Submission to the Oireachtas Joint Committee on Disability Matters

The Irish Association of Social Workers Perspective on Ireland's Implementation of Articles 16 & 19 of UNCRPD in Congregated Settings.

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29 March 2022

1. Introduction

Social Work: The Lead Profession in Adult Safeguarding

There are almost 5,000 registered social workers in Ireland and the Irish Association of Social Workers is the representative body of the profession. **Social work is the named lead profession for child protection and adult safeguarding[1],** tasked with the primary responsibility for policies which support people at risk of abuse and neglect, including children and adults with disabilities.

Safeguarding failures in any setting may impact upon people with disabilities. Social workers work with people with disabilities in their homes and communities, in disability services, nursing homes, homeless services, direct provision centres, prisons and other settings. We work with many adults with disabilities who have never been formally assessed or supported by a disability service.

As lead profession, social work champions a **human rights-based approach to safeguarding**, recognising safeguarding is equally about promoting the rights and well-being of a person, as it is about protecting people from abuse and neglect[2]. **It is in scenarios and cultures where rights are overlooked and well-being is ignored, where a person lacks choice and autonomy in their own lives, that abuse is most likely to occur.**

The IASW is presenting to the Committee on **safeguarding in congregated settings**, in accordance with the requirements of Articles 16 & 19 of the UNCRPD[3]. As safeguarding is a broad, complex topic, the IASW wishes to focus the Committee's attention today on one of the least protected groups; adults with disabilities in congregated settings, who comparative to children, have far less legal protection in their own 'home'. **It is a fact that legal protection from abuse, neglect and exploitation decreases for every person, including a person with disability, when they turn 18 in Ireland.**

Safeguarding Data: Gaps in our Knowledge.

Ireland does not collate adequate data about the abuse of adults with disabilities in Ireland, which impacts negatively on service planning**.** While **51,000 concerns about the abuse and neglect of adults** have been reported to the HSE Safeguarding and Protection Social Work teams since 2015[4], it is unknown how many relate to people with disabilities. Through analysis of responses to parliamentary questions, the IASW has established that **143 sexual assaults** against residents of care settings were reported to HIQA from 2015 to 2022, 87 of these assaults in nursing homes where many people with disabilities reside and 56 in disability centres[5]. Again, through analysis of parliamentary questions, the IASW has established that An Garda Síochána cannot provide figures about the rates of abuse and neglect of residents in nursing homes or disability centres reported to them[6]. The fact that such accountability and transparency is only achieved through persistent IASW follow-up and through responses having to be provided to Parliamentary Questions, is indicative of the gaping gulf in real information and even basic data in this area.

2. Background to the Development of Adult Safeguarding in Ireland

In 2007, the HSE established a national Social Work Elder Abuse Service, in response to abuse and neglect of those aged 65 and over. In 2014, RTE 'Prime Time Investigates' **highlighted abusive practices in Áras Attracta, a HSE service for adults with intellectual disabilities,**[7] resulting in a national outcry. A HSE National Adult Safeguarding Office and **nine Safeguarding and Protection Social Work teams were established** to implement a new HSE *Safeguarding Vulnerable Persons at Risk of Abuse, National Policy, and Procedures* (2014)[8]. Designated Officer roles within Older Persons and Disability Services were created, envisioning that those organisations would manage safeguarding concerns with support from the new Safeguarding and Protection teams.

The 2014 policy applies to all adults over 18 using services provided by the HSE Social Care Division and HSE Social Care funded services, along with adults in the community not linked to formal services. The policy excluded adults using services such as mental health services, private nursing homes etc.

In 2019 a new HSE draft adult safeguarding policy was published, identifying new safeguarding roles and responsibilities *without any commitment to increased staffing and resources*. Multiple stakeholders have expressed concerns about both the viability of this and the overall policy direction the HSE is taking in adult safeguarding. The 2019 policy remains under consultation and is not yet implemented.

The Department of Health is developing a national adult safeguarding policy for the entire health sector, together with accompanying legislation[9]. **The IASW has repeatedly called on the Department to expedite this process, given adults are at increased risk of preventable abuse in the gap of action.** No interim measures have been taken to address risks in safeguarding practices and systems.

Operationally, there are nine Community Healthcare Organisations (CHO) delivering primary and community-based services as part of the HSE. Each CHO has a **Safeguarding and Protection Social Work team, led by a Principal Social Worker** who reports to a Head of Quality, Safety and Service Improvement, who in turn reports to the most senior manager in each CHO, the Chief Officer. Due to a number of challenges, including critical under-resourcing, safeguarding referrals are responded to in different ways by each safeguarding and protection social work team.

Meeting the Requirements of Articles 16 & 19

Ireland is not currently meeting the requirements set out in Articles 16 and 19. **Our move toward deinstitutionalisation, where people can live with choice and autonomy and exert their will and preferences in their own lives, is unacceptably slow**[10] **and safeguarding within existing services is far too weak.**

Safeguarding concerns regularly enter the public domain through media reports and review processes. There were acknowledged failures to uphold rights and protect adults in **Leas Cross (2005)**[11], **Áras Attracta (2014)**[7] and in the '**Grace' case** when 'Grace,' a woman with intellectual disability lived in an

abusive situation in her adulthood from 1989 to 2009[12]. In the **'Brandon' case**, a vulnerable man with intellectual disabilities who required protection himself, was identified as having committed over 100 sexual assaults on adults with disabilities living in the full time care of the HSE from **2003 to 2016** with full knowledge of HSE staff and management.[13] The media has reported delays in reporting of sexual abuse of unconscious adult patients in **Naas General Hospital in 2018**[14], failures in the management of safeguarding concerns in **HSE area CHO7** (Kildare, West Wicklow, Dublin West, South City & South West) from **2018 on**[15] and a pattern of **safeguarding failures in HSE area CHO1** (Leitrim, Monaghan, Sligo, Donegal), most recently relating to the **repeated access of a resident with an intellectual disability to child sexual abuse imagery (up to July 2021)**, resulting in HIQA questioning the HSE's ability to provide safe services for people with disabilities.[16] while Minister Anne Rabbitte is reported to have requested reports on other safeguarding concerns in residential services.[17]

In 2019, HIQA published a five-year overview of regulation of disability services[18], welcoming progress but calling for improvements in safeguarding practice and legislation. **Appendix A** to this submission outlines excerpts from HIQA reports in the last two years, **evidencing the lack of autonomy some residents have in their own lives.** The 'Wasted Lives' report[19] shares similar concerns.

Among other groups (where there may be also intersections with disability, i.e., among Travellers, ethnic minorities, older people), **people with disabilities, particularly women, are at higher risk of experiencing abuse and exploitation[20], with no targeted strategy to address this in Ireland.** Adult Safeguarding services remain **poorly resourced and governed and operate in the gap of essential legislation.** There has been ***consistent under-resourcing*** of social workers and Designated Officers at local service level, even when there is a high-profile case or crisis in an individual HSE CHO area/local service[15].

There are challenges in information sharing in adult safeguarding. The interpretation of GDPR and lack of statutory bases for interagency work and information sharing, severely restricts safeguarding practice. As a practical example, this means that **a hospital social worker who is asked to review an adult with a disability admitted with signs of serious neglect from a nursing home or disability centre, cannot then identify that individual to HIQA for follow up, but rather can only express general concerns about care standards in that centre.**

Comparative to child protection, social work has less influence in adult safeguarding practice and policy development. Operational social work governance and expertise, drawing on our human rights lens and approach to practice, is absent at senior HSE management level which in turn has significant **implications for how the HSE understands and responds to adult safeguarding throughout the country. This has a direct impact on people with disabilities living in residential care settings.**

The National Independent Review Panel is a panel established by the HSE, which reviews cases related to serious failings by the HSE and/or its funded organisations. **In the 'Brandon' report, the National Independent Review Panel advised that HSE management disregarded the advice and expertise of the Safeguarding and Protection social work team in terms of how serious safeguarding concerns should be dealt with.** This was despite the establishment of a HSE National Safeguarding Office, the introduction of a national safeguarding policy and advice from an expert social work team. IASW have

shared accounts from families of residents and social workers outlining the challenges of raising abuse within their organisations[21]. While social workers have expertise to challenge this culture, it is clear from multiple system failings, that many others do not.

As seen in the 'Brandon' report, ignoring safeguarding expertise can result in use of poor judgement (i.e., around scope and resourcing of safeguarding investigations, waiting lists, or instructing social workers to stop putting concerns in writing[22]). **This can all result in missed opportunities to intervene and prevent abuse. It can also result in a failure to optimise use of social work expertise.**

As an example, concerned by the sole focus on cocooning residents, IASW wrote a rights-based model[23], supporting the rights of residents in care settings during lockdown. The Department of Health and the HSE did not respond to our submission, but it was identified by The Economist Intelligence Unit as **one of only five European projects for inclusion** in 2020 global report on rights focused ageing[24].

There is a concerning and **uniquely Irish lack of transparency when safeguarding failures occur**. Unlike in the UK, where swift, cost-effective safeguarding reviews are published in full (for example Winterbourne View [care home]; Time for Change[25]), **adult safeguarding reviews are rarely published in full in Ireland** and are 'owned' by the HSE/Service Provider who are then the **gatekeeper of information about failures in their own services**. Challenges in accessing HSE safeguarding reports have even been referenced at Ministerial level. **Residents and families are uninformed** about the true extent of failings within their 'home', while Irish social workers rely on international safeguarding reports to learn from what can go wrong and seek to improve practice accordingly here.

The HSE plans to introduce new safeguarding roles (alongside existing social work safeguarding posts) solely for the nursing profession[26], apparently basing this on both the size of the nursing workforce and the fact that most *designated officer* roles are occupied by nurses. This is a concerning extension of our existing medicalised approach and ignores the central message of the 'Brandon' report, **that we must move away from viewing safeguarding through a clinical, medicalised lens and instead operate from a rights-based model with a broad range of professional expertise and perspectives.** Given the size of the nursing workforce already present in both strategic management and frontline practice posts, the HSE should include additional and holistic perspectives in the safeguarding of their systems, **to avoid dominance of any one clinical or professional paradigm.** The proposed new roles should also be open to a wide range of professions **such as social care, speech and language therapists, psychologists, occupational therapists etc. to bring a truly holistic and rights-focused lens to adult safeguarding.**

There is a continued societal tolerance for abuse against people with disabilities. While there was appropriate outrage and a redress scheme set up in response to children harmed in the CAMHS failure in Kerry, no such scheme has been proposed for residents who were repeatedly sexually assaulted in the 'Brandon' case. Shortly after the 'Brandon' report, another serious safeguarding failure in the same area (CHO1) emerged, causing HIQA to question the HSE's ability to provide safe services for people with disabilities[27]. We have yet to see any 'forensic' follow-up on this matter and the proposed and urgently required independent review of CHO1 has yet to be confirmed. **Peer abuse in particular is often minimised, ignoring the fact that it is akin to experiences of domestic violence for a resident in a care setting. Minimising language, i.e., 'rough handling' instead of physical abuse,** 'inappropriate

use of resident finances' (instead of financial abuse), 'poor quality care' (instead of neglect) are often used in public domain.

Provision of information and education on how to avoid, recognise and report instances of exploitation, violence, and abuse.

Department of Health research shows people do not know how or where to report abuse[28]. **Pandemic-type 'lockdowns' increase the risk of abuse, including within congregated settings,** making it difficult for residents to seek help from 'within the cocoon'. In response, over the course of the pandemic, the IASW proposed increased safeguarding measures to the HSE and Department of Health[29], urging them to adopt examples of child protection and domestic violence services and **run a national information campaign advising how people can access Safeguarding and Protection Services, with a targeted campaign for residents and their families.** IASW asked the HSE to reflect the heightened risk of institutional abuse during lockdown in their staff adult safeguarding training. Specific IASW proposals were not adopted and while child protection and domestic violence referrals increased, the HSE reported a 9% decline in adult safeguarding referrals in 2020, at a time when overall abuse of adults in reality was probably increasing.[4]

Unlike Tusla, there is no 'one stop shop' to report adult abuse. **Residents and Families are 'bounced' between services,** contacting Safeguarding and Protection Social Work teams (who do not have a remit in private services), HIQA (who do not investigate individual complaints), the Ombudsman (who does not investigate clinical complaints), the Office of the Confidential Recipient (who can only accept concerns in relation to HSE services) and the Gardai. In between, the needs of the person with disability are easily lost.

We welcome the recent announcement on research in gender-based violence experiences of people with disabilities by Minister Anne Rabbitte[30] and the establishment of an annual Adult Safeguarding Day by Safeguarding Ireland, commenced in 2021.

Provision of monitoring.

IASW acknowledges the vital role of regulation and supports HIQA calls for increased regulatory powers and safeguarding legislation.

IASW has met with HIQA and recommended that attention is paid to language in HIQA reports so that abusive practices are at all times, clearly named as abuse, neglect, violence or exploitation, as appropriate. IASW also asked if **HIQA publishes annual comprehensive data about safeguarding concerns received, and interventions taken, including reports to authorities** (i.e., Gardai, Safeguarding and Protection social workers) and queried why residents and families were not fully and formally informed of risks in their own environment at the same time as the service provider. Instead, residents and families must wait several months for the publication of a HIQA inspection report.

The activity of Safeguarding and Protection Social Work teams are not currently monitored by HIQA, though we know the value this monitoring brings to child protection social work practice.

There are concerning variations in the type and quality of adult safeguarding reviews commissioned by organisations when failures arise.

Of most importance, residents are often denied information about their own care setting and their voices are often absent or marginal in discussions about monitoring of the system in which they are the most important stakeholder. The quality of sex and sexuality education in congregated settings is unknown. Understanding about and approaches to the management in residential services of those who have committed sexual offences is variable across settings.

Supports around Recovery & Reintegration:

We lack specialised teams, staffed with appropriate professionals, such as social workers, speech and language therapists, psychologists, occupational therapists, counsellors, and social care staff, to provide person-centred support in the aftermath of abuse. Many people with disabilities, which may include communication difficulties, are able to tell their story of abuse, at their own pace and in their own way and with the right supports.

We saw in the national discourse around the 'Brandon' case, that 'Brandon's' own needs, as a vulnerable man, perpetrating abuse, were overlooked and he was described solely as a perpetrator, rather than someone who needed protection himself.

The provision of effective legislation and policies; to ensure that instances of exploitation, violence, and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

While we provide protection for children under the law, Ireland does not have comparable adult safeguarding legislation in place. **Despite multiple scandals and reviews, there appears to be insufficient political urgency to prioritise introduction of legislation.**

Failure to report and follow up in the 'Brandon' case where the abuse of adults with disabilities repeatedly occurred over decades, and was known to HSE staff and management, demonstrates **the clear need for new and effective legislation to mandate staff to report abuse of adults in residential services and in certain other circumstances.**

Even when there are serious concerns of abuse, we lack **appropriate legal mechanisms to support social work access to the adult at risk of abuse, in cases when access may be denied by service providers** (i.e., private residential services) or individuals (i.e., private dwellings)**.** On occasion, social workers have received legal letters from private service providers, denying access.

People with disabilities are often regarded as 'unreliable witnesses.' The relatively new Garda National Protective Services Unit does not highlight work with people with disabilities as being within their remit and expertise. **This may mean that those who are most at risk of abuse are less able to protect themselves, less able to report the abuse and have less access to justice and reparation processes.**

Article 19: Will, Preferences and Access to Supports.

The Committee already has expert knowledge in the lack of autonomy and choice people with disabilities have in their lives[31]. We disproportionately invest in residential care services, compared to community-based models and **Appendix A** gives voice to the human experience of this. The lack of statutory right to home care, along with the staffing crisis in our privatised home care sector, means people with disabilities are being prematurely admitted to nursing homes, against their will and preferences, which in essence is a deprivation of liberty[32]. People with disabilities who use safeguarding services are often viewed solely as recipients of services, rather than rights holders, with their own wishes and preferences. The HSE has not commissioned *any research* to understand the preferences of people who use safeguarding services. **This means the voices of adults at risk are absent, giving imbalanced weight to the views of professionals and paid advocates. More research has been funded into the experience of care staff, rather than residents of care settings over the time of Covid.**

Covid disproportionately removed choice and autonomy from the lives people with disabilities, as the national response was not appropriately informed by human rights expertise. **There were no 'red lines' in the HSE response to disability services, with prolonged service closures, redeployment of essential disability staff (as recently as December 2021, the HSE failed to develop contingency plans to protect disability staff from redeployment during new Covid surges[33]) and missed opportunities to invest in rights driven solutions used elsewhere to restore family life (visiting spaces, heated gardens etc, care partner schemes etc)**.

Under the *Assisted Decision-Making (Capacity) Act, 2015,* regardless of the support people need, they must have choice and control in their lives. In the absence of action, people and their rights will continue to 'fall through the cracks.'[34] Safeguarding legislation will help and is essential, but **as a society, our fundamental beliefs and service responses to people must radically change if people are to live a life free from abuse and harm and have choice and control over where they live, who they live with and *how* they live.**[35]

3. Recommendations

The IASW proposes:

1: Introduce Legislation and an Independent Statutory Authority.

a) Expedite **comprehensive adult safeguarding**, underpinned by human rights principles. Among other measures, legislation must:

b) Place **the wishes and preferences, including right to live independently** of adults at the heart of safeguarding in line with the underpinning principles of the Assisted Decision-Making (Capacity) Act, 2015, an act which must be fully resourced.

c) Establish a 'Tusla type' model of an **independent statutory social work led adult safeguarding agency outside the remit of the HSE.**
d) Ensure all adults **have equal access to all primary care health and social care services**.
e) Introduce **legal mechanisms to support social work access** to adults at risk, used as a last resort, when all reasonable efforts to establish access have been denied by a third party.
f) Introduce **mandatory reporting in certain circumstances** and in all cases involving the abuse of a resident in a care setting.
g) Regulate **Mandatory, Transparent, Safeguarding Adult Reviews across all health and social care services carried out by suitably qualified personnel**, with reports published in full.
h) **Collate and publish** safeguarding data to inform service responses.

2. In the Gap of Legislation, Recommendations for Immediate Action include:

a) The **proposed independent review into CHO1, proposed already by Minister of State Anne Rabbitte, to be undertaken as a matter of urgency** and measures taken to ensure full Ministerial access to safeguarding reports.
b) Government to expedite statutory **home care legislation**.
c) **The practice of senior HSE managers, who lack relevant expertise, making clinical or operational safeguarding decisions must end.** Social work as the relevant expert profession must have responsibility and accountability for safeguarding decisions and processes, with appropriate governance structures and operational autonomy. Final decision making **on *all safeguarding concerns* must rest with an accountable, registered Chief Social Worker appointed in the HSE.**
d) Increased **HIQA regulatory powers**, to include inspection of social work safeguarding activity.
e) Publish full and transparent safeguarding adult reviews
f) **Address organisational cultural barriers** which prevent staff speaking up, through research and training.
g) **Adult safeguarding training** must become a mandatory requirement for all HSE and HSE funded staff and **should be updated to reflect the lessons of the pandemic**.
h) **HSE safeguarding audits** must be fully published and publicly available and accessible.
i) All relevant HSE job descriptions must refer to the requirement to demonstrate competency in adult safeguarding, including reporting procedures. In advance of legislation regarding mandated reporting – as an employer or funder of a services **the HSE can make it a condition of employment or contract to report abuse or suspicions of abuse** – as happened in children's services up to 2015.
j) **Workforce planning** for adult safeguarding **must use a multidisciplinary focus** recognising the lead role of social work, as well as vital skills of other health and social care professionals, including occupational therapists, speech and language therapists, psychologists, and nurses.
k) All agencies with a safeguarding remit **must resource** social workers/Designated Officers to carry out their work.
l) Solutions around current problematic **information sharing practice** must be provided.

m) Groups at **higher risk of abuse**, including adults with disabilities, must be included in the new national gender-based violence strategy.
n) Safeguarding and Protection social workers and An Garda Síochána must be **resourced to carry out investigations with adults with disabilities** when abuse is reported. Joint training and co-interviewing protocols would assist in this.
o) Access to **specialist expertise** (therapeutic services) must be available to assist both the person with a disability and the investigation teams, in the aftermath of a report of abuse.
p) Public health **visiting guidance must be placed on a statutory footing** with consequences for service providers who introduce excessive visiting restrictions.
q) Publication of **detailed safeguarding activity** by HIQA, An Garda Síochána, Safeguarding and Protection Teams and service providers to inform service responses.
r) The **voice of people with disabilities** in safeguarding policy and practice must be addressed through research and meaningful participation structures.

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Appendix A: Extracts of Safeguarding Concerns from HIQA Reports 2020 – to Date.

It is important to note that the following safeguarding concerns occurred, despite the establishment of a HSE National Safeguarding Office, a national Safeguarding Policy (2014) and Safeguarding & Protection social work teams in 2015.

Centre 1: Inspection Date 8th -10th December 2021.

'*The inspectors were concerned on arrival to this centre that there was a complete absence of an appropriate management presence in the centre. Staff were "unsure and unaware as to who was in charge" and a "safe and high-quality service was not evident". Inspectors found that systems in place to safeguard residents and ensure residents were appropriately supported in the areas of self-care and protection were inadequate. For example, it was not evident that safeguarding plans were in place to manage an identified and ongoing safeguarding concern in the centre. This involved a resident who engaged in behaviours of concern that placed themselves and others at risk. Safeguarding incidents reviewed by inspectors indicated further assessment regarding the compatibility of residents living together needed to be undertaken. In addition, the inspectors reviewed a sample of safeguarding incidents and found that these incidents were not being managed or reported in line with the national policy for safeguarding vulnerable adults.*'

Centre 2: Inspection Date: 25th November 2021

'*a small trend of allegations of abuse remained and it was not evident that safeguarding plans were proving fully effective as similar allegations continued to occur.'*

Centre 5: Inspection Date: 3rd November 2021

Overall, the inspectors found that the provider was not demonstrating they had the capacity and capability to provide a safe service to all residents. The provider failed to ensure the service provided was safe, effective, sufficiently resourced and monitored, or meeting residents' needs. It was also found the service provided was not reflective of a human-rights and person-centred approach to care and support.

Centre 4: 20th October 2021

'*It was found that the arrangements were not transparent and prevented residents from having ready access to their own money. In one case a resident had less than 20 euro for more than five months, which significantly limited their ability to engage in leisure activities or buy personal items such as clothing or toiletries. Staff in the centre ensured that the resident had a supply of all basic hygiene products and attempted to include the resident in activities they could afford, however it was of concern that the resident did not have access to their money or opportunities to make choices about how they spent it. While this had been identified by the person in charge as a safeguarding risk, and escalated in line with the provider's safeguarding policy, there had been no progress made with regard to addressing the issue.*'

Centre 5: Inspection Date: 27th July 2021

'A review of a sample of residents' records found that staff expenses such as takeaways, meals and coffees were being charged to residents' accounts. Due to the local accounting practices, the inspector was unable to calculate a total for these types of charges made, however, concluded that over a prolonged period of time that such expenditure was a significant cost for the resident group.'

Centre 6: 3rd and 8th March 2021

'*During the inspection, inspectors identified that residents were still subject to undue restrictions, with no clear rationale for why these restrictions had been implemented. For example, it was documented that a number of residents were not allowed to use the bathroom when they accessed services in community facilities. This was despite a number of these residents having individual support needs such as anxiety and incontinence*.'

'*There was a delay in the identification of concerns raised by residents such as an allegation of suspected abuse, and there was no evidence of advocacy supports for residents to support them to raise complaints and concerns… it was observed that two residents had raised concerns about an allegation of suspected abuse. However, it was identified that the allegation of suspected abuse had not initially been recognised as such. This resulted in a delay in the initiation of an investigation in relation to the incident, and the notification of the incident to the relevant statutory body. It was also noted that there were inconsistencies in relation to the incident reported to HIQA, and the information contained in the preliminary screening carried out following the alleged incident. It was identified that three residents witnessed the alleged incident. Staff members met with the residents individually to seek clarity on the concern raised. It was documented that due to one of the resident's limited communication skills, that they were unable to get an account of events from this resident's perspective. There was no evidence of communication support or advocacy support being provided to the resident, to support them to communicate their account of the event. At the time of the inspection, which was completed 3 months after the alleged incident had occurred, an investigation into the alleged incident had not been carried out.'*

Centre 6: Inspection Date: 2nd March 2021

'*The manager who was also the designated officer for safeguarding and told inspectors that they had reported protection risks to the national safeguarding and protection team due to concerns for the safety of residents, but there has not been a robust response to address this risk. Inspectors found that there were safeguarding plans in place for five residents in this centre, but the safeguarding plans did not have a robust action plan in place to safeguard residents from the frequent abuse and upset they experienced at the centre. Furthermore, safeguarding plans shown to inspectors were interim plans and had not been updated since they were developed in August 2020. In addition, inspectors found several incidents of unexplained bruising to residents, with one incident not being subject to a preliminary safeguarding screening and referral to the resident's GP for review*.'

Centre 8: Inspection Date: 29th July 2020

'*Inspectors reviewed 50 safeguarding concerns with management on the day of inspection. These varied from alleged cases of physical, psychological, sexual, financial, neglect and institutional abuse occurring in this centre. While inspectors found a much-improved system for the reporting and recording of safeguarding concerns (than had been evident on the previous inspection) further improvements were still required in this area. For example, the volume of safeguarding concerns, the emergence, management, and conclusion of retrospective/current allegations. In addition, improvements were also required in safeguarding follow up and response (in some cases). For example, a number of cases had no reported evidence of follow up following a recent meeting between the provider and local HSE safeguarding team*.'

Appendix References:

1. Report of an inspection of a Designated Centre for Disabilities (Adults). Issued by the Chief Inspector. Name of designated centre: The Court – Kingsriver 07 December 2021 08 December 2021 and 10 December 2021. Available via https://www.hiqa.ie/areas-we-work/find-a-centre/court-kingsriver
2. Report of an inspection of a Designated Centre for Disabilities (Adults). Issued by the Chief Inspector Name of designated centre: Hawthorns Name of provider: Health Service Executive Address of centre: Co. Dublin 25 November 2021 https://www.hiqa.ie/areas-we-work/find-a-centre/hawthorns
3. Report of an inspection of a Designated Centre for Disabilities (Adults). Issued by the Chief Inspector Name of designated centre: Stewarts Care Adult Services Designated Centre 28 03 November 2021. Available via: https://www.hiqa.ie/areas-we-work/find-a-centre/stewarts-care-adult-services-designated-centre-28
4. Report of an inspection of a Designated Centre for Disabilities (Adults). Issued by the Chief Inspector Name of designated centre: Baldoyle Residential Services Name of provider: St Michael's House Address of centre: Dublin 13 Type of inspection: Unannounced Date of inspection: 20 October 2021. Available via: https://www.hiqa.ie/areas-we-work/find-a-centre/baldoyle-residential-services
5. Report of an inspection of a Designated Centre for Disabilities (Adults). Issued by the Chief Inspector Name of designated centre: Kinvara Park Group-Community Residential Service Name of provider: Daughters of Charity Disability Support Services Company Limited by Guarantee Address of centre: Dublin 7 Date of inspection: 27 July 2021 Available via: https://www.hiqa.ie/areas-we-work/find-a-centre/kinvara-park-group-community-residential-service
6. Report of an inspection of a Designated Centre for Disabilities (Adults). Issued by the Chief Inspector SVC - SDN Name of provider: Daughters of Charity Disability Support Services 15th June 2021 Available via: https://www.hiqa.ie/areas-we-work/find-a-centre/svc-sdn
7. Report of an inspection of a Designated Centre for Disabilities (Adults). Issued by the Chief Inspector Name of designated centre: Edencrest, Riverside & Cloghan Flat Name of provider: Health Service Executive 02 March 2021: Available via: https://www.hiqa.ie
8. Report of an inspection of a Designated Centre for Disabilities (Adults). Issued by the Chief Inspector Name of designated centre: Camphill Community Kyle Name of provider: Camphill Communities of Ireland Address of centre: Kilkenny Type of inspection: Short Notice Announced Date of inspection: 29 July 2020 https://www.hiqa.ie/reports-and-publications/inspection-reports/3625-camphill-community-kyle-29-july-2020