Position Paper on Adult Safeguarding: Legislation, Policy and Practice

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IASW

Irish Association of Social Workers

by

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Foreword

The issue of adult safeguarding is of utmost importance for social workers and for the IASW. For those adults in need of safeguarding, the support and vindication of their integrity, autonomy, and human rights, as well as their protection and safety, may be dependent in large part on the role played by state agencies and civil society. Social workers have a particularly key role to play in adult safeguarding. The present position paper has been developed in the context of emerging legislation and new structures, policies, and services. In publishing the present position paper, which now supersedes a previous paper, the IASW seeks to influence the development and implementation of appropriate legislation, policy, and practice. This is in line with human rights values and best practices and based on our unique role, expertise, and experience as social workers, as well as being influenced by the voices and needs of the people we work with and their families. This is ultimately to seek to ensure that those adults who need professional safeguarding interventions, and their loved ones, receive the best possible services and protection.

I want to express my deep appreciation, on behalf of the IASW, to Sinéad McGarry, who led for the Association in the drafting of this position paper, with Dr. Sarah Donnelly, School of Social Policy, Social Work & Social Justice, UCD, our Academic Advisor on Adult Safeguarding. Together, Sinéad and Sarah have invested a huge amount of expertise and effort in drafting and redrafting the paper. As part of our review, consultation and redrafting process, a range of individuals and groups of social workers contributed to the generation of this document. I, therefore, thank sincerely all those IASW members, individual social workers, and social work teams, IASW Special Interest Groups, the IASW's Adult Safeguarding and Protection Group, IASW Board members, advocacy groups, organisations, and others, too numerous to mention, who contributed most helpfully through their invaluable suggestions, comments, and observations on earlier drafts.

Finally, I want to acknowledge that adult safeguarding, as with other areas of social work practice, is a complex issue This complexity is added to because of the current stage of development in terms of safeguarding legislation, which in turn will influence subsequent policies, structures, and services. Given the above, the IASW is making the most positive contribution it can to the development of improved adult safeguarding services in Ireland, in the context of the present set of relevant circumstances. At the same time, we will need to be flexible and creative in responding to future developments in this area, and to review and update this paper if and as needs be in due course, while holding firm to the fundamental values and ethics that underpin the social work profession.

Vivian Geiran

Chairperson, Irish Association of Social Workers **September 2022**

Glossary

Adult at risk: an adult who is unable to exert their rights or protect themselves from abuse/neglect because their care and/or support needs.

Abuse and Neglect: refers to experiences which can be categorised as Physical, Sexual, Psychological, Financial and Material, Neglect & Acts of Omission, Self-Neglect, Domestic Violence, Coercive Control, Adult at Risk Perpetrating Abuse, Discriminatory Abuse, Organisational Abuse and Modern Slavery.

Physical abuse: includes assault, hitting, slapping, punching, kicking, hair-pulling, biting, pushing, rough handling, scalding/burning, physical punishments, inappropriate/unlawful restraint/restricted movement (i.e., tying someone to a chair/barricading exit from their bed), making someone purposefully uncomfortable (e.g., opening a window and removing blankets), involuntary isolation or confinement, misuse of medication (e.g., over-sedation), forcible feeding or withholding food.

Sexual abuse: includes any contact or non-contact sexual activity which occurs without consent, i.e., rape, attempted rape or sexual assault, inappropriate touch anywhere, non-consensual masturbation of either or both persons, non-consensual sexual penetration or attempted penetration of the vagina, anus or mouth and any sexual activity that the person lacks the capacity to consent. It also includes inappropriate looking, sexual teasing or innuendo or sexual harassment, sexual photography or forced use of pornography or witnessing of sexual acts and indecent exposure.

Psychological abuse: includes enforced social isolation – preventing someone from accessing services, educational and social opportunities and contact with their friends and family, removing mobility or communication aids or intentionally leaving someone unattended when they need assistance, preventing someone from meeting their religious and cultural needs, preventing the expression of choice and opinion, failure to respect privacy, preventing stimulation, meaningful occupation or activities, intimidation, coercion, harassment, use of threats, humiliation, bullying, swearing or verbal abuse, addressing a person in a patronising or infantilising way, threats of harm or abandonment and cyberbullying.

Financial or material abuse: includes fraud, scamming, preventing a person from accessing their own money, benefits or assets, employees taking a loan from a person using the service, undue pressure, duress, threat or undue influence put on the person in connection with loans, wills, property, inheritance or financial transactions, arranging less care than is needed to save money to maximise inheritance, denying assistance to manage/monitor financial affairs, denying assistance to access benefits, misuse of personal allowance in a care home, misuse of benefits or direct payments in a family home, someone moving into a person's home and living rent-free without agreement or under duress, false representation, using another person's financial details, exploitation of money or assets, e.g. unauthorised use of a car, misuse of a power of attorney or other legal authority, rogue trading – e.g. unnecessary or overpriced property repairs and failure to carry out agreed repairs or poor workmanship without compensation.

Neglect and acts of omission: includes ignoring medical 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. Failure to provide or allow access to food, shelter, clothing, heating, stimulation, and activity, personal or medical care, failure to administer medication as prescribed, refusal of visits, ignoring cultural, religious, or ethnic needs, ignoring educational, social and recreational needs, ignoring or isolating the person, preventing a person from making their own decisions, preventing access to glasses, hearing aids, dentures and failure to ensure privacy and dignity.

Self–Neglect: includes a wide range of behaviour neglecting to care for one's personal hygiene, health or surrounding and includes behaviour such as hoarding. Includes lack of self-care to an extent that it threatens personal health and safety.

Domestic Violence: "Any incident of threatening behaviours, violence or abuse between adults who are or have been in a relationship together, or between family members, regardless of gender or sexuality". Domestic violence includes emotional abuse as well as forced marriage and so-called "honour crimes". It is abuse if a partner, ex-partner, or a family member, threatens/frightens/assaults the person, makes the person fear for their safety, and uses coercive control to control the person.

Coercive Control: coercive control is an abusive behaviour that can arise in human relationships and refers to a range of acts perpetrated by an individual designed to make a person subordinate or dependent. Behaviours typically include isolating the person from their support, exploiting their resources for personal gain, depriving them of the means of independence, and regulating their everyday behaviour. Coercive control can be perpetuated in any relationship, including intimate, family, friendships, and paid care relationships.

Adult at Risk Perpetrating Abuse: often referred to as 'peer abuse,' there may be times when an adult at risk may experience abuse from another person who can also be identified as an adult at risk. It is essential to consider that those experiencing abuse in these situations can expect the same response as any person at risk of abuse. It is also important to note that the needs of the person at risk who is the alleged subject of abuse should be addressed separately from the needs of the person alleged to be causing them harm.

Discriminatory abuse: Includes discrimination on grounds of race, gender and gender identity, disability, sexual orientation, religion, and other forms of harassment, slurs, or similar treatment. Unequal treatment based on age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex or sexual orientation Verbal abuse, derogatory remarks or inappropriate use of language related to a protected characteristic. Includes denying access to communication aids, not allowing access to an interpreter, signer, or lip-reader, harassment, or deliberate exclusion on the grounds of a protected characteristic, denying basic rights to healthcare, education, employment, and criminal justice relating to a protected characteristic and substandard service provision relating to a protected characteristic.

Organisational abuse: Includes neglect and poor care practice within an institution or specific care setting like a hospital or care home, e.g., this may range from isolated incidents to continuing ill-treatment. Acts may include, discouraging visits or the involvement of relatives or friends, authoritarian management or rigid regimes, lack of leadership and supervision, insufficient staff or high turnover resulting in poor quality care, abusive and disrespectful attitudes towards people using the service, inappropriate use of restraints, lack of respect for dignity and privacy, failure to manage residents with abusive behaviour, not providing adequate food and drink, or assistance with eating, not offering choice or promoting independence, misuse of medication, failure to provide care with dentures, spectacles or hearing aids, not taking account of individuals' cultural, religious or ethnic needs, failure to respond to abuse, neglect and acts of omission appropriately, interference with personal correspondence or communication, failure to respond to complaints.

Modern Slavery: includes human trafficking, forced labour, illegal exploitation of people for personal/ commercial gain. victims trapped in servitude they were deceived or coerced into, criminal exploitation i.e., pickpocketing, shoplifting, drug trafficking, domestic Servitude forced to work in private houses with restricted freedoms, long hours, no pay, verbal and physical threats, sexual exploitation, sex for rent, prostitution. Other forms include organ removal, forced begging, forced marriage and illegal adoption and debt bondage – being forced to work to pay off unrealistic debts.

(Definitions adapted from Social Care Institute of Excellence (SCIE), 2022. Available: https://www.scie.org.uk/safeguarding/adults/introduction/types-and-indicators-of-abuse)

Introduction

Social Work: The Lead Profession in Adult Safeguarding

Social work is the named lead registered profession for adult safeguarding in Ireland,[1] tasked with the primary implementation of policies that support adults at risk of abuse, neglect, and extreme self-neglect.

Social work is an **advocacy-based profession**. Social work responds to social injustice and inequality at an individual level and advocates for socially just, human rights focused policy change at societal and political level. These core values inform this position paper and drive social work to advocate for improved adult safeguarding practice which respects the dignity and rights of all adults at risk.

Social work champions a **human rights-based approach to adult safeguarding**, which recognises that safeguarding practice has three equally important functions:

- The promotion and protection of the rights of adults.
- The promotion of measures that optimise the health and well-being of adults.
- The empowerment and protection of people to live life in accordance with their wishes and preferences, free from abuse and neglect. [2]

Empowering people to have autonomy in their own lives is central to social work practice. Social workers uphold the rights of those who are unable to fully express their own will and preferences, due to particular disabilities, cognitive impairment, coercive control, or other circumstances.

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.

Social work is a **relationship-based profession,** and it is within trusting relationships, built over time that our work is completed There are times when relationship building with an adult at risk is prevented by a person or system causing harm. Within our current policy and legislative landscape, social workers face challenges in overcoming these barriers to ascertain the will, preferences, and capacity of an adult at risk to choose to live a life free from abuse.

The Case for Change in Adult Safeguarding Practice:

The Irish State has a poor record of safeguarding adults. Social work concerns are well evidenced; as seen in the failure to protect adults from abuse and neglect in **Leas Cross (2005),**[3] **Aras Attracta (2014),**[4] and in the '**Grace' case** when 'Grace,' a woman with intellectual disability was left in a situation of severe abuse in adulthood from 1997 to 2009.[5] In the **'Brandon' case**, a vulnerable man with intellectual disabilities who required protection himself, committed at least 108 sexual assaults on fellow residents from 2003 to 2016 with full knowledge of HSE staff and management. [6] The media have reported significant delays in reporting of allegations of sexual abuse of unconscious adult patients in **Naas General Hospital,**[7] failures in the management of safeguarding concerns in **HSE area**

CHO7,[8] and in the pattern of **safeguarding failures in HSE area CHO1** resulting in HIQA questioning the HSE's ability to provide safe services.[9]

Over **51,000 concerns about the abuse and neglect of adults** were reported to the Safeguarding and Protection Social Work teams since 2015.[10] Established trends confirm that older women,[11] people with disabilities,[12] female Travellers,[13] and other groups are at higher risk of abuse, yet we have **no adult safeguarding strategy targeting the abuse of high-risk groups**. **One hundred and forty-three (143) sexual assaults** against residents of care settings from 2015 -2022 were reported to HIQA,[14,] yet we lack specialist services in working with victims of abuse who may have a cognitive impairment or intellectual disability.

There have been **calls for routine safeguarding reviews for people who die in homelessness,**[15] or in other circumstances where agencies might have prevented serious harm or death of an adult at risk of occurring. In 2020, while child protection and welfare reports increased,[16] and domestic violence reports also increased by 17%,[17] during the pandemic, **adult safeguarding reports to the HSE dropped by a concerning 9%** [10] as HSE services did not demonstrate the ability to reach adults at risk during such restrictions, despite warnings that 'lockdowns' increase risk of abuse to this population.[18]

HIQA have warned that they need more powers to adequately protect vulnerable adults in residential services and continue to identify examples of serious safeguarding failings in care settings,[19, 20] while social workers struggle to provide a safeguarding service in the gap of legislation and with limited professional autonomy.[21] There is a lack of quality data on adult safeguarding trends and IASW routinely seeks information *via* Freedom of Information requests or use of parliamentary questions to source information about both the abuse of adults and responses to it in Ireland.

These systemic failings echo failings in the delivery of child protection services in Ireland in the 1970s, 1980s and 1990s when Ireland experienced a similar pattern of repeat child abuse scandals; before fundamental reform led to the introduction of legislation and a designated agency with a clear remit to safeguard children. While adults at risk of abuse have different needs and rights, the designation of child welfare and safeguarding responsibilities to Tusla, an independent statutory agency (with other functions) is of immense value when we consider how best to respond to adult safeguarding.

Informed by evidence and frontline social work practice, this position paper:

1. Provides a brief background to adult safeguarding in the Irish context.
2. Outlines current challenges in safeguarding adults at risk in Ireland.
3. Provides clear proposals and recommendations to address these challenges.

2. Background to the Development of Adult Safeguarding in Ireland

As the first profession in Ireland to call for improvements in adult safeguarding,[22] social workers in State, voluntary and charity sectors have contributed to the development of adult safeguarding policy and practice for many years.

In 2007, the HSE established a national social work Elder Abuse Service, to manage allegations of abuse and neglect of those aged 65 and over. In December 2014, an RTÉ *Prime Time Investigates* television programme highlighted abusive practices in Áras Attracta, a HSE service for adults with intellectual disabilities,[4] resulting in a national outcry. This led to the establishment of a HSE National Adult Safeguarding Office and nine Safeguarding and Protection Social Work teams to support the implementation of a new HSE protocol – *Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures* (2014).[23] 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 applied 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 who were not linked to formal services. The policy excluded adults using other services such as mental health, acute hospitals, primary care settings, 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 and with the apparent expectation that 'safeguarding is everybody's business.' Multiple stakeholders have expressed concerns about how viable this policy is in practice.

The Department of Health is developing a national adult safeguarding policy for the entire health sector, together with accompanying legislation.[24] The IASW has called on the Department to expedite this process, given adults remain at increased risk of preventable abuse in the gap of legislation. No adequate interim measures have been taken to address risks in safeguarding practices and systems and solutions proposed by the IASW appear to have been have been ignored.[25]

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.

3. Current Challenges in Adult Safeguarding Practice

A lack of adult safeguarding legislation has resulted in a fragmented system where adults at risk regularly 'fall through the cracks'.[2] This is evident in **research commissioned by the Department of Health which shows the Irish public do not know how to report the abuse of adults.**[26] From the perspective of frontline social workers, additional challenges include the following:

3 (a): Institutionalised Approaches

People who use safeguarding services are often viewed solely as recipients of services, rather than rights-holders, with their own wishes and preferences about how to live their lives. **The HSE has not commissioned *any* research to understand the experiences of those who use safeguarding services. This means the voices of adults at risk are absent, giving disproportionate weight to the views of professionals and paid advocates.**

For those living in congregated settings, our move toward deinstitutionalisation, where people can live with choice and autonomy and exert will and preferences in their own lives, is unacceptably slow[27] and safeguarding within existing services is far too weak.[28, 29]

Under the *Assisted Decision-Making (Capacity) Act, 2015,*[30] regardless of the level of support people need, they must have choice and control in their lives. Safeguarding legislation will help and is essential, but **as a society, our fundamental beliefs and service responses to people have to radically change if those 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.**[31]

3 (b): Safeguarding in the Gap of Legislation

For a variety of complex reasons, some adults, acting in accordance with their own will and preferences decline interventions designed to protect them from abuse and neglect. IASW fully respects their right to do so.

Social workers routinely work with adults at risk who have difficulty or who are unable to express their will and preferences about their experience of abuse, neglect, or mistreatment. This may be due to disability, illness, frailty, reduced capacity, or the impact of coercive control/undue influence (for example, in modern slavery/human trafficking cases**). At times the individual/s/systems perpetrating abuse create barriers to prevent access to the adult at risk.** These include cases where family members, paid carers, organisational responses, human traffickers, and other parties hinder, restrict, or prevent access of the adult at risk to formal services and informal

support networks (see Appendix A). Social workers report challenges accessing adults at risk in the care of service providers (e.g., private nursing homes /residential services/ voluntary/charitable providers). On occasion, social workers have received letters from nursing homes advising that they will be prosecuted if they attempt to enter the premises (see Appendix A).

In such cases, and in prescribed circumstances, a legal right of access and in some cases, a legal right to removal of the adult at risk is required. The watershed cases of 'Grace' and 'Brandon,' show that in certain circumstances, adults at risk repeatedly experienced abuse, which could have been prevented with timely and appropriate legal measures. Without these legal measures, adults at risk of abuse in Ireland remain in a legal lacuna, with potentially prolonged experiences of abuse resulting (see Appendix A, Case Study 1).

In addition, reporting requirements in accordance with the *Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012* [32] are poorly understood, with no apparent monitoring of compliance with the requirements of the Act.

The IASW believes that provision of additional legal measures and interventions are urgently required, to include:

- **Mandatory reporting** of abuse and neglect of adults, and
- **Access and removal orders**, which nevertheless must be a last resort, time limited and used under appropriate oversight and only when all other reasonable efforts to intervene have failed.

It is essential that adults at risk, acting in accordance with their own will and preference can refuse specific interventions but can still maintain, if they wish to do so, a trusted relationship with a professional skilled in understanding abuse and neglect, who can support them in maximising their safety in their current situation. All too often, adults at risk who decline intervention, experience complete service withdrawal.

3 (c): Access to Practical Supports

Unlike in the UK,[33] there is no legislation in Ireland compelling the State to identify and respond to social care rights and needs (i.e., provision of home care/carer support/housing/respite), which might reduce or eliminate the risk of abuse/neglect and support an adult to live their lives in accordance with their will and preferences (see Appendix A, Case Study 2). Currently, what presents as almost random access to certain health and social care services is frequently described as a 'lottery' or being dependent on one's postcode. For example, residents in private nursing homes frequently lack access to many of their primary care community services.

3 (d): Governance & Accountability

Each of the nine Safeguarding and Protection Social Work teams accept and respond to referrals in different ways. Comparative to child protection, social work has less influence on 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 the senior HSE management level which has significant implications for how the HSE understands and responds to adult safeguarding nationally.

Within existing structures, social workers do not always have the necessary professional autonomy required to carry out their roles. The National Independent Review Panel (NIRP) is a panel established by the HSE, with an independent Chair, which reviews cases where it is suspected there are serious failings by the HSE and/or its funded organisations that have led to serious harm or compromised quality of life. It is noteworthy that **the National Independent Review Panel advised in the 'Brandon' report 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.**[6]

As seen in the 'Brandon' report, ignoring safeguarding expertise can result in the 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). [31] This can all result in missed opportunities to intervene and prevent abuse.

While HIQA systematically inspects the work of Tusla social work teams, there is no such quality assurance process for the activity of adult safeguarding social work teams. There are also **concerning variations in the type and quality of safeguarding reviews commissioned by organisations when failures arise.** While the National Independent Review Panel established by the HSE, is staffed, and chaired by social work safeguarding experts, private companies also carry out safeguarding reviews, without any agreed national process or competency framework to assess the qualifications and suitability of the people carrying out the review.

3 (e): Culture in Adult Safeguarding

Cases already cited, highlight a concerning culture within the HSE and other organisations which at times, fails to address experiences of abuse and appears to prioritise the protection of the agency in question, rather than the adult experiencing or at risk of harm.

IASW has received accounts from the people we work with and social workers [34] outlining challenges they have experienced in raising abuse concerns with organisations. While social workers have the

expertise to challenge this culture, it is clear from multiple system failings, that many health and social care staff do not.

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, Northern Ireland Commissioner for Older Persons Investigation into Dunmurry Manor Care Home),[35] adult safeguarding reviews are rarely published in full in Ireland and are 'owned' by the HSE/Service Provider who is then the gatekeeper of information about failures in their own services. Residents and families remain uninformed about the true extent of failings within their 'home', while Irish social workers are forced to rely on international safeguarding reports to learn from what can go wrong and seek to improve practice accordingly here. Our costly reviews, as seen in the 'Grace' case, fail to deliver essential lessons in a timely way.[36]

It is noteworthy, that despite repeat scandals, adult safeguarding training is not mandatory for the majority of HSE staff and unlike child protection, references to adult safeguarding knowledge are not made in a range of job competency requirements, even for senior managers working with high-risk groups.

3 (f): Resourcing of Social Work

Social work teams require additional staffing, resourcing, and advanced clinical training to support their complex work and carry out their role to the highest standard possible. There has been ***consistent under-resourcing*** of HSE Safeguarding and Protection Teams and of social workers in Designated Officer roles at the local service level, even when there is a high-profile case or crisis in an individual HSE CHO area/local service.[37, 38]

The development of the HSE Safeguarding Vulnerable Adult Policy, 2014 increased the workload of social workers in many agencies, without additional resources. Social workers, particularly within the acute hospitals and mental health services, report **delays in attending to other duties, while they deal with complex safeguarding cases, for example, delaying hospital discharge planning, due to the labour-intensive nature of safeguarding work.**[2]

3 (g): Interagency Working and Information Sharing

Central to ethical adult safeguarding is effective interagency and inter disciplinary working. Social workers have reported challenges in the capacity and willingness of some agencies to share/accept information effectively and in a timely manner. GDPR is often cited and interpreted selectively, resulting in barriers around information sharing. The current lack of statutory interagency working protocols and information sharing guidance severely restricts safeguarding practice (see Appendix A,

Case 3). Safeguarding issues can present over the entire life course. In some cases, children who have been in abusive situations grow into adults and experience the same level of risk and harm on an ongoing or recurring basis, yet **services frequently do not work effectively or share information in relation to this transition.**

3 (h): Proposed HSE Policy Direction

Under the proposed (since 2019) new policy, HSE and HSE funded services decide when, or if, they need to consult with safeguarding social work experts to complete assessments and safeguarding plans, including when investigating institutional abuse:

> *It is the responsibility of staff and services who have raised a concern to take the necessary action to ensure the protection and welfare of an adult at risk of abuse. In each Community Healthcare Organisation (CHO), Safeguarding and Protection teams are available at all stages of the process* ***to support and give advice*** *on the response to concerns of abuse. The safeguarding and Protection Teams will,* ***in certain situations directly manage*** *particularly complex concerns. Requests for* ***co-working/case management*** *can be made to the Principal Social Worker in the Safeguarding and Protection Team. Should there be a concern regarding adequate of timely intervention the* ***HSE CHO Chief Officer or delegate can direct*** *Safeguarding and Protection team involvement at any stage in the safeguarding process. (HSE Final Draft Policy 2019, par 7.1, p 21).* [39]

The identification and management of safeguarding concerns is complex work and requires specialist expertise, in assessment and intervention. The proposed (2019) policy assumes that health and social care staff can carry out this role on the basis of annual safeguarding training alone, despite all evidence to the contrary from the serious failings already highlighted.

The new policy does not give social workers the essential authority to intervene and take responsibility for safeguarding in underperforming agencies with weak safeguarding culture. Social workers have highlighted the risks of 'safeguarding from afar,' relying on the quality of information available from care settings, including those with unsafe organisational cultures that minimise or fail to adequately identify or address abuse. Senior HSE management have effectively ignored social work guidance in previous situations regarding how to manage serious safeguarding concerns and caseloads.[6, 40]

3 (i): HSE Safeguarding Workforce Planning

The HSE plans to introduce new safeguarding roles (alongside existing social work safeguarding posts) solely for the nursing profession,[41] basing this on both the size of the nursing workforce and the fact that most Designated Officer roles are occupied by nurses. **This proposal ignores the key lesson 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.** It is thus a concerning extension of our existing medicalised approach. The HSE proposal overlooks the equally important, vital expertise of other health and social care professionals such as occupational therapists, speech and language therapists and psychologists for example, who generally bring a more holistic lens to adult safeguarding.

Given the size of the nursing workforce already present in both strategic management and frontline practice posts in the HSE, the HSE should include additional, holistic perspectives in the safeguarding of their systems, to avoid dominance of any one clinical or professional paradigm. Social workers are concerned about the weak safeguarding culture within the nursing profession. Adult safeguarding reports from nurses working in nurse managed services has consistently declined in recent years[23] and nurse managed services have failed to protect people from ongoing abuse in the Brandon case, in Aras Attracta and elsewhere. IASW is concerned that the HSE, rather than opening professions up to external expertise, is instead committing to siloed approaches, where each profession leads their own delivery of care and safeguarding of that care.

As occurs in other jurisdictions, 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, to allow professions to see outside the limits of their own lens and to challenge their own culture. The HSE response to appoint specialist nurse only safeguarding roles shows a failure to understand the most basic lessons of the Brandon report. This multi-disciplinary approach is critically important going forward, within the context of the full implementation of the *Assisted Decision-Making (Capacity) Act, 2015* from June 2022.

3 (j): Lack of Specialist Policing Support

The lack of clearly identified specialist Garda units and joint interviewing protocols with Safeguarding and Protection social workers, including in complex cases where the adult at risk of abuse has a disability, cognitive impairment or complex health needs which may make identification of abuse challenging and limits effective investigations, needs to be rectified. The relatively recently established Garda National Protective Services Bureau currently does not clearly name this work as

being within their remit. **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.**

4. Social Work and Safeguarding Expertise: An Untapped Resource

While it is vital to consider and learn from the experience of other jurisdictions, this should be balanced and complemented by understanding and learning from social work expertise in Ireland. Ireland has yet to commission any research to capture and understand safeguarding expertise and knowledge among Safeguarding and Protection teams and those in Designated Officer roles, in order to inform a model of adult safeguarding delivery here. Expertise in the Irish context must be understood, especially to further strengthen and develop services.

As an example, the IASW developed a model for safeguarding and supporting the rights of residents to communicate with their families during the pandemic, which received no response from the Department of Health and the HSE but was identified by the American Association of Retired Persons (AARP) & The Economist Intelligence Unit as one of only five European projects for inclusion in a global report on innovative ageing.[42] It was thus easier for Irish social workers to share their expertise on the international stage, than at Irish policy tables.

Aware that lockdowns increase the incidence of experiences of abuse, IASW met with the HSE and wrote to the Department of Health with **proposals to address social work concerns about a likely decrease in safeguarding referrals** throughout the pandemic and among other measures recommended similar campaigns to those used by Tusla and domestic violence services which ensured the increase in abuse was reflected in referral rates to their services**. IASW proposals were not adopted, no new measures were taken and the HSE subsequently reported a 9% decline in adult safeguarding referrals.**[10]

The National Independent Review Panel, which investigates serious failures in adult safeguarding, is staffed by social workers, who recognise social work expertise in assessing where and how things went wrong. **Yet once the National Independent Review Panel publishes their report, operational social work does not have a lead strategic role in the implementation of the learning or recommendations arising.**

Many of the repeat system failures to date relate to areas of practice that lie within the social work training, knowledge, and expertise (including management of open disclosure, risk, and rights-based service delivery). Many of the issues which can be challenging for management generally, also sit comfortably within the role and scope of social work knowledge and expertise. Investment in social work at the senior management level in the HSE will result in significant dividends in the effective management of these issues going forward.

As lead profession in the delivery of safeguarding services, social workers have little opportunity to lead or influence policy. Repeat requests by IASW for appropriate social work representation in the Department of Health safeguarding structure have been denied.[43]

5. Recommendations

Recommendation 1: Introduce Legislation

Comprehensive adult safeguarding legislation must be introduced. Legislation must:

I. Be underpinned by human rights principles.
II. Define adult safeguarding in its broadest sense, equally valuing safeguarding practice that upholds rights, promotes well-being as well as practice that provides intervention to support and protect adults at risk.
III. Place the will and preferences of adults at risk at the heart of safeguarding services in line with the *Assisted Decision-Making (Capacity) Act, 2015*.
IV. Ensure all adults regardless of their means, address, including those in public and private residential care services, have equality of access to all primary care health and social care services.
V. Recognise the right of all adults to live independently in their own community.
VI. Recognise that safeguarding is the responsibility of all health and social care staff and wider society.

In addition, legislation must:

a) **Introduce Mandatory Reporting in certain circumstances:**

I. When people are unable to seek interventions to protect themselves from abuse and neglect (e.g., due to illness, frailty, capacity, disability).
II. Where there is evidence that the abuse is allegedly perpetrated by a person in a paid/unpaid position of care who has access to other adults who may be vulnerable to abuse (e.g., residential care staff/ resident perpetrating abuse in care setting/bus driver in disability service, home care worker).
III. Where there is evidence that the level of coercive control/undue influence experienced by the relevant adult prevents them from making a decision in accordance with their own will and preference. (See Appendix B for further information).

b) **Introduce additional legal measures regarding access and removal including**:

I. Legal access to an adult at risk, where all reasonable efforts to establish initial contact and access to the person have been unreasonably hindered or denied over a reasonable timeframe. This may include supervision or monitoring orders, which should only be granted by a Court.

II. Legal powers of removal of an adult at risk, where all reasonable efforts to establish access to the person have been unreasonably hindered or denied over a reasonable timeframe; where there is evidence that the adult is at continued or increasing risk of harm and it is neither safe nor is it possible to support the person in their usual place of residence.

III. High thresholds must apply and the legal power for access to/removal of an adult should only be granted by a Court Order (See Appendix B for further information).

c) **Introduce appropriate sanctions for service providers** that fail to provide safe and reasonable standards of care, where there is evidence the adult at risk experienced avoidable harm, which may not have occurred if those standards were adhered to.

d) **Introduce and publish mandatory, transparent, Safeguarding Adult Reviews carried out by suitably qualified personnel** in cases where serious injury or loss of life of an adult occurs due to abuse and neglect (whether known or suspected) and there is concern that agencies could have worked together more effectively to protect the person. There must be provision for such reviews to take place across the entire spectrum of adult social care, including residential services, hospitals, nursing homes, direct provision, prisons, homeless services, mental health settings and any service providing care or support to a vulnerable adult.

e) Create statutory information sharing and interagency cooperation processes.

Recommendation 2: Establish an Independent, Statutory Adult Safeguarding Agency

Establish an independent statutory social work led adult safeguarding agency outside the remit of the HSE, with a focus on multidisciplinary, holistic, and rights-focused practice, with appropriate legal authority, accountability, and oversight.

a) **The functions of the new independent statutory social work led adult safeguarding agency must include:**

I. A clear remit in the prevention of abuse and promotion of human rights and well-being of adults at risk.
II. Provision of a specialist safeguarding service to all adults at risk, with a case management role as required and full authority to support, direct and intervene with services in their safeguarding functions.
III. Statutory requirement to share information and for interagency collaboration and cooperation.
IV. Timely monitoring, publication, and responsiveness to emerging safeguarding trends, with particular attention to known high-risk groups.
V. Commissioning of research to seek the views and lived experiences of people who use safeguarding services to better inform agency responses.
VI. The operational functions of the agency must be regulated by HIQA.
VII. The agency must operate from a human rights basis, with human rights and service user expertise and representation on the Board of the Agency.
VIII. IASW calls for consideration to be given to the introduction of a lifecourse safeguarding authority, based on integrated lifecourse, ecological systems and family safeguarding models, rather than solely providing age-related (child and adult) safeguarding services.

b) IASW believes Adult Safeguarding is ultimately best situated with the Department of Children, Equality, Disability, Integration and Youth (DCEDIY), given that Department's expertise in disability, inequality, marginalisation, and childhood adversity/abuse/safeguarding, all of which are inextricably linked with experiences of abuse in adulthood. [44] DCEDIY has expertise in human rights and lifecourse approaches which address the macro structural issues of disadvantage and inequality and engages with issues that persist across the life course creating vulnerability to abuse. Adults are placed at risk by an intersecting mix of personal, relational, societal, and structural factors across the life course, therefore the IASW believe that the existing mandate, knowledge, expertise, and

guiding principles of DCEDIY make it the most appropriate departmental 'home' for adult safeguarding at national level**.**

c) **Mirroring the experience from child protection and welfare in Ireland**, there is a need to **legislate or otherwise provide for a Chief Social Worker in the new statutory agency and full representation at Departmental level,** similar to the Child Care Performance and Social Work Unit in the Department of Children, Equality, Disability, Integration and Youth.

Recommendation 3: Take Immediate Interim Measures

In the gap of legislation, interim measures to enhance current safeguarding practice must include the following:

a) Concerning Related Legislation: IASW calls for the **full implementation *and resourcing* of the *Assisted Decision-Making (Capacity) Act, 2015*** to ensure that the will and preferences of adults at risk are heard and acted on and urgent action is taken to **progress necessary home care legislation.**

b) Concerning Governance, Accountability and Culture:

I. Final decision making on *all* safeguarding concerns must rest with an accountable, registered Social Worker. The HSE should appoint a Chief Social Worker as the most senior operational lead with professional autonomy and responsibility for adult safeguarding in the HSE. **The practice of senior HSE managers, who lack relevant expertise, making clinical or operational safeguarding decisions must end.**

II. The Chief Social Worker should urgently introduce standardisation of practice and service provision in adult safeguarding across CHOs.

III. Regulation must be introduced to ensure that quality safeguarding reviews are conducted by suitably qualified personnel. Safeguarding reviews should be available to relevant Ministers with full cooperation from the HSE and HSE-funded organisations.

IV. The HSE and all state-funded services must (as in our neighbouring jurisdictions) publish full and transparent safeguarding adult reviews. This may require a review of the terms of reference of the National Independent Review Panel.

V. The HSE should commission research on frontline organisational culture in safeguarding, addressing organisational cultural barriers which prevent staff from speaking up.

VI. Adult safeguarding training must become a mandatory requirement for all HSE and HSE-funded staff.

VII. HSE safeguarding audits must be fully published and easily accessible and available to the public.

VIII. 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 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.

IX. The HIQA remit should be extended to include inspection of Safeguarding and Protection Social Work teams.

c) Concerning Workforce Planning:

I. Workforce planning for adult safeguarding must use an interdisciplinary focus recognising the lead role of social work, as well as the vital skills of other health and social care professionals, including occupational therapists, speech and language therapists, psychologists, forensic nurses etc.

II. All agencies with a safeguarding remit must recognise the complex and labour-intensive nature of this work and ensure that their staff (including but not only social workers, social care staff and others) are resourced and supported to carry out their role, without sacrificing other critical 'frontline' responsibilities and services.

III. Safeguarding and Protection Social Work teams must be adequately resourced, reflecting the population size and any other relevant demographics of their individual CHO geographical area.

IV. Dedicated ring-fenced funding for (a) social work-specific research and (b) appropriate education and training initiatives to upskill the social work workforce and to help develop evidence-informed policy and practice responses.

d) Regarding Information Sharing: Clarification and possible solutions to relevant issues must be sought from the Data Protection Commissioner, to address issues with some current interpretations of GDPR, which serve to restrict information sharing between agencies around safeguarding.

e) Concerning High-Risk Groups: The unique needs of groups who experience disproportionate levels of abuse, including older women, homeless people, people with intellectual disabilities or cognitive impairments, women in the Travelling community, people living with dementia, refugees, asylum-seeking and migrant populations for example, must be recognised at national strategic level with appropriate operational responses.

f) Concerning Access to Justice:

I. Expansion and resourcing of specialist units in An Garda Síochána, and clarification of their role, to support and carry out investigations where people experiencing abuse have complex clinical histories, or have an intellectual disability, cognitive impairment etc. to ensure all citizens have equal access to justice and reparation.

II. Safeguarding & Protection teams and An Garda Síochána should be able to request and access specialist expertise, for example, speech and language, occupational therapy,

forensic/gerontological nursing/medicine or psychology to assist investigating Gardaí in communication and other sensitive work with adults who may have experienced or be at risk of abuse, as required.

III. Joint training and co-interviewing protocols between Safeguarding and Protection social workers and An Garda Síochána would assist in this regard and should be put in place.

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Appendix A: 'Falling through the Cracks' Case Studies [2]

Case 1

What is the story about?	**Lack of governance/oversight in private nursing homes**
Who, when, where?	Jack is a 56-year-old man who has been placed in a private nursing home under the Nursing Home Support Scheme (NHSS) following a road traffic accident which resulted in him being wheelchair dependent with a high level of physical care needs. Jack sustained a traumatic brain injury which means he has significant cognitive impairment and communication difficulties. Jack has no family who are involved in his care and appears to have no support persons or friends who are in contact with him. Jack is admitted from a private nursing home to the acute hospital for treatment of a respiratory tract infection. During his admission, the medical and nursing team observe that Jack has pressure sores and extreme contractures to his limbs. The medical and nursing team alongside the Medical social worker assess that Jack had been neglected while in the care of the private nursing home and a referral is made to the Safeguarding and Protection Team (SPT) for investigation and follow-up. *"I suppose it came up as a care concern then became more about safeguarding concerns because we felt it wasn't safe to send him back, that people weren't taking on board what we were saying. They weren't demonstrating the competencies to look after him."*
Complicating Factors	• Jack is deemed not to have decision-making capacity and while a Ward of Court application was instigated when he sustained his original injury in the road traffic accident, this was never followed through and processed. • A referral is made to An Garda Síochána and a report is made to HIQA however, due to GDPR the acute hospital cannot provide Jack's name or individual details. HIQA's role is to monitor nursing home facilities and not to monitor the welfare of individual residents. • The acute hospital staff and SPT highlight their concerns about Jack's care to the private nursing home who strongly deny that Jack has been neglected and issue a letter from their solicitor in respect of the neglect allegations. The private nursing home state they are not prepared to have Jack return to their care. • The Medical social worker is now working with another family who wish their relative to be placed in the private nursing home in question but due to GDPR cannot share information about their concerns relating to poor standards of care and neglect of residents. *"So, what I found in that situation was that there was just, like the nursing home I felt fell between stools, so I got onto safeguarding and they just said you know we can't, this isn't, and doesn't really come under us. You'll have to report it to HIQA. When we were onto HIQA they said, which we did, we wrote to HIQA and they said you know we can't investigate, we can investigate the nursing home, or we can do a visit, but we can't investigate a particular case."*
Impact	Acute hospital staff and the SPT are extremely worried about the welfare and care of other residents in the private nursing home but have no other mechanism to further investigate or follow up as the private nursing home is unwilling to engage in any further discussions or investigation. *"GDPR has made things very difficult and I'm not sure the legislation was written to cause the trouble, it has caused. The person causing it (abuse) is not named anymore. In terms of pattern forming because that's part of the stuff that we would look at when we get preliminary screens, pattern forming so you're kind of targeting it. And that would be in and around institutional*

	abuse because if they're continuing to let the same things kind of happen time and time again then the institution aren't implementing perhaps what they can or looking at what mixes they've got in their units…"
Result	Due to Jack's high level of care needs, NHSS funding is no longer sufficient and 'top-up' funding must be sought from HSE Disability Services in order to identify an alternative placement for Jack. The Medical social worker encounters huge difficulties trying to identify a suitable placement that can meet Jack's care needs compounded by the fact that HSE Disability Services state that they can't provide top-up funding. Jack remains in an acute hospital bed for 9 months awaiting funding and for an alternative placement to be identified.
Outcome	Jack has been made a Ward of Court and has finally been transferred to a specialist facility that can adequately meet his care needs.

Case 2

What is the story about?	**HSE failure to provide care to an adult at risk**
Who, when, where?	Susan is 86, has limited mobility and dementia. Her daughter, Jackie, lives 10 km from her and has been caring for her mother for 8 years. As Susan's health declines, Jackie is finding it more difficult to juggle work, and family commitments e.g., care of grandchildren and looking after her mother. Susan has been staying in bed most days. Recently, Susan fell out of bed, her daughter called the ambulance, and she was admitted to hospital. While Susan only suffered bruising in the fall, on examination it was discovered she had grade 4 pressure sores and was malnourished and dehydrated. However, her pressure sores healed quickly with good nursing care. While Susan has dementia, she was clearly expressing her wish to return home and her family wanted her to come home. A family meeting was organised to discuss Susan's discharge plan. There was general agreement that Susan needed regular care throughout the day and that Susan could return home with a combination of a significant package of privately funded care and HSE funded home care. Although a financial stretch for Susan and her daughter, the family agreed to pay for four hours of private home care per day Monday– Friday and that Jackie and Susan's family would also provide full-time care at the weekends. The Medical social worker applied to the HSE for 10 hours per week of a home care package however no hours were provided. Susan was subsequently discharged to home. She is left alone from 8 pm until 11 am the next morning; a carer comes in at 11 am and stays until 1 pm, then no carer calls until the next day.
Complicating Factors	• Unintentional neglect – The family want to do their best for Mam and support her wish to live at home, but they are struggling to meet Susan's increasing care needs. • Timing of discharge - an embargo on HSE home support services was introduced in the catchment area where Susan lives. Care hours deemed essential to the safeguarding plan negotiated and agreed upon with Susan's family, cannot now be delivered by the HSE. • Susan is discharged without the support needed to keep her safe and to meet her basic care needs. • Susan's family abide by the safeguarding plan, paying for 20 hours of home care per week which is a significant cost, and they are also providing full-time care on weekends. The HSE are providing no carer support hours to Susan and her family. • A further request was made to the HSE by the Primary Care social worker for a carer to call in the morning. Susan was eventually approved for 2.5 hours per week = one carer to call for 30 minutes Monday to Friday. However, Susan requires the assistance of two people for transfers, so needs a minimum of a further 5 hours of home care per week. *"It's very hard to safeguard people in the community without the proper resources to do that."*
Impact	Susan remains at risk as her care needs cannot be met within the resources of the family. The public body responsible for delivering care and safeguarding adults who are vulnerable (HSE) has not provided the care that Susan requires to keep her safe and to meet her care needs.
Result	Susan's family lost trust in the social worker due to home supports not being provided as promised. The therapeutic relationship has been damaged, and they no longer wish to engage with the system. They are now denying the PHN and the social worker access to Susan. Susan has returned to a situation that was only marginally safer, having spent two months in an acute hospital bed. Months of work by the social worker spent building a relationship with Susan and her family, drawing up and negotiating a safety plan is now wasted.

	"We're left without any ability to monitor this lady at home and bear in mind she'd already been admitted with severe pressure sores, malnourished, dehydrated."
Outcome	Back to square one, more drastic steps such as a Ward of Court application are now being considered to admit Susan to nursing home care (against her wishes), when/if she is admitted to the acute hospital again: *"At some point, if her care continues to deteriorate, we'll have to arrange, probably readmission to hospital and if the family or the HSE can't put in enough care at home then we're going to be looking at another wardship application which is ridiculous."*

Case 3

What is the story about?	Interagency Working and Sharing of Information
Who, when, where?	Matthew is 19, has an intellectual disability and has been in the care of TUSLA from the age of 8 to 18 as a result of abuse and neglect by his biological parents. Matthew is now transitioning into adult services and his case has been referred to the Safeguarding and Protection Team (SPT) social workers as supported accommodation cannot be accessed, and he has been returned to the care of his parents. Day-care and respite support has been arranged for Matthew, but his parents are preventing him from accessing these supports as they feel they can look after him and don't want any services involved. SPT are concerned that Matthew is being chronically neglected and that his parents can't cope.
Complicating Factors	• Sharing of information: GDRP means TUSLA requires the consent of both the adult and parents (if they represent concerns when a child was under 18) to share information. • Matthew's parent's desire to keep control and authority results in attempts to sabotage respite, and day care arrangements and they appear to be able to act without any consequences to them. *"…When he returned to live at home, there was a serious adult protection matter. So, we looked to get information from TUSLA, given that he had had extensive involvement with them. And due to GDPR and other factors, the information wasn't shared or couldn't be shared."*
Impact	SPT spent a lot of time trying to access TUSLA information. Despite working closely with Matthew and his parents about the need for him to receive support services, Matthew's parents refuse and disengage from all discussions. *"The only way that it could be shared was with the consent of the parents who were the persons causing concern. And even then, we couldn't review the files, I had to prepare a series of questions for them (TUSLA) to answer and then to return to me…how can somebody who doesn't have the capacity to consent for their historic files to be reviewed where there are serious safeguarding concerns? It took us 10 months to actually get that information."*
Result	SPT were unable to fully access previous social work records as Matthew's parents wouldn't give consent. Matthew was eventually made a Ward of Court as it was felt he did not have decision-making capacity and that he was unable to protect himself. The Ward of Court office directed that Matthew's parents must allow him to attend day care services and respite.
Outcome	Matthew was eventually transferred to supported accommodation and remains a Ward of Court. Ward of Court legislation meant that Matthew could receive services and be protected.

APPENDIX B: ADDITIONAL LEGAL MEASURES – SUPPLEMENTARY INFORMATION

Mandatory reporting to apply to the following key categories of persons:

I. relevant professionals,
II. paid staff and volunteers, including
III. people in receipt of carers' allowance.

All of the above must report any concern related to the abuse or neglect of a person who is unable to adequately seek support for themselves, due for example to illness, frailty, capacity, intellectual or physical disability or mental health issue; or where there is evidence of severe coercive control influencing their ability to provide informed consent on matters related to personal safety.

Those in the above designated categories of key persons (including professionals, paid staff, and volunteers, and including people in receipt of carers allowance) must report concerns about abuse when the alleged perpetrator is in a paid or unpaid position and may have access/responsibility for to other adults who may be vulnerable to abuse.

In other cases, where an adult experiences abuse and neglect and does not wish to report it to An Garda Síochána and/or to a relevant safeguarding social work service, the person who would otherwise be required to make a mandatory report to the appropriate authorities, must clearly record the support offered, the decision made, on what basis, and the offer of a continuing relationship to maximise safety in the current circumstances.

All interventions, including those mandated by law, must be person centred. The person must remain at the heart of all interventions and targeted support provided to ensure they have maximum opportunity to freely communicate their will and preferences in accordance with the *Assisted Decision Making (Capacity) Act, 2015* and any other relevant legislation. **Removing someone from their usual place of residence must be a last resort and used only in cases where the person themselves is unable to exert their own rights to protection from abuse and neglect, or where it is not possible to ascertain their wishes, preferences, and consent, due to the impact of coercive control. High thresholds must apply in such instances and the legal right to access, and removal must only be granted following an application to a Court.**

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