which the vulnerable adult has not or could not consent and/or was pressured into consenting;
- psychological abuse - threats of harm or abandonment, coercive control, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks (coercive control is an act or pattern of acts of assault, threats, humiliation, intimidation or other abuse that is used to harm, punish or frighten the victim);
- financial abuse in relation to people who may have needs for care and support -. Indicators of this include:
  - unexpected change to their will.;
  - sudden sale or transfer of the home;
  - unusual activity in a bank account;
  - sudden inclusion of additional names on a bank account;
  - signature does not resemble the person's normal signature;
  - reluctance or anxiety by the person when discussing their financial affairs;
  - giving a substantial gift to a carer or other third party;
  - a sudden interest by a relative or other third party in the welfare of the person;
  - bills remaining unpaid;
  - complaints that personal property is missing;
  - a decline in personal appearance that may indicate that diet and personal requirements are being ignored;
  - deliberate isolation from friends and family giving another person total control of their decision making.

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[71] Welsh Government, "Social Services and Well-Being (Wales) Act 2014 Working Together to Safeguard People Volume I – Introduction and Overview Guidance on Safeguarding" (Cardiff, 2016), http://gov.wales/docs/phhs/publications/160404part7guidevol1en.pdf, para 26.

Appendix 4: Key adult safeguarding principles – Care Act 2014 Guidance

Six key principles underpin all adult safeguarding work

Empowerment

- People being supported and encouraged to make their own decisions and informed consent.
- I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.

Prevention

- It is better to take action before harm occurs.
- I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.

Proportionality

- The least intrusive response appropriate to the risk presented.
- I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed.

Protection

- Support and representation for those in greatest need.
- I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.

Partnership

- Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.

Accountability

- Accountability and transparency in delivering safeguarding.
- I understand the role of everyone involved in my life and so do they.