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| Title | Falling Through the Cracks: The case for change. Key developments and next steps for Adult Safeguarding in Ireland |
| Authors(s) | Donnelly, Sarah; O'Brien, Marita |
| Publication date | 2019-12-11 |
| Publisher | University College Dublin |
| Item record/more information | http://hdl.handle.net/10197/11242 |

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2019

Falling Through the Cracks

The Case for Change, Key Developments and Next Steps for Adult Safeguarding in Ireland

SUMMARY OF FINDINGS

Dr. Sarah Donnelly
Dr Marita O'Brien

Commissioned by:
Senator Colette Kelleher

Acknowledgements

We would like to thank Senator Colette Kelleher for commissioning this piece of research and for her ongoing support and encouragement throughout the research process.

We would like to extend our sincere thanks to all the study participants who gave so generously of their time to participate in the research.

We would also like to acknowledge and thank our study collaborators:

The HSE National Safeguarding Office

The Irish Association of Social Workers (IASW)

The Alzheimer Society of Ireland

Sage Advocacy

We would like to thank Professor Jim Campbell, School of Social Policy, Social Work and Social Justice, UCD for providing a peer review of this research summary.

Please cite as: Donnelly, S and O'Brien, M (2019). *Falling Through the Cracks: The case for change. Key developments and next steps for Adult Safeguarding in Ireland*. Dublin: University College Dublin.

Joan friends



Adults are at risk of and experiencing harm and abuse all over Ireland, and for a variety of reasons including psychological, physical and financial abuse. According to a report commissioned by the Banking & Payments Federation Ireland (BPF), entitled 'Financial Abuse in Ireland, 2019', 20% of adults have experienced financial abuse and physical abuse of vulnerable adults has been witnessed/suspected by 1 in 3 adults. Last year there were 11,780 safeguarding concerns received by HSE Safeguarding and Protection Teams across Ireland according to the National Safeguarding Office Annual Report.

So today in Ireland whilst many thousands of people experience and/or are at risk of harm and abuse, the current law, policy and protections are inadequate to safeguard the wellbeing of adults in certain situations. Put simply people are 'falling through the cracks' and coming to harm or being abused because of gaps in our current systems. Frontline Social Workers and others who come into contact with people in these situations just don't have the ways, means or powers to support and safeguard them.

The realisation of the vulnerability of some people to harm and abuse and the imbalance of protections available to them led me to move the Adult Safeguarding Bill 2017, which passed second stage in the Seanad in April 2017 with cross party support. The Bill defined harm and abuse, proposed the establishment of a National Safeguarding Authority with a variety of powers to support and intervene in situations of abuse, as well as a reporting regime.

Since 2017 adult safeguarding has been prioritised as a key policy area for attention and development by the Department of Health. Adult safeguarding features as a priority in the Law Reform Commission's fifth programme which was published this year.

As well as introducing the Bill in 2017, I have sought to make a constructive contribution to the evolution and development of adult safeguarding law, policy and practice. To that end I have convened a number of seminars with ‘lived experience’ experts, civil society organisations, on the ground practitioners, as well as with politicians, policy makers and lawyers.

I have also commissioned new research¹ and am presenting the latest in the adult safeguarding series ‘*Falling Through The Cracks*’ through composite case studies gathered from real life situations reported from the frontline. The nine case studies feature people with intellectual disabilities, older people, people with acquired brain injuries, people with dementia and the gaps and cracks in support, safeguards and protection which they are falling through. It’s clear that practitioners need better means to support and intervene to end the abusive circumstances in which large numbers of people find themselves. So there are recommendations in this report from the frontline for specific actions and suggestions to improve adult safeguarding law, policy and practice in Ireland.

Much thanks to the team Dr Sarah Donnelly from UCD’s School of Social Work and Dr Marita O’Brien, an Independent Health Policy Analyst, the HSE and members of the Safeguarding and Protection Teams as well as Sage, Alzheimer Society of Ireland, Irish Association of Social Workers and everyone who contributed to this important research. I hope you find this report of use and interest as we work together to find the best ways to safeguard and support adults at risk and experiencing abuse or harm in Ireland

Yours sincerely



¹ ‘The establishment of Cosáint, The National Adult Safeguarding Authority’, 2017, Institute of Public Administration
‘Speaking Up About Adult Harm: Options for Policy and Practice in the Irish Context’, 2018, Sarah Donnelly and Marita O’Brien

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Falling Through the Cracks: The case for change. Key developments and next steps for Adult Safeguarding in Ireland

Section 1: Introduction

1.1 Background

The Adult Safeguarding Bill 2017 was introduced by Senator Colette Kelleher in the Seanad in April 2017. The Bill aims to put in place additional protections and supports for adults, in particular, for those who may be unable to protect themselves. It does two main things: Part 3 provides for mandatory reporting by specified/named persons/professionals and others where an adult has experienced abuse or harm, is experiencing abuse or harm, or is at risk of experiencing abuse or harm. Part 2 establishes a National Adult Safeguarding Authority ‘that will be required to respond effectively if significant concerns of abuse or harm are reported’ (Section 7:7). Provisions include that the authority will have the power to investigate, including the power to enter any premises that is not a dwelling (i.e. premises occupied as a private dwelling). The Authority may also direct the Executive² or local authority to make available health or social care, legal, accommodation or other services including emergency supports (Section 11:3).

This study described below sets out to explore how the absence of Adult Safeguarding legislation in the Irish context may be impacting on adults within the current safeguarding system from the perspective of social work practitioners, professionals or advocates who are working with them. The study seeks to shed light on how practitioners are navigating cases in the absence of primary legislation and to explore what benefits or challenges there might be should Adult Safeguarding legislation be fully enacted in the Irish context.

The collaborators involved in this study include: the HSE National Safeguarding Office, the Irish Association of Social Workers (IASW), The Alzheimer Society of Ireland and Sage Advocacy. The principal investigator is Dr Sarah Donnelly, School of Social Policy, Social Work and Social Justice and the co-researcher is Dr Marita O’Brien, Independent Researcher and Health Policy Analyst.

²“Executive” means the Health Service Executive;

1.2 Methods

A mixed-method research design was employed using semi-structured interviews, focus groups and an online survey. The aim was to gather the different perspectives of professionals and advocates involved in adult safeguarding processes to explore how primary adult safeguarding legislation may help mitigate individuals 'falling through the cracks' of the current system.

Interviews and focus groups

A purposeful sampling approach was used to recruit participants from each Community Health Office area for the focus groups and narrative interviews. The HSE National Safeguarding Office assisted in the recruitment of Safeguarding and Protection Social Workers; the IASW in the recruitment of medical, primary care, disability and mental health social workers; The Alzheimer Society of Ireland and Sage Advocacy in the recruitment of Dementia Advisors and a SAGE Regional Coordinator. The sample is described in Table 1 below:

Table 1: Study sample

| Focus Groups | Dublin Focus Group (n=5) | Galway Focus Group (n=3) |
|----------------------|--|--|
| Narrative Interviews | 6 x Safeguarding and Protection Social Workers | 2 x Disability Social Workers 2 x Primary Care Social Workers 2 x Medical Social Workers 2 x Mental Health Social Workers |
| | 2 x ASI Dementia Advisors | 1 x SAGE Regional Coordinator |

Seventeen semi-structured audio-recorded narrative interviews (Jochelovitch & Bauer, 2000) and two focus groups were undertaken. Participants included 21 women and four men.

Issues explored in the narrative interviews included:

- cases that represent barriers to achieving a positive outcome due to absence of legislation
- cases that represent current use of legislation to good effect
- cases that represent current legislation that cannot be used to produce desired outcomes

- cases where current legislation is of no benefit and other variables such as skills or resources lead to a good outcome
- cases where good outcomes can be achieved with what services and interventions were available.

Online survey

An online survey was administered via a 'SurveyMonkey' questionnaire to social work practitioners. The IASW assisted in distribution of the online survey to their members. The aim of administering the online survey was to provide complementary data to the interviews and to get a sense of the attitudes of social work practitioners to different legislative duties and powers in adult safeguarding practice. The survey was completed by N=116 respondents.

Informed consent, data collection and management

The study was approved by the University College Dublin Human Research Ethics Committee in 2019. Prior to the focus group/interview all participants received written information and were given time to read this information and ask any questions about the purpose of the study. Participants then signed a consent sheet. An unobtrusive digital audio-recording device was used for all focus groups/interviews. Verbal consent was taken at the start of the recording, and no participants declined to be recorded. All audio-recordings were transcribed verbatim, using station notation by an experienced transcription agency. Transcripts were read in conjunction with audio-recordings to ensure the quality of the transcription. The management of research data meets the requirements set out under GDPR and Irish data protection legislation.

Data analysis

A coding framework for data analysis was developed and all data was analysed and coded using Labov's (1972) narrative analysis framework. The researchers validated and shared with participants all case typologies developed via email prior to them being made available in the public domain. This helped to ensure that participants had an opportunity to voice any concerns relating to how the data has been presented and interpreted. Data gathered from the focus groups and interviews were then used to create a narrative exploration of experiences, highlighting the issues from as many perspectives as possible through the lens of the professional/practitioner.

Section 2: Falling Through the Cracks- Case Studies

This section of the research includes nine case studies which were developed from the interview and focus group data. The cases are based on key themes which emerged during the focus groups and interviews as well as actual cases which participants discussed. These case typologies help shed light on how adults are ‘falling through the cracks’ within our current safeguarding systems.

2.1 Case 1: Mathew

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| What is the story about? | Child in care of TUSLA transitioning to adult services |
| Who, when, where? | <p>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 have 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.</p> |
| Complicating Factors | <ul style="list-style-type: none"> • Sharing of information: GDPR 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 parents desire to keep control and authority, results in attempts to sabotage respite, day care arrangements and they appear to be able to act without any consequences to them. <p><i>“...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.”</i></p> |
| Impact | <p>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.</p> <p><i>“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 capacity to consent give consent for their historic files to be reviewed where there are serious safeguarding concerns? It took us 10 months to actually get that information.”</i></p> |
| Result | <p>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 daycare</p> |

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| | 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. |

2.2 Case 2: Lily

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| What is the story about? | Coercive control of an older person by their adult child |
| Who, when, where? | <p>Lily is an 83 year old widowed woman who has Type 1 diabetes, cognitive impairment and lives with her son Seamus who is 49. Lily has one daughter, Heather who lives in Australia and visits once a year. A year ago, Seamus returned to live with Lily after the breakdown of his marriage. He had been drinking heavily and had lost his job. Seamus often becomes aggressive when he is drunk, shouting at Lily and frightening her. Seamus has taken control of Lily's pensions and savings and says he will 'look after them' for her. The Primary Care social worker had arranged for Lily to get a home care package, a carer to help her with washing, dressing and medications twice a day. Seamus is refusing to allow carers access to the house and Lily now spends most of her time in bed.</p> <p>When Lily missed an important appointment at the Diabetes OPD, the PHN and Primary Care social worker try to visit Lily to check on her. Seamus refuses to answer the door and tells Lily they have called as they want to put Lily into a nursing home, take her money and she will never see him again. After the PHN and social worker fail to get access on another two occasions, they ask the GP, Dr Mullan to try and Seamus agrees to allow him to see Lily. Dr Mullan discovers that Lily has a urinary tract infection, is delirious and requires urgent medical attention and rings an ambulance. Lily is admitted to hospital and put on a course of antibiotics. Lily confides to the doctor that she is scared of Seamus, but she can't ask him to leave as he has nowhere else to go and that he's her only son and she couldn't see him on the streets.</p> |
| Complicating Factors | <ul style="list-style-type: none"> • Seamus comes to the hospital and tells Lily he is taking her home and that he can look after her better. • The hospital multidisciplinary team (MDT) are very concerned about Lily's welfare, but she is deemed to have decision-making capacity to self-discharge against medical advice to the care of Seamus. • Seamus agrees with Lily's treating consultant and MDT to allow Lily's carers back into the home and to make sure Lily gets her medications. • When Lily gets home, Seamus refuses to allow carers access. The GP, PHN and Primary Care social worker are extremely worried that Lily isn't getting her medications and is being neglected. <p><i>“Gardaí advised us to look at the domestic violence legislation to go in and get a third-party barring order to prevent her son from being there. But when we went down through the provisions of that legislation the mother had never expressed any wish for the son to be out of the house, so it wasn't appropriate.”</i></p> |
| Impact | A referral was made to the Safeguarding and Protection Team (SPT) when Lily was admitted to hospital and made the initial disclosure. |

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| | <i>“The support isn’t there. In terms of, so dealing with a case like that is, emotionally, extremely draining...it’s very disheartening but also the other piece for me is that there is not social work support up through the management structure in the HSE.”</i> |
| Result | <p>The SPT are unable to gain access to carry out their assessment and have no powers to access the home nor to compel Seamus to allow carers access. The GP, PHN and Primary Care social worker are also unable to get access despite numerous attempts. Eventually the Gardaí agreed to accompany the GP, PHN and social worker on grounds of ‘endangerment’ and Seamus does allow the GP and Gardaí access to the house and to Lily. Lily is found in her bed, unconscious and in a diabetic coma; Seamus said he thought she was asleep.</p> <p><i>“People want the abuse to stop but they don’t want the relationship to finish. And we have to respect that... But then, there are times when our intervention is so, it has to be so direct and accusatory that it will destroy the relationship. So, that’s a difficult dilemma for us.”</i></p> |
| Outcome | <p>Lily was brought to hospital by ambulance and admitted to intensive care. Lily eventually stabilised medically however Seamus began presenting to the hospital intoxicated, and on several occasions attempted to ‘remove’ his mother from the ward resulting in hospital security being called. At this stage Lily’s capacity was reassessed, she was deemed not to have capacity and an application to the Ward of Court office was made and a nursing home placement was sought.</p> <p><i>“Where does the impact of coercive control come into the capacity to make decisions and how do those two interact and cross each other, that’s a key.”</i></p> |

2.3 Case 3: Jack

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| What is the story about? | Lack of governance/oversight in private nursing homes |
| Who,when, where? | <p>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.</p> <p><i>“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.”</i></p> |
| Complicating | <ul style="list-style-type: none"> • Jack is deemed not to have decision-making capacity and while a Ward of Court |

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| <p>Factors</p> | <p>application was instigated when he sustained his original injury in the road traffic accident, this was never followed through and processed.</p> <ul style="list-style-type: none"> • 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. <p><i>“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.”</i></p> |
| <p>Impact</p> | <p>Acute hospital staff and the SPT are extremely worried about the welfare and care to 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.</p> <p><i>“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...”</i></p> |
| <p>Result</p> | <p>Due to Jack's high level of care needs, NHSS funding is no longer sufficient and 'top-up' funding has to 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 which 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.</p> |
| <p>Outcome</p> | <p>Jack has been made a Ward of Court and has finally been transferred to a specialist facility which can adequately meet his care needs.</p> |

2.4 Case 4: Kim

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| <p>What is the story about?</p> | <p>Adult with an intellectual disability whose care is transferred by their parents to other relatives</p> |
| <p>Who, when, where?</p> | <p>Kim is 52 and has down syndrome. She has always lived with her parents in a rural area. Kim attended school but has not engaged with intellectual disability services now for nearly 40 years. Her parents are now in their 80s and both have dementia. Kim has not attended her GP in eight years, nor seen any other health and social care professional in this time.</p> <p>Last year, Kim moved into live with her brother and his wife. Her disability benefit was transferred from her parents to her brother. Kim came to the attention of the HSE when her sister-in-law brought Kim to the primary care centre and requested residential care for her, saying she could not cope.</p> <p>A residential place was secured for Kim and over the next couple of months her medical needs and personal care needs were addressed. Kim engaged fully in social activities and was noted to be “thriving” in her new home. Her disability benefit was transferred to her, and she was able to save some money. Nine months into the placement, her brother and his wife arrived and took Kim back to live with them. The residential service contacted the Gardaí and the Safeguarding and Protection team (SPT) and all three met with Kim’s relatives and negotiated for her to return to the residential facility. However, some months later after seeking legal advice, her brother requested that Kim be returned to them. Having no other option, the disability service had to allow them take Kim. The following day, Kim’s savings were withdrawn, and her bank account closed.</p> |
| <p>Complicating Factors</p> | <ul style="list-style-type: none"> • A family can easily transfer care and disability benefit of an adult with an intellectual disability to another relative. • Kim was ‘not in the system’ so had no contact with anyone except her family. On leaving the education system, there was no transition pathway for Kim. • Issue of ‘service decliners’ – offered services over the years but parents would have declined on behalf of their adult child • Parents or relatives acting as proxy decision-makers for adults with an intellectual disability. • Culture of stigma in the 60’s in relation to having child with an intellectual disability; children kept at home, out of sight, now aged in their 50’s, isolated and living with ageing parents, not linked to the outside world. • Tendency for the judiciary to favour family member accounts over those of service providers or HSE health and social care professionals. <p><i>“You’ve someone else saying they don’t need to go into a service, and then the judge will turn around and say fine, yes they don’t, because they believe them rather than believe the service providers or the HSE.”</i></p> |
| <p>Impact</p> | <p>There is a cohort of older individuals with intellectual disabilities now aged in their 40’s, 50’s recorded as “service decliners” who are now living with ageing parents, who they are dependent on for support. This group of people may never have had opportunity to develop skills needed to be as independent as possible. Decision-making as to their future care and support rests with family. In Kim’s case, the only oversight in relation to her safety and welfare is being provided by the court visitor/ accessor.</p> |

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| | <i>“They’re really lost (in the system) ...when you’re out of mind, then I believe then you’re at risk.”</i> |
| Result | <p>The HSE made an application for wardship. When taking up her place in the residential facility, Kim had been assessed as not having capacity at that time however, it was felt wardship was an unnecessary step (wanted to wait for Assisted Decision-Making Capacity Act, 2015 to be fully commenced). Her brother is obstructing the social worker and PHN from seeing her. For example, he takes Kim with him on the farm when he knows they are coming:</p> <p><i>“I think he had got to the stage where he thought we were a show, you know that we had no clout. We weren’t able to really deliver on what we were talking about. And he could manipulate us. So, he actually got to be openly kind of contemptible with us, open contempt with us. As in I’m not going to let you in, and I don’t want you coming here.”</i></p> |
| Outcome | The Judge has sent out a court visitor/ assessor a number of times and they reported back that the family are looking after Kim well. Kim has not engaged with any support services since moving back in with her brother. |

2.5 Case 5: Susan

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|---------------------------------|---|
| What is the story about? | HSE failure to provide care to an adult at risk |
| Who,when, where? | <p>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, 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, was malnourished and dehydrated. However, her pressure sores healed quickly with good nursing care.</p> <p>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 8pm until 11am the next morning; a carer comes in at 11am and stays until 1pm.</p> |
| Complicating Factors | <ul style="list-style-type: none"> • Unintentional neglect – 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 with Susan’s family, cannot now be |

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| | <p>delivered by the HSE.</p> <ul style="list-style-type: none"> • Susan is discharged without the supports 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. <p><i>“It’s very hard to safeguard people in the community without the proper resources to do that.”</i></p> |
| Impact | <p>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) have not provided the care which Susan requires to keep her safe and to meet her care needs.</p> |
| Result | <p>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.</p> <p>Susan has returned to a situation which 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.</p> <p><i>“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.”</i></p> |
| Outcome | <p>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:</p> <p><i>“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.”</i></p> |

2.6 Case 6: Jason

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| <p>What is the story about?</p> | <p>Young man with a traumatic brain injury whose behaviour is posing risk to his siblings and there are safeguarding concerns in relation to him from his father</p> |
| <p>Who, when, where?</p> | <p>Jason is 22 and was in a car crash while joy riding when he was aged 16. He lives with his father, his father's partner and their two children aged 7 and 9. Jason suffered a traumatic brain injury resulting in constant headaches, mood changes, agitation, aggressiveness and poor concentration. He attends a rehabilitation service on and off and they do great work with him. He gets an hour a day support from a personal assistant, Monday to Friday. Jason's stepmother has contacted social services seeking help as there have been a number of incidents in the last year where Jason has hit and kicked his step siblings over minor disagreements. These incidents are becoming more regular and serious since Jason started using cannabis to cope with his headaches and anxiety. The last assault resulted in him breaking his half-brother's arm. Jason's father is also finding the situation difficult to handle and he has assaulted Jason a number of times. TUSLA and the Safeguarding and Protection Team (SPT) have been notified and are involved.</p> <p><i>"We are holding it by trying to establish a social work relationship with the father and stepmother and the boy. And that is not our brief but if we weren't in there doing that, then we would have a dire situation. And what he actually needs is a proper package of care but what he's got is like about 5 hours a week from an agency who put in a PA (personal assistant) who doesn't know what they're doing."</i></p> |
| <p>Complicating Factors</p> | <ul style="list-style-type: none"> • To safeguard the other children in the household, TUSLA have recommended that Jason should leave the family home. • SPT believe Jason is not safe living in the house with his father. • Jason is unable to live without support; he has very complex care needs requiring specialist support. Jason needs a place in an independent or supported living unit. There are no places available locally and Jason does not want to move away from his friends and family. <p><i>"He's got a very complex brain injury and he's 22 ... without any right to services and without any resources, we go in sort of with a begging cup ... there's no point in having safeguarding there if you haven't got care there."</i></p> |
| <p>Impact</p> | <p>Both TUSLA and SPT do regular visits to the house. The situation is being held by the SPT working with Jason, his stepmother and father to put in safety measures such as getting Jason support to address his anger management and drug addiction and trying to source additional hours from a personal assistant.</p> <p><i>"I mean we make the most of a very, very difficult situation and we've tried. And we've got the support of the rest of the family. Again, it's an acquired brain injury case. They're some of the most difficult ones."</i></p> |
| <p>Result</p> | <p>Jason's behaviour is becoming more challenging; his father wants him out of the family home. Jason's complex needs means he cannot live independently. A place has been sourced for him in the local psychiatric unit. If he does not accept this place, he will be homeless.</p> <p><i>"He is only 22 years of age and he is being left in psychiatric unit, as HSE / disability service say they don't have a residential place for him."</i></p> |

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| Outcome | <p>There are no resources to get Jason into an independent or supported living facility. Jason's will and preference to remain living in his local community is not being upheld and his care needs are not being adequately met.</p> <p><i>"He needs a wrap-around package, he's got a very complex brain injury and he's 22... he's not going to go away."</i></p> |
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2.7 Case 7: Patsy

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| What is the story about? | Self-neglect in the community |
| Who,when, where? | <p>Patsy is a gentleman aged in his 70s, living at home, not in contact with his family and socially isolated. He has some cognitive impairment and mild mental health issues but has decision-making capacity. His home, a mid-terrace house, has become uninhabitable because of hoarding. Patsy is not linking in with any services (not even a GP). The Primary care social work team have been working with Patsy for over a year building a trusting relationship and trying to get Patsy to improve his living conditions and quality of life by linking him in with community services.</p> <p>Patsy was malnourished, and he agreed to take meals on wheels, but stopped them after a couple of months. Neighbours contacted the Primary Care social work team reporting that they had had to call the fire brigade in relation to a chimney fire in Patsy's house and they were very concerned that Patsy's living conditions (hoarding, open fires, gas heater in kitchen, Patsy's smoking) were posing a fire risk to him and his immediate neighbours.</p> |
| Complicating Factors | <ul style="list-style-type: none"> • An individual's right to self-determination means that support services can't be imposed and Patsy's consent is required. • Patsy's neighbours also have a right to live safely and to be protected. • It takes a huge amount of time to build rapport and a trusting relationship, while at the same time addressing the issues that place Patsy at risk: <p><i>"We won't force it on them, we'd respect their right to self-determination but try to keep them safe in their home."</i></p> |
| Impact | <p>Patsy is finding activities of daily living more difficult to undertake due to his deteriorating health. However, it is up to Patsy to invite health and social care professionals into his life; he has capacity to make the decision to live with that risk; he cannot be forced to comply or accept supports. However, Patsy is also putting his neighbours at risk.</p> |
| Result | <p>Over a number of months, the Primary Care social worker continues to visit, sometimes just leaving food outside Patsy's door, building a rapport. Eventually Patsy agrees to accept meals on wheels again and allows fire alarms to be installed in his home. He also allows a GP to visit and the GP persuades Patsy to attend the Psychiatry of Later Life service for an assessment. Patsy's medication is changed, and weekly dispensing is set up with the local pharmacy:</p> <p><i>"So only for our skills, that man would never have actually engaged at all, now he's still living in quite poor conditions but that is his choice."</i></p> |

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| Outcome | <p>Pasty continues to live at home and while his living circumstances are far from ideal, some of the basic risks have been minimised and his quality of life has vastly improved.</p> <p><i>“He was very, very clear and he did not want to leave his home. But at least the basic risks of him not eating and not drinking, not getting any medical care were diminished. But only because I suppose the safeguarding social worker at the time and the public health nurse were willing to really think outside the box. And so, I don’t think you can legislate for that.”</i></p> |
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2.8 Case 8: Joe

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| What is the story about? | Older adult without capacity where an Enduring Power of Attorney has been enacted |
| Who,when, where? | <p>Joe is 86, is a farmer and has lived all his life on his farm in a rural area. Joe has dementia but continued to live in his own house beside that of his son on the family farm- the farm was signed over to his son when Joe retired 10 years ago. Joe’s wish has always been to live and die on the farm. Joe’s son and wife have been looking after him since he developed dementia. Joe’s daughter lives in the UK, she is a doctor and visits Joe every couple of months. When diagnosed with dementia, Joe’s daughter encouraged him to put in place an Enduring Power of Attorney, naming his daughter as his attorney. Last year this was enacted as Joe was assessed as no longer having decision-making capacity.</p> <p>Joe’s daughter is not happy with the way her brother is looking after Joe. Her brother has agreed to get more care hours for his Dad (Joe has savings to pay for care). However, Joe’s daughter is still not happy with this arrangement; she feels that her father is unsafe being on his own at night-time and that he would be better cared for in a nursing home. While she is in Ireland looking after her father while her brother is on holidays, she arranges for her father to fly back with her to the UK. She then moves Joe into a nursing home there. Joe’s son is very upset and demands that Joe be returned home and requests the name of nursing home so he can visit his father. Joe’s daughter ignores this request and stops communicating with her brother and will not tell him which nursing home his father has been placed in:</p> <p><i>“When we contacted the Gardaí in relation to this and sought their intervention, there was no intervention. If that was a child, they would be all over it. This person couldn’t consent to where they wanted to be.”</i></p> |
| Complicating Factors | <ul style="list-style-type: none"> • Joe’s expressed will and preference was to remain in his own home. • Joe’s safety is a concern. Both children want what’s best for Joe, but what’s best from their perspective, rather than looking at Joe’s expressed will and preference. <p><i>“I know I’m going to be buried here, I’m going to live here, this is where I want to be. And you know with my family.”</i></p> |
| Impact | <p>Where conflict exists between siblings or a family member within an Enduring Power of Attorney arrangement, the sibling acting as the attorney can take control over the parent and make decisions the from their perspective and opinion.</p> <p><i>“And she took him out of the country... well we don’t know, against his wishes.”</i></p> |

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| | <i>But it wasn't the wish or the view that he had shared with other people and (his daughter) refused to let anyone know where he was. Family members or anything."</i> |
| Result | <p>Despite numerous attempts by the Safeguarding and Protection Team social workers, they were unable to secure any assistance or support from the Gardaí or international social services in helping to identify what nursing home Joe had been placed in.</p> <p><i>"We had contacted international social services to see whether they could intervene, but they only cover if there's trafficking component to be able to do that."</i></p> |
| Outcome | Joe's son still does not know what nursing home facility his father has been placed in and he has had no contact with his father since he was taken out of the jurisdiction. |

2.9 Case 9: Jane

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| What is the story about? | Undue influence and coercive control where a person at risk does not live with perpetrator and is not in an intimate relationship. The adult at risk has a mild intellectual disability, mental health illness or is emotionally naïve. |
| Who, when, where? | <p>Jane is in her 50s and has a mild intellectual disability and some mental health issues but generally functions very well. She lives alone in local authority housing in the community. Jane receives disability benefit and a number of years ago she received a significant financial settlement through a redress scheme. Jane has been befriended by a group of men in the town where she lives. She allows them to stay over in her home, treating them to food and drink, and allows them to store drugs in her home. Her neighbours are concerned and over the years, have reported their concerns to the primary care centre. Attempts have been made to engage with Jane, but while Jane will listen and agree that she needs to better protect herself, she never takes any action.</p> <p>Over a number of years, the Safeguarding and Protection Team (SPT) have received 15 safeguarding notifications in relation to Jane, pertaining to these men, some of whom she has had relationships with. These relate to incidents of assault (physical and sexual), mainly at weekends, where Jane has been drinking with this group of men. Sometimes Jane reports these incidents to the Gardaí with support from her neighbours, but then changes her mind and withdraws the statements. Jane has recently been asking a neighbour for a loan of money and when questioned has divulged that she has 'lent' thousands to one of the men who has befriended her:</p> <p><i>"She was like a honey pot to certain people who flocked around her and stayed with her and were with her and obviously used her to access resources, her resources."</i></p> |
| Complicating Factors | <ul style="list-style-type: none"> • Desire for friendship (Jane spent time in an institution and has unmet emotional needs). • Vulnerability is increased where a person has access to a large sum of money. • Certain men are known in the local community for befriending people with vulnerabilities. • Jane is knowingly giving money and choosing to have relationships with these men. • Jane and the men in question are known to Gardaí, but they cannot act where the adult at risk will not make statement. Jane has built up a reputation as not following through, so |

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| | <p>the Gardaí tend to see her as some who is always making complaints.</p> <ul style="list-style-type: none"> • Jane has decision-making capacity. • Jane often declines to engage with support services and the SPT. • Large sums of money and assets have been given away. However, while the adult at risk is under undue influence, this is by ‘friends’ and not family members. • Safeguarding and social work services are only available during the day. Crisis incidents relating to Jane occur regularly at night-time or weekends. <p><i>“As it happens in our particular area it’s the same group of perpetrators amongst a small cohort of women in the community.”</i></p> |
| Impact | <p>There is a significant difficulty in marrying a person’s will and preference with them being taken advantage of and being financially exploited and assaulted. Capacity assessments undertaken to ascertain capacity in situations where money and assets are being given away may not be thorough enough, and there may be a need for more specialist assessments, which examine the adult at risk’s executive functioning.</p> <p><i>“What we’re trying to do, respect her wish to be as independent as possible and allow her to associate as she has a right to choose you know. But reduce the risk because of the people she does actually associate with.”</i></p> |
| Result | <p>30 safeguarding meetings regarding this case have been convened over a number of years.</p> <p>Actions taken include:</p> <ul style="list-style-type: none"> ❖ Gardaí speak with the men involved. They also call in to check on Jane at weekends which results in fewer disturbances at the weekends. ❖ The SPT social worker calls regularly to see Jane, building a relationship with her and supporting Jane to get involved in a community craft group. Jane trusts her social worker and now shares information when incidents occur, and she is interacting more with others in the community. ❖ Despite a huge amount of time and effort put into trying to safeguard Jane, she is still living with risk. <p><i>“The Gardaí have been involved, there have been times when she’s agreed to make a statement, there have been times when she’s agreed for it to be notified to the guards. There have been times when she hasn’t, but it has been notified. There have been times when she’s agreed to give a statement and subsequently withdrawn that agreement.”</i></p> |
| Outcome | <p>Jane is no longer an attractive target to the men involved (her lump sum of money is now gone); Gardaí are calling regularly, and Jane is not as socially isolated. Jane is still involved in an on/off relationship with one of the men, who meets her on the day she gets her disability benefit and they go drinking together, often ending in her house with her being assaulted:</p> <p><i>“I have attended [many] meetings in the last [few] years in relation to this woman, and yet the degree to which she is safer is not that much more than it was before we had any meetings.”</i></p> |

Section 3: Key areas of concern

The safeguarding of adults at risk of abuse, neglect and exploitation by others is often complex. The majority of citizens in Ireland can act to protect themselves when faced with these situations however, there are some who find it more difficult. Safeguarding means putting measures in place to promote and protect people's human rights, their health and wellbeing, and empowering people to protect themselves. The cases outlined relate to five key areas where current legislation and safeguarding policy are not sufficient to protect people's human rights.

3.1 Against will and preference

A key area, where it can be difficult to protect the wellbeing and human rights of adults at risk, is where adults are prevented from activating their autonomy.

Findings indicate:

- A hidden cohort of older individuals with an intellectual disability now aged in their forties and fifties who were identified as 'service decliners', where parents act as proxy decision-makers and decline services. These adults are now living with their ageing parents, who they are dependent on for support and care. Frequently, decision-making as to their future care and support rests with family members.
- Ageing parents or other family members can often decide informally to transfer their care and disability benefit to another relative. Participants reported there is nothing to stop a relative removing an adult with intellectual disability from a care setting and the family making a decision to cease engagement with health and social care professionals and service providers.
- There appears to be few available interventions or protective actions to address situations where an older person or an adult at risk is assessed as not having decision-making capacity, who are not a Ward of Court, but are subject to an enacted Enduring Power of Attorney arrangement and are removed from a nursing home facility or taken to another jurisdiction by a family member with power of attorney (against the wishes of other family members and where the known will and preference of the adult at risk is to remain in Ireland).
- Cases where family members bring an older relative to Ireland from another country for a holiday, but then the family decide it is best if their relative remains living with them, for example, to care for their children, even though the parent wants to return home. The parent

often has no English language skills or access to their finances; in effect they are completely socially isolated and cannot return home.

- In situations where a next of kin ‘takes control’ of the life of an adult with a cognitive impairment, such as an intellectual disability or dementia, but who has capacity, often there are few avenues of intervention to protect their autonomy and their right to self-determination, in terms of occupation and choice of where to live.
- Conversely, where a person has no family or is estranged from their family, issues can arise in balancing an adult’s right to self-determination while at the same time acting to safeguard their wellbeing, and those living nearby, in situations of self-neglect.

3.2 Coercive control

Another theme relates to coercive control and undue influence of either older adults with care needs or adults with an intellectual disability by family members resident in their home, or ‘friends’/acquaintances living in their locality. Although the *Domestic Violence Act, 2018* applies to issues of coercive control, the attachment and dependency with the family member combined with cognitive and/or physical impairment, is often a barrier to the parent agreeing to take concrete action. The adult at risk is required to attend court and activate any orders granted. Third-party accounts for example, from a social worker are often not enough for the case to proceed to prosecution.

- These situations involve a family member acting as a gate keeper or exerting undue influence and preventing their relative receiving services they have consented to through intimidation or threatening behaviour.
- Other situations involve men in the local community known to befriend women who are vulnerable due to impairments such as an intellectual disability and/or mental illness in order to access their resources including savings, accommodation, and sexual activities.
- On the one hand, social workers must accept the adult at risk’s will and preference to continue in a relationship with the abuser(s). On the other hand they are required to follow policy and procedures to act to protect the adult at risk from being taken advantage of and being financially exploited, sexually or physically assaulted. These situations pose ethical and moral dilemmas for the professionals involved.

- As no law has been broken (or can be proven if entry denied), Gardaí do not have to respond (though in many cases they will accompany the professional during a home visit, for example).

3.3 Failure to provide any health and social care services

Early intervention and the implementation of effective safeguarding and protection plans is difficult due to a lack of services and resources such as home supports. In some instances, there were relatively few social workers available to carry out these roles or their caseloads were so high that waiting lists were in operation.

- Lack of availability to community supports and limited access to housing or supported accommodation created barriers to safeguarding adults at risk. Places of safety cannot be secured for older people experiencing domestic violence; acute hospital beds or women's refuges are not appropriate placement options for this cohort. The public body responsible for delivering care and safeguarding adults who are at risk, the HSE, are not obliged to provide support services to keep adult at risk safe.
- The failure of the HSE to provide home care supports viewed to be essential to safeguarding plans, particularly in situations of unintentional neglect, was repeatedly highlighted. Situations where the persons' will and preference are to remain living at home, but their care needs are such that their family no longer have the capacity or financial resources to meet their care needs places these adults at significant risk.
- People with acquired brain injury or mental health difficulties were identified as having distinctive needs and who tended to fall through the cracks of service provision. Their behaviour can pose a risk to other family members, while at the same time they may be at risk to themselves and others. Mental health social workers described ethical challenges relating to their safeguarding role and the difficulty in practice of balancing 'care and control' of their service users in safeguarding investigations, particularly where their service user is the alleged perpetrator.
- Carrying out safeguarding work in an environment of reduced staffing levels and the current HSE recruitment embargo is extremely challenging. . This issue was deemed to be particularly critical for Primary Care and Mental Health social workers with participants

reporting that service users can wait 6 to 8 weeks to access a Primary Care social worker in some areas.

- The lack of services to support the specific needs of people with dementia and their family carers was a recurring theme. Particular challenges related to caring for those who have significant behavioral and psychological symptoms of dementia due to the complete absence of support for carers of people with dementia for example, who wander at night-time. In situations where the person with dementia's behavior cannot be managed or is posing a threat to themselves or others, the only form of support available to a family carer is to ring the Gardaí or emergency services.

3.4 Poor information sharing

The practical challenges of carrying out safeguarding investigations with a range of agencies in the context of *General Data Protection Regulations, 2016* (GDPR) was highlighted as a significant barrier to effective safeguarding.

- GDPR requirements mean that TUSLA requires the consent of both the adult at risk and their parents (if they represent concerns when a child was under 18) to share information with other social workers in relation to children who were in care and who are now transitioning to adult services. Participants described having to engage in protracted, bureaucratic processes to access information.
- It was often the case that information about cases known to Safeguarding and Protection Teams could not be shared with medical social workers if a client is admitted to hospital, unless the adult at risk gives consent. In many instances however, it is not practical to seek this consent if the adult at risk is too ill or does not have the capacity to give consent at that time.
- Safeguarding and Protection Teams can share information with the Gardaí, but the Gardaí are often limited in what information they can share; participants reported that the Gardaí can only share information with others if it is deemed to be an emergency situation.
- Agencies or service providers can only use the initials of persons' names when reporting safeguarding incidents to Safeguarding and Protection Teams or HIQA. Participants believed that this poses significant barriers to pattern forming assessments where there may be ongoing concerns or multiple incidents relating to one individual.

- Lack of access to information meant that safeguarding investigations can be limited and restricted. For example, a person may be a service user of the mental health services, but mental health staff cannot share information on the person's diagnosis, making it extremely difficult to carry out risk assessments. This may also create situations of risk for staff.

3.5 Challenges and implications for safeguarding practice

The social work role in adult safeguarding processes is underpinned by core values and principles including, self-determination, human rights, empowerment, seeking consent and building trusting relationships. Participants reported that in, the majority of cases, effective outcomes are achieved drawing on existing legislation and the *HSE Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures, 2014*.

However, the findings identified a number of challenges:

- There is a considerable lack of consistency in practice, in terms of available resources, roles and responsibilities and interagency working across HSE Safeguarding and Protection social work teams.
- The referral process for adult safeguarding was described by participants as being in disarray, with different initial assessments being carried out in different Community Health Office (CHO) areas. Differing thresholds were reported (some take an early intervention approach to prevention while others require abuse to have happened). There were also variations in practitioners' understandings of what constitutes abuse and differing interpretations of what constitutes a 'vulnerable adult'.
- The discretionary nature of how cases are taken on by Safeguarding and Protection Teams and the absence of an appeals or review process when there were refusals to accept a referral to the Teams was a cause for concern.
- Discharge from hospital to community and other transition points were highlighted as problematic, as often there was ambiguity and a lack of clarity in relation to who should follow-up on actions where there were adults at risk.
- The absence of available interventions used to address situations where a person is resident in a private nursing home and their care needs as outlined in the hospital discharge care plan are not been met, leading to situations of neglect was highlighted.

- A lack of privacy and difficulties in carrying out an initial assessment or to interview an adult at risk in private when family members or alleged perpetrators are in proximity was reported. In a number of cases, for example, family members recorded interviews.
- Existing safeguarding statistics are under-reporting safeguarding activities and current levels of abuse. Mental Health social workers reported that currently there are no statistics gathered relating to the safeguarding cases they investigate and are responsible for.
- Criminal legislation requires the person who has been abused to give a statement of complaint to Gardaí, otherwise they cannot take concrete action. Currently, there is no provision for specialist interviewing or joint interviewing between Gardaí and social workers in the way that there is in child protection cases; this makes it more challenging to engage with the adult at risk.
- In situations where financial abuse has occurred and the victim is cognitively impaired or has dementia, participants stated that it is unlikely that a prosecution will occur.

Reflection 1: What helps in safeguarding processes?

Participants described several enablers to safeguarding processes including the role of Gardaí at the local level, improved policies and training for bank staff in situations of financial abuse and the appointment of a Designated Safeguarding Liaison Officer in the Department of Social Protection.

- While the Gardaí have high ranking officers in a range of regional safeguarding committees, this expertise and knowledge may not filter to Gardaí in local communities. Participants commented, however, on how the intervention of Gardaí at a local level can bring about positive outcomes for example, having ‘a chat’ with person of concern or visiting the adult at risk’s home to check if they are safe.
- Good training for bank officials facilitated sharing of information with social workers, enabling positive outcomes. Participants reported significant challenges, however, in engaging with other financial institutions who do not have specific training or policies relating to financial abuse.
- The appointment of a Designated Safeguarding Liaison Officer in the Department of Social Protection was reported to be beneficial in enabling Safeguarding and Protection Teams

where there were safeguarding concerns involving financial abuse and social welfare payments.

- Domestic Violence legislation offers some protections and the opportunity for positive outcomes. Participants felt that in situations of child to parent abuse, parents want their relationship with their child to continue and access to relevant support services. Living their final years estranged from their child may not justify the ends from their perspective.
- Where different agencies work together, with a willingness to share responsibility and funding, such as TUSLA working with agencies to support a young adult to transition to education or adult services, then good outcomes can be achieved.
- Reasonable legal accommodations should be made for people with cognitive and/ or physical impairments for example, the option of providing video-link evidence in court proceedings.

Reflection 2: Ward of Court Processes (WOC)

Where lack of decision-making capacity can be shown, findings suggest that WOC legislation can offer protection, but it is generally used as a last resort, when all other avenues have failed. As a result, more restrictive outcomes can occur, for example when the adult at risk is moved to nursing home care due to the absence of community supports such as a home care package.

- A benefit of WOC is that it allows third parties to be involved and enables everyone to have voice. The appointment of a Guardian Ad Litem to adults with an intellectual disability can be beneficial and helps to support their voice, will and preferences.
- The WOC Office can direct the HSE to provide care or support and allows professionals or a social worker to seek assistance of the Gardaí and gives authority for them to intervene. The WOC Office can instigate a Fair Deal application in situations where family members will not engage with the process.
- The composition of the Committee in WOC processes can be problematic. Findings suggest that, in some cases, there is a need for more rigorous interrogation of evidence relating to the role of family members and that greater consideration should be given to the views of the professionals involved in the case.

- Ancillary orders such as Protection Orders, make individuals accountable to the court. The person of concern can be summoned to appear before the judge if they are being obstructive. However, Gardaí have no powers to arrest under this legislation in order to prevent a person of concern fraternising with an adult at risk. On the other hand, participants highlighted that they would have power to intervene if a Safety Order had been applied for.
- Keeping WOC cases under review can be helpful on the one hand, as the decision on the Wardship arrangement is not final. On the other hand, a review arrangement creates uncertainty for the Ward and the professionals involved, in relation to where the Ward will reside on a long-term basis.
- Time delays in WOC application processes were highlighted as a significant issue. The HSE have no authority to keep an adult at risk in a place of safety for example, an acute hospital, while the WOC application is processed. Family members can remove an adult at risk in the interim unless an ancillary order is granted.
- Where an acute hospital applies for a WOC in respect of an adult at risk and the adult is subsequently discharged, participants reported that there may be no follow up on the application.

Section 4: Findings and Observations

4.1 Survey Findings

Survey respondents (n=116) were asked to rate what additional legislative provisions and duties they would find helpful in their safeguarding work. All respondents were social workers in the areas of adult safeguarding, mental health, primary care, medical, intellectual disability, physical disability and child welfare and protection. Findings indicate that respondents believe strongly that current legislative provision is not adequate and that in some situations, additional duties and powers would be helpful. The following section details the key survey findings.

- ❖ **Duty to report (with consent or where the person doesn't have decision-making capacity):** obliges designated categories of people to report incidents of abuse/neglect
91% of respondents felt this would be helpful or very helpful.

- ❖ **Mandatory reporting:** obliges designated categories of people to report incidents of abuse/neglect regardless of whether consent to report is given by the adult at risk
61% of respondents felt this would be helpful or very helpful

- ❖ **Duty to provide assistance:** relevant bodies can be directed to make available health or social care, legal, accommodation or other services to person assessed as in need of protection; and/or assist the adult in obtaining those services
90% of respondents felt this would be helpful or very helpful

- ❖ **Duty to cooperate:** obliges specified bodies (for example, the Gardaí or Banks) to cooperate with inquiries
92% of respondents felt this would be helpful or very helpful

- ❖ **Duty to consider importance of providing advocacy and other services:**
91% reported this would be helpful or very helpful of respondents felt this would be helpful or very helpful

- ❖ **Powers to obtain information:** authorized to interview anyone who can assist with an investigation (spouse, near relatives, friends) and have powers to obtain information required (for example reports from GP, healthcare providers, person who manages financial affairs)

88% of respondents felt this would be helpful or very helpful

- ❖ **Duty to secure adult involvement in decision-making:** adults in need of protection should be involved to as great an extent possible in decision-making about support and/or assistance

94% of respondents felt this would be helpful or very helpful

- ❖ **Assessment Orders:** can apply to court for an assessment order to allow for an adult at risk of serious harm to be taken to a more suitable place in order to conduct an interview and/or a medical examination. No power to detain the person if they choose to leave

79% of respondents felt this would be helpful or very helpful

- ❖ **Removal Orders:** can apply to court for a removal order to protect an adult from abuse. The person is removed to a place of safety for 7 days. There is no power to detain the person if they choose to leave

75% of respondents felt this would be helpful or very helpful

- ❖ **Banning Orders:** A judge may grant a banning order against a person who poses a risk

89% of respondents felt this would be helpful or very helpful

4.2 Summary findings on additional protections

While participants outlined the usefulness of some existing legislative provision, they also highlighted the necessity of additional legislative duties or powers in order to ensure adults at risk are fully safeguarded and do not ‘fall through the cracks’. This section will incorporate findings from the focus group, interviews and survey data; qualitative comments will be used to illustrate these views.

Legislative underpinning of roles and responsibilities

Some participants argued that legislation is required to clarify roles and responsibilities within safeguarding processes. This would help address some of the problems and ambiguity in the current system:

“The establishment of safeguarding teams who case manage, investigate, intervene and review concerns of abuse and are mandated to do so. The current policy is dangerous in

that we have safeguarding teams who only need to act as consultants to others. Expecting those who work with older people but who do not have the skills and time to manage safeguarding plans is counterproductive and likely going to lead to people taking a ‘blind eye’ approach to abuse concerns because they don’t feel they are equipped or supported to do what is required.”

“Need a clear legal framework as with child protection to ensure adult safeguarding is taken seriously. Social workers support and advocate for clients every day - this role needs to be recognised, supported and amplified - not undermined by ‘new initiatives’.”

Duty to Report

Participants described how a duty to report should be more like a duty to have a conversation with the adult at risk. The onus on the professional was to work with the person to get ‘buy in’, to engage with the person gain consent, rather than just having an obligation and duty to report. Participants explained how gaining consent and ‘bringing the person with you’ makes the possibility for intervention much greater:

“Have you got that person’s consent because no more than in any social work intervention be it with children or be it with adults, you know unless they have actually said look I’m concerned about you and you know there’s a social worker that could sit down and meet with you if you were open to that, but mandatory reporting, it seems that they don’t have any responsibility to tell the person that they are highlighting it.”

Mandatory Response

Some participants believed that there should be a mandatory response requirement which has a legislative underpinning:

“My experience in relation to safeguarding, people are certainly willing to refer but there’s a risk that nobody wants to do the safeguarding. Safeguarding as everybody’s business is another great cliché...But again I make the point, one person or one team on their own is not going to save anybody, it’s not going to reduce the risk. It is a multiagency and multidisciplinary effort so I think anything that would formalise that approach more. I would certainly welcome that. Because my experience has been to date that...you know some individuals and professionals see safeguarding as merely reporting and that’s it.”

Duty to provide assistance

The majority of participants stated that new legislation should include a duty to provide assistance and mandated provision of resources for early intervention and prevention. This could include, for example, carer support, independent living units, housing, addiction services and access to appropriate diagnosis and treatment. Participants believed strongly that legislation should be introduced which would compel the HSE to provide such appropriate services. This would enable social workers to intervene in the knowledge that safeguarding plans could be implemented and service provision would enhance the rights of the person at risk:

“Biggest issue I have in working in area of safeguarding in the community is the lack of supports to offer as part of a safeguarding plan. It is easy to identify the risks and write up a plan of what might reduce the risks but the resources are not there to back this up - simple resources like access to day care and respite to provide and outlet for the person, and to relieve the stress of carers.”

Power to act where adult at risk consents to safeguarding intervention

Participants highlighted the need for legislation to give them the power to implement safeguarding plans where an adult at risk consents. This could enable home care providers to deliver home care services in the home of a person who has consented to services where a family member is resistant. This would help support the adult at risk to have their care needs met at home for longer, rather than having to remove them from their homes to a place of safety (usually an acute hospital), and then to nursing home care. It would be useful if this type of legislation could also offer protection to care staff both entering a person's home, but also working in day and residential care settings where there is intimidation or threatening behaviour by family members, wishing to sabotage service provision and placements:

“The mother she was quite happy with it but the daughter didn't want people coming into the house so she would be quite I suppose a combination of her being threatening towards them, and being verbally abusive ... all of our efforts none of them provided really satisfactory solution over any period of time.”

“Families don't have authority to make those decisions but at the same time that doesn't work on a day to day practice because they're at home with the family, they're being cared for by the family they're living with family, we can't force our way into, we can't insist that home help hours are implemented.”

Duty to secure involvement of adult at risk

A duty to secure the involvement of the adult in need of protection to the greatest possible extent in decision-making about support and assistance is also essential. Participants reported how teams can get “*bogged down in risk rather than autonomy*”. In these situations, the adult’s will and preferences may not be ascertained or acted on where their wish is to return to a risky situation and their capacity is diminished:

“Hugely important, traditionally operated on a best interest principle in our care provision. Consent policy talks about the person having to give consent and that nobody can give consent on behalf or retain consent on behalf of anybody else. That would be very important to enshrine that in law, as much as anything else ... We’ve a culture where we’ve deferred to the next of kin traditionally.”

“At the moment it’s more down to individuals and I think that’s more of a culture thing so having something in legislation to make sure that people are included I think would be very helpful.”

There should be an obligation on nursing homes to ensure admission is voluntary, and that residents have their wish to stay there reviewed at defined periods:

“Nursing homes should be legally obliged to ensure admission is voluntary. This is very important when Local Placement forum has not been involved. People in nursing homes should have access to a social work service and have their wish to stay reviewed at defined periods.”

Power of entry

Participants stated that legislation to provide for power of entry is required in some situations where there is an immediate concern for the safety of an individual. They described situations where an adult at risk would consent to entry however a family member may be acting as a gate keeper, refusing access and attempts to negotiate with family member have been protracted and failed. In these situations, many participants believed they should be able to go to the district court to seek an order to gain power to enter. It was also important that the law should identify the thresholds in these circumstances:

“Right of entry or the right of removal would be helpful, we’ve had a couple of cases locally where just I suppose it’s the flip side of assistive technology, the family members got bugs and recording devices on the premises.”

Some participants believed that there should be mandated powers to interview the adult at risk in private, particularly in situations of undue influence or coercive control:

“Either to remove the vulnerable individual or request that person who is causing concern leave the home until you’ve been able to complete whatever assessment you need to complete, definitely.”

Power to obtain information

A duty to share information was also recognised as critically important by participants. In light of the difficulties associated with the implementation of the GDPR, legislation is required to ensure that information can be shared appropriately. Under existing legislation, Safeguarding and Protection Teams, other social workers, HIQA, the Gardai and service providers have limited powers to share detailed information such as the name of an alleged perpetrator.

“Getting information is a big issue...Somebody may be referred to safeguarding but they may already be under mental health team, but it’s impossible to get that information. Not always, sometimes if there is good working relationships and you can pick up the phone and check...So, somebody could be presenting and saying that they were being abused but in fact they could have paranoia...It’s absurd really, when you’re actually trying to assess whether or not somebody needs protection and you don’t know what their condition is.”

“It’s so hard to get information relating to person’s finances from bank and social welfare particularly in the last year with GDPR. Issues arise when you’re trying to access anything and for the most part, we would always try and have the person beside us, like the patient, when we’re ringing...And like for the most part that works, they can give their consent over the phone for you to talk about my bank statements or whatever but it does get really complicated when the person isn’t in a position to do that. If they don’t have capacity (mentally unwell) at that particular time and they’re not able to communicate that properly.”

Duty to cooperate

While participants reported some positive experiences of cooperation between different professionals and agencies, others felt that there were significant barriers and a reluctance by many to cooperate in safeguarding investigations. It was argued therefore that there should be a legislative duty to cooperate:

“Definitely think we need that, legislation does change things, if the legislation has a duty to cooperate, to have a safeguarding committee that has a bit of bite, that would be much better. I want to sit with the guards and the guards see it as part of their job. I want to sit with the, the consultant or the mental health team and them understand that safeguarding is as much their business as it is mine. That they can’t throw me half the information on something, and I make a miracle happen, that they have to integrate it into what they’re doing in their team. And I think legislation would do that.”

“One of the issues as well is inter-agency cooperation with regards to children coming into adulthood so those people are going to be vulnerable throughout their lives. So that transition from Tusla and say children in care, that have been in care in the past, that there is that handover into adulthood. And I think that needs to be in legislation because Tusla won’t cooperate otherwise.”

Participants suggested that a legislative duty to cooperate needs to extend beyond the health and social care sector and the Gardaí, it should also include the Department of Social Protection, financial institutions and local authorities:

“Services and agencies can opt out, biggest issue at the moment is housing. Huge amounts of people with mental health issues are unable to provide housing from their own means and as a result they end up staying here on the ward because they’ve nowhere for them to go you're totally at the mercy of what's available and the person that you're dealing with. It would be helpful if agencies linked in a bit more... It would be good to have something much more formal like a mechanism that other agencies have to comply or work with us, that might help because sometimes like it does feel like externally you can opt out, and there's very little that we can do then.”

Oversight of private nursing homes and private home care providers

Participants argued that there is a need for further oversight of nursing homes and private home care providers to ensure care and protection of adults at risk. This would, it was argued, reduce the possibilities of institutional abuse and in particular, neglect of nursing home residents. Residents in private nursing homes should be afforded the same protections as those in HSE funded facilities:

“We view people in private nursing homes in the same way as people living in the community- the nursing home is their home and they need protected the same way as everyone else however HIQA don’t deal with individual cases....”

There is no legal duty on private nursing homes or residential facilities to cooperate with safeguarding investigations:

“Some of the private nursing homes are quite good and they will ring us and say listen this, that and the other, they’re not duty bound to send in any kind of (report).... We had an interesting one where they had a system of you know previously good relationship of submitting preliminary screenings, and a lot of that related to where there was peer to peer (abuse). A report had come in then in relation to a staff member, we gave the advice (to the nursing home) as we would do any advice and then based upon that then we received a legal letter from (the nursing home), looking to take our member of staff to court because of the advice that we were giving.”

Procedural due process

Participants pointed out the need for a reporting and investigation process that protects the rights of both parties in situations of alleged peer to peer abuse. Protection also needs to be put in place for family members supporting an adult at risk with day to day tasks:

“...It was early days, it was an allegation, it had to be treated seriously and properly but that it was unfair to automatically sort of label this man as a perpetrator and then discriminate against him and potentially affect (his future), before any investigation had even taken place... we felt it was quite premature but because we didn’t have anything to I suppose help with, anything formal to guide with that it meant that, you know, that his view wasn’t taken on board ...we had nothing to go back and say to the people who were arguing that he needed to be reported, we had nothing to go back and say no we don’t. So, I think something around, you know, the limits of reporting.”

Section 5: Conclusion

Safeguarding is not a one size fits all process, that can be achieved in an authoritarian way. When it works best, it involves an educating, supporting and engaging environment. Professionals need to build a therapeutic relationship with an adult at risk over many months, even years, which can help build their confidence to take control and act to protect and safeguard themselves.

Legislation should not be a panacea for good practice in safeguarding adults at risk of harm and any legislative powers introduced should be used sparingly and appropriately. Issues of consent and the balancing of risk are important principles in this field. Professionals require a strong skill set to know when to use legislative powers and managers should not direct the use of legislation as a 'quick solution' guided by a desire to protect an organisation:

“Fear that we will end up with relatively recently qualified staff or possibly people who aren’t social workers or aren’t necessarily qualified in the relevant field, having access to legislation that could give them power of entry, power of assessment, power to interview and that that might be in some cases be abused. Potential to lose contact or put at increased risk.”