COPNI Commissioner for Older People for Northern Ireland

Legislative options to inform the development of an Adult Protection Bill for Northern Ireland Consultation

Response from the Commissioner for Older People for Northern Ireland

March 2021

COPNI Commissioner for Older People for Northern Ireland

Role of the Commissioner

This is a response to the Department of Health's public consultation to inform the development of an Adult Protection Bill. The Commissioner for Older People Northern Ireland is an independent voice and champion for older people with legal duties and powers defined by the Commissioner for Older People Act (Northern Ireland) 2011. This is a statutory role, at arms-length of government which takes an active role in safeguarding and promoting the interests of older people in Northern Ireland.

The Commissioner has an extensive range of general powers and duties which provide the statutory remit for the exercise of the functions of the office. In addition, the Commissioner may provide advice or information on any matter concerning the interests of older people. The wide-ranging legal powers and duties include amongst others:

- To promote and safeguard the interests of older people (defined as being those aged over 60 years and in exceptional cases, those aged over 50 years);
- To keep under review the adequacy and effectiveness of law and practice relating to the interests of older people;
- To keep under review the adequacy and effectiveness of services provided for older persons by relevant authorities (defined as being local councils and organisations including health and social care trusts, educations boards and private and public residential care homes);
- To promote the provision of opportunities for and the elimination of discrimination against older persons;
- To review and where appropriate, investigate advocacy, complaint, inspection and whistle-blowing arrangements of relevant authorities;
- To assist with complaints to and against relevant authorities;
- The power to bring, intervene in or assist in legal proceedings in respect of relevant authorities;
- To issue guidance and make representations about any matter concerning the interests of older people.

The Commissioner has a duty to advise government when older peoples' interests are not being supported and respected by any policy, law or practice. COPNI welcomes the opportunity to respond to the Department's consultation on the development of an Adult Protection Bill.

COPNI Commissioner for Older People for Northern Ireland

Consultation Questions

1. **Do you agree with the title 'Adult Protection Bill'?**

For many years the term of 'adult safeguarding' has been used in practice and has become a familiar term within the adult safeguarding system. The distinction between safeguarding and protection has been one of the key challenges within the current system resulting in cases being unrecognised, under reported and therefore unaddressed. If the term 'Adult Protection' is introduced as the title for the legislation, with a threshold of intervention defined as 'serious harm' the well evidenced existing risks within the system could remain unaddressed.

There must be a very clear understanding of definitions throughout the legislation and guidance. The definitions will be critical to the operation of the law in practice as the powers and duties set out for professionals to use will only be triggered at the threshold for intervention.

Safeguarding and protection are defined in the consultation paper with much emphasis placed on the current regional Adult Safeguarding Prevention and Protection in Partnership Policy continuing to provide the framework for addressing safeguarding while the new Bill will "introduce additional protections to strengthen and underpin the adult protection process."

This does not recognise or address the weaknesses of the current policy and the resulting abuse of older people that was formally investigated in both the Cherry Tree Review, and in the Commissioner's Home Truths report. The Commissioner has been asked to assist older people in numerous cases where clear failures in the system resulted from poor practice and under reporting of serious allegations of abuse and harm to older people. Conversely, CPEA has commented on the poor implementation of safeguarding policy resulting in the reporting of issues that are not "safeguarding", diverting the resources of safeguarding officers and creating additional work and disruption.

To date, there has been much confusion over what is an internal 'quality monitoring' incident and what requires safeguarding and protection interventions. The lack of a clear threshold and definitions, plus the absence of a central body with responsibility for safeguarding has led to abuse and neglect going unchallenged.

It has been the sustained position of the Commissioner that unclear thresholds and definitions have contributed to a lack of clarity about roles and responsibilities in the adult safeguarding and protection process. The findings of the reports and investigations provide a compelling case for legislation that clarifies legal responsibility and accountability for ensuring that all concerns and complaints are followed up.

The consultation paper rightly notes that the proposals for a threshold of 'serious harm' for a new Adult Protection Bill in Northern Ireland would place a higher threshold here than in similar legislation across other parts of the UK. This alone raises concerns regarding overall aims and purpose of the new legislation. In the Home Truths report the Commissioner stated that "An Adult Safeguarding Bill for Northern Ireland should be introduced without delay. *Older People in Northern Ireland must enjoy the same rights and protections as their counterparts in other parts of the United Kingdom".*

Adult safeguarding legislation will not on its own end elder abuse and neglect; suitably trained practitioners, adequate resources, and improved services all have a part to play. However, the success of these will always be inhibited by the lack of clarity of legal responsibility.

The Commissioner accepts the rationale of the consultation document that a proposed Bill will primarily address 'protection interventions' as distinct from 'preventive safeguarding such as training staff to recognise and report abuse'. A focussed approach has advantages, but the Commissioner would urge consideration of the full implications of the distinction of removing entirely the concept of safeguarding and introducing a high threshold for intervention. Current practice has revealed systemic failures in the safeguarding system, which still need to be addressed, where early intervention can disrupt a pattern of behaviour or abusive treatment.

Northern Ireland has the opportunity to introduce new legislation that recognises the importance of including adults at risk of harm and those who have experienced or are

experiencing it, with clear preventative and reactive duties for professionals to respond.

2. **What are your views on a definition of 'adult at risk and in need of protection'?**

New adult safeguarding legislation in Northern Ireland should adopt the 'adult at risk' approach. The definition of 'adult at risk and in need of protection' should be clear and easy to understand. It should also state the criteria to be met and additional guidance should be provided to assist those using the definition.

Whether legislation adopts a general definition that relies on the assumption that 'it will be recognised when seen', or a more detailed definition, it is crucial that any description must not be exhaustive or too narrow. For the legislation to be effective, such a definition must cover the broad spectrum of abuse (including but not limited to physical, psychological, financial, sexual abuse and neglect). As it is impossible to predict the totality of abuse, it is important that a legal definition of 'adult at risk' be correlatively supple to meet the intention of the legislation.

The response to this question must also be considered with the definitions for potential offences of ill treatment and wilful neglect (question 14) where specific statutory offences are required to protect older people in care homes.

Any new definitions (and substantive measures) in the Adult Protection Bill must be developed with an awareness of the rapidly evolving legislative environment in Northern Ireland (Mental Capacity Act 2016; Domestic Abuse and Family Proceedings Bill; the introduction of Domestic Abuse Protection Notices and Orders). It is imperative that the operation of an Adult Protection Act sit comfortably within the developing suite of measures to protect adults at risk of abuse. Otherwise, through duplication, overlapping measures or as a consequence of legislative gaps, the intended operation of this proposed legislation will be impeded.

COPNI contends that the definition of abuse/harm which is used within legislation must be broad enough to include the breadth of cases of abuse/harm. Attempts to narrow

the definition of abuse/harm are likely to result not only in the inability of appropriate authorities to pursue instances of abuse but would have a side-effect of introducing a level of ambiguity to an adjudication of what constitutes abuse.

There are operational reasons for proposing a restrictive definition of abuse/harm placing a high threshold for action, namely the risk that a broad interpretation would impose considerable commitments upon HSC and criminal justice agencies. However, COPNI holds that while there will be resource implications arising from a broad definition at first (increased enquiries, investigations and prosecutions), ultimately the personal, social and financial costs of reducing the abuse of people at risk will be greatly diminished over time. An Adult Protection Act, if drafted to cover a broad spectrum of abuse, will in due course ensure fewer cases of abuse as the public, care professionals, corporate entities and statutory bodies adopt a zero-tolerance approach to abuse/harm in all its guises and in whatever location.

3. **Do you agree with the list of principles proposed? If no, what would you suggest as an alternative approach?**

The Commissioner welcomes the proposal to include a clear set of principles within the legislation. Doing so, has the advantage of clarifying legislative intention thereby assisting stakeholders using the Act. Regarding the nature and formulation of the principles, the cited list (Autonomy, Empowerment, Dignity Proportionality, Partnership and Accountability) has merit. The list takes account of the personal choice of an adult at risk (the first 3 principles); and considers the conduct of others (the latter 3 principles).

Outlining (sometimes) competing principles, such as autonomy versus protection within the legislation and Codes of Practice, can assist in the effective operation of legislation. Powers of intervention are intrusive and engage human rights; overarching principles are necessary to prevent misuse. Autonomy is not absolute; the Human Rights Act 1998 recognises this. For example, when an adult is consenting or refusing, practitioners must satisfy themselves the person is acting of their own free will and had the opportunity of making an informed decision. Highlighting these tensions by

stating such foundational principles in the legislation will serve to support good decision-making rather than to confuse professionals.

The Commissioner urges that the principles of an Adult Protection Bill be explicitly situated within the established Human Rights law framework (the Human Rights Act 1998), so that the principles carry the weight, precedence, and effectiveness of such human rights instruments. While any Bill would need to be fully human rights compliant with or without reference to the Human Rights Act 1998, explicitly contextualising Adult Protection within a rights framework ensures its principles/measures are positioned appropriately. COPNI recommends that the finalised principles refer to the obligations entailed by the Human Rights Act 1998 and sees merit in this approach for all measures within the proposed Bill to ensure that the eventual Adult Protection Act adopts a fully rights-based approach to adult protection.

Any law proposing powers of intervention in the lives of people at risk must be compliant with the Human Rights Act 1998. A number of rights are engaged as the justification for such a law. Articles 2 and 3 of Schedule 1 of the Human Rights Act 1998, guarantee the right to have life protected and the right to live free of inhuman and degrading treatment. Article 5 provides for the right to liberty. Only in very limited circumstances and with essential safeguards, is it acceptable to deprive a person of their liberty in their own home or in an institutional setting. The Article 8 right to private life, family life, home and correspondence is important as it protects the right to autonomy and the right of people to live the way they want to live.

The CPEA evidence paper ‘Adult Safeguarding within a Human Rights Based Framework’ makes clear recommendations to support definitions and states that there needs to be “a strong commitment to respecting and upholding people’s human rights and freedoms; the primacy and common understandings of concepts of ‘home’; the use of readily understandable language; the development of all training within a human rights-based framework; modelling behaviour which reflects a valued and personalised approach, and doing so in ways that sustain people’s dignity and respects their humanity.”

4. **What are your views on principles being set out on the face of legislation or in Statutory Guidance?**

The principles underpinning the Adult Protection Bill must be set out on the face of the legislation. Placing a clear set of principles embedded in the established human rights framework at the start of the Bill will ensure that the measures within the law are interpreted and operated through a human rights lens.

Choosing to locate the principles elsewhere (for example, in guidance) would remove a key interpretive resource from stakeholders using the measures within the Act. Including the principles at the start of the Bill enables parties assessing a particular protection case to focus on and rely on agreed foundational priorities.

5. **Do you agree with mandatory reporting? Should there be a new duty to report to the HSC Trust where there is a reasonable cause to suspect that an 'adult is at risk and in need of protection'?**

AND

6. **Should a new duty be placed on HSC Trusts to make follow up enquiries?**

AND

12. **Do you agree with the proposal to introduce a duty to cooperate? Are there any aspects of the duty that you would change?**

The Commissioner maintains that the proposed duties mentioned in Questions 5, 6 and 12 are interdependent and their inclusion in an Adult Protection Bill is vital for the increased protection of people at risk.

Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home (2018), stated:

> *[U]nder the proposed Adult Safeguarding Bill there should be a clear duty to report to the HSC Trust when there is reasonable cause to suspect that there is an adult in need of protection. The HSC Trust should then have a statutory duty to make enquiries.*
> (Summary, p.55)

In light of overwhelming evidence gathered during the Dunmurry Manor investigation, the Commissioner holds that those who are given reasonable cause to suspect that an 'adult is at risk' must report to a single authority (HSC); that authority must investigate; and those with relevant information must cooperate to the fullest extent possible.

The Commissioner has found widespread evidence that the continuation (and escalation) of abuse is frequently attributable to failures: to report, to investigate and to cooperate.

The *Home Truths* report identified failures to report.

The current situation is one in which suspected cases of abuses are not routinely reported. There was 'a pattern of evidence of consistent failure within Dunmurry Manor to report significant numbers of incidents ("notifiable events") to the RQIA and to the Trust' (Summary, p.17). The Commissioner found that this arose in part from 'a lack of clarity with regard to roles and responsibilities and complaints management' (Summary, p.34). The Commissioner is frequently asked to intervene on behalf of older people whose abuse has not been reported, or properly investigated. In summary, when there is reasonable cause to suspect abuse, those with such information do not systematically report, let alone systematically report to a single authority. As a consequence of the normalisation of non-reporting, cases of abuse continue and frequently escalate. Patterns of abuse or behaviour can remain unrecognised. The Commissioner strongly supports the inclusion in the Adult Protection Bill of a far-reaching duty to report when an adult is at risk of abuse.

A duty to report any suspected cases of abuse or harm should be placed on all identified relevant organisations.

The *Home Truths* report identified failures to investigate (or 'to make follow up enquiries').

In Northern Ireland there is no specific statutory 'duty' to make enquiries or conduct investigations to safeguard adults at risk, other than when a suspected crime is reported to the Police Service of Northern Ireland (PSNI).

The PSNI has a duty to investigate reports of criminal conduct under relevant existing legislative powers. This does not apply to all adult safeguarding cases as not all abuse against older people at risk would be classed as criminal conduct.

The Commissioner holds that a duty to respond to suspected abuse should use the language 'duty to investigate' rather than 'duty to make follow up enquiries'. The rationale for opting for this language is that 'follow up enquiries' places a low expectation on the responding body. In the case of Dunmurry Manor such a duty, were it in place, might have been met by the 'high volume of inspections carried out between July 2014 and August 2017' (Summary, p.34) and yet significant levels of abuse and neglect were present during and after this period. A 'duty to investigate' indicates a more robust and pro-active response to abuse than 'follow up enquiries' and so should be the preferred language of such a duty.

The current situation is one in which suspected cases of abuse when reported are not routinely investigated. The Dunmurry Manor investigation found 'consistent examples reported by residents' families, HSC Trusts and workers / former staff of inhuman or degrading treatment' (Summary, p.18). Despite serious, consistent and sustained concerns being raised regarding suspected cases of abuse at Dunmurry Manor, there was no whole system processing of complaints and subsequent investigation. There was an 'inadequate response by HSC Trusts to concerns raised by officials of potential institutional abuse in Dunmurry Manor' (Summary, p.18). Similarly, the Board of the Regulation and Quality Improvement Authority was 'not aware of ongoing issues of concern in Dunmurry Manor' (Summary, p.34) despite a high volume of inspections carried out between July 2014 and August 2017' (Summary p.34). The Home Truths report found that there was overall, 'a failure of responsible bodies to act on findings

of poor care (Summary, p.34). No authority received all the complaints, processed all of these complaints and pursued a full/effective investigation into allegations of abuse.

The bare minimum for safeguarding legislation is identifying a single authority with legal responsibility for ensuring safeguarding happens, and a threshold for referring concerns to that responsible body. The most obvious candidate in Northern Ireland are the Health and Social Care Trusts. They are uniquely placed to undertake the responsibility. They should have primary responsibility for adult safeguarding; they will be the route into adult safeguarding. This does not remove the necessity for other organisations to undertake their own investigations where relevant (for example the PSNI). By introducing this duty into the legislation, it will place the requirements of the current joint protocol arrangements on a more secure statutory footing.

The *Home Truths* report identified failures to cooperate.

Currently, when suspected cases of abuse are reported and under investigation, there is no duty on all relevant parties to cooperate. As a consequence, identifying and tackling cases of abuse is much more challenging than were there a duty to cooperate. Broadly, such a duty would have two effects: a) it would create an expectation that all parties familiar with the matter under investigation will actively assist as far as possible; and b) it would create an expectation of effective data and information sharing between relevant bodies to identify issues at an early stage.

Regarding the former, the *Home Truths* report found that efforts to identify and address suspected cases of abuse encountered a 'Blame Culture' within senior management that affected management and staff negatively (Summary, p.41). There was a 'lack of ownership and accountability for progressing improvement action plans following inspections' (Summary, p.48). A duty to cooperate, in this case upon the independent provider, would have imposed a specific obligation on the provider and its staff at all levels to assist an investigating body.

As to the latter effect of such a duty, creating an expectation of effective data and information sharing between relevant bodies, the *Home Truths* report found

'insufficient evidence of effective partnership working between responsible bodies' (Summary, p.34); 'evidence of poor complaints handling' (Summary, p.45); and 'evidence of poor learning from complaints processes' (Summary, p.45). In sum, the bodies responsible for (aspects) of care and complaints handling (RQIA, Trusts, and the independent provider), failed to cooperate effectively to address abuse and improve care quality. In contrast a new duty to cooperate on all relevant parties, (and coordinated by a single responsible authority), will more likely deliver effective handling of complaints and use of intelligence which in turn will better protect those at risk of abuse.

Throughout the safeguarding process, all relevant organisations should be bound by a legislative duty to cooperate with each other in order to best protect an older person at risk of harm or abuse. A duty to cooperate must be included within the proposed Adult Protection Bill so that no party with relevant information regarding suspected abuse can refuse to assist fully on specious bases, such as corporate protocols; or that the abuse falls outside a particular body's remit; or on grounds of data protection. An effectively drafted duty, with checks and balances, will account for reasonable limits on this obligation.

This should be supplemented by a further duty to share information. The requirements in the rest of the U.K emphasise the importance of sharing information. However, much of the detail is contained in the codes and guidance. There should be a duty on practitioners and public bodies to share information when necessary, subject to data protection laws and confidentiality in the legislation. This would concentrate minds and help to break down the culture of non-sharing. The duty should be qualified by the need for a lawful justification for sharing. Consent should be the primary justification for sharing information. However, any code or guidance accompanying the legislation should spell out when sharing information without consent is permissible and expected.

7. **What are your views on a new power of entry to allow a HSC professional access to interview an adult in private? Do you think any additional powers should be available on entry?**

The inability to access a person who may be an adult at risk frustrates many safeguarding enquiries.

Entry may be impossible because the person objects or somebody is 'objecting on their behalf'. The right to a private life and home life are important and a power to enter a person's home without permission prima facie intrudes into those rights. However, these rights are not absolute and there may be circumstances in adult protection cases where it is necessary to override them to protect a person.

Any proposed power of entry for a private interview would need to be predicated on the basis of consent to the action being the first option. Research has shown that most times social care and health care practitioners can get access using their professional skills. However, this may still leave some adults at risk in danger, especially where coercive or controlling behaviour is present.

The Commissioner is aware of a number of cases in which there have been concerns that a person is at risk and yet access to the individual was prevented by a suspected perpetrator. While fully cognisant of the Human Rights implications of granting such a power of access, the Commissioner holds that the protection of people at risk can be improved by permitting this intervention if its use is properly defined, regulated and assessed.

The Commissioner recommends that the powers should include the power of access to allow a HSC professional access to an adult at risk of harm for confidential interview. The criteria for such a measure would include reasonable cause to suspect a person is at risk of abuse or neglect; 'reasonable cause' being tested via application to a court; access unavailable through any other means; and exercise of the power not resulting in the person being at greater risk of abuse or neglect.

8. **How many times in the last 12 months, have you been aware of a situation where, had a power of entry existed, it would have been appropriate to use it? What were the circumstances?**

The response to this question is best evidenced through anonymised case examples.

Case Study 1: Safeguarding concerns about a relative who was residing in a Care Home.

The older person had learning difficulties and had married another resident of the care home. The family were extremely concerned and sought assistance from social services in an attempt to stop the marriage. The older person was discharged from the Care Home by a relative of the new husband. Her family were not informed of where she had gone or where she was residing. The family finally managed to locate her whereabouts and discovered her in a serious state of neglect to the extent that they had no alternative but to involve PSNI and the local Health Trust. Despite these concerns, she remained in the care of the new husband's relatives as she was deemed to have capacity at that particular time. The family of the older person at risk were later contacted by a concerned neighbour who advised them that their relative had been hospitalised due to dehydration and malnourishment. The family obtained a court injunction preventing this older person's carer from having further contact with them.

How would a power of access have assisted?

- When the family contacted Trust initially a power of access interview would have allowed practitioners to conduct a private interview to assess whether the older person was making decisions freely.
- A power of access for private interview would have the revealed the level of abuse and neglect at an earlier stage.

Case Study 2: Suspected financial abuse - unnecessary works at an older person's house for extortionate cost.

Enquiries revealed there were also serious safeguarding concerns about the elderly lady in relation to her welfare and living conditions. The relative was also concerned about the older person's mental capacity as she was displaying increasingly erratic

behaviours including hoarding, poor hygiene and inadequate diet. The situation was further complicated by the older person not allowing her son into the home to check on her and he had no way of knowing if she was taking proper care of herself. She had been a targeted victim of financial abuse from strangers for several years. A conservative estimate of financial loss is around £250k.

How would a power of access have assisted?

- A power of access interview would have allowed an independent practitioner to assess capacity of the older person when making financial choices and decisions.
- A power of access for private interview would have revealed the poor living conditions of the older person.

Case Study 3: Care home placement.

An elderly couple resided in a property which they own jointly own, mortgage free, in a co-habiting relationship. The older lady suffered a stroke and upon discharge from hospital was moved to a nursing home 25 miles from her home. Initially this placement was for respite only however the placement was later made permanent. The elderly gentleman was seeking assistance in having his partner moved in order that she could be closer to home to allow him to visit on a more regular/daily basis. The Trust informed COPNI that the partner in this instance does not have any rights and that any decisions regarding the lady's care are taken by her son who is next-of-kin. Attempts are being made to make contact with the lady via a third party to confirm if her wishes are in accordance with the instructions of her partner.

How would a power of access have assisted?

- A power of access interview by an independent practitioner could ascertain this lady's wishes in relation to her current placement.

Case Study 4: Coercive control.

A lady in her early 70s, living independently in England, near friends and relatives. She began a relationship with a man from Northern Ireland who she met on holiday. He arrived unexpectedly to stay saying that she had invited him to spend time with her and infiltrated her social life, causing upset and isolating her from her normal social circle, eventually moving her to Northern Ireland. Her concerned family were not informed of this move. Her relatives were not assured of her ability to understand what was happening and to consent to this move. They expressed further concern about coercive behaviour including use of her money and assets and questioned whether she had capacity to consent to sexual relations. Despite contact with PSNI, Social Services and a private solicitor, her relatives could not get any authority to undertake a confidential interview to assess the risks to her physical and mental health, to have her seen by a cognitive specialist to assess her capacity to make decisions about her wellbeing and finances. Eventually it was medically assessed that her capacity was impaired to make choices about her living arrangements and financial affairs. Despite this assessment, she still was living under significant coercive control. Her relatives (all of whom were elderly) even considered kidnapping her back and returning her to England, however, her GP assessed that she would not survive the trip home. Following the death of her partner, a decision was taken be social services for the lady to move into a care home for those living with Dementia. The Office of Care and Protection appointed a controller to manage her affairs and she lived for a number of years in NI, until her death.

How would a power of access have assisted?

- A power of access interview by an independent practitioner could have ascertained if coercion was involved at a much earlier stage.
- A power of access interview would have allowed practitioners to conduct a private interview to assess whether the older person was making decisions freely.

9. What are your views on statutory provision for independent advocacy in the context of adult protection?

The Commissioner contends that high-quality, independent advocacy can prove effective in the context of adult protection. However, there are a number of concerns regarding the proposal for such provision.

Practically, as regards consideration of dovetailing the service with those envisaged in the Mental Capacity Act (NI) 2016, the Act has not fully commenced. This in itself raises a number of points. Firstly, the need for adult protection legislation is urgent and the proposed dependence on stalled legislation may diminish confidence in the overall ambition of an effective Adult Protection Act. A more substantive concern is that it will be important to evaluate the effectiveness of the advocacy provision of the MCA 2016 before any proposed broadening of services. Similarly, and of great importance, the MCA 2016 is a provision 'relating to persons who lack capacity'. The proposed Adult Protection Bill relates to those at risk of abuse rather than lacking capacity. Therefore, the nature of any advocacy provision would likely be substantially different.

Provision of similar statutory independent advocacy across England, Wales, and Scotland has significant limitations. Nevertheless, an independent advocate may still make an important contribution to adult protection decision making. Independent advocacy provision would require:

- Specialist training for advocates, including continuous professional development requirements
- Independence from any public authority involved in providing services to the persons at risk
- Determination of the correct funding mechanisms to ensure independence from any public authority having responsibility for making enquiries
- Eligibility criteria to identify who is eligible and the circumstances giving rise to the duty to provide advocacy
- The inclusion of a duty to provide advocacy services and the eligibility criteria within the legislation or in delegated legislation.

10. Do you agree that an Independent Adult Protection Board should be established and placed on a statutory footing?

The Commissioner agrees that an Independent Adult Protection Board should be established and placed on a statutory footing. An adult safeguarding board empowered by statute should be created to act as an oversight body to protect older people at risk of harm or abuse.

It would be a matter for this board to hold the relevant membership organisations to account. It is expected that "relevant organisations" would include all statutory, community and voluntary organisations working with older people.

Adult protection cases are currently addressed, in disparate ways and by a number of bodies. The Dunmurry Manor investigation showed the consequences of such a patchwork approach to adult safeguarding. Relevant bodies were unaware of the totality of the abuse/neglect landscape in the care home and/or considered remedial intervention to be the duty of another party. In summary, there was no appropriate body which had a view of all complaints and allegations of abuse, and therefore there was no appropriate body which could lead a response in an effective and timely manner, through investigation and prosecution.

The confusion and ambiguity regarding roles and complaints management identified in the *Home Truths* report (2018) leads the Commissioner to the conclusion that such a single independent authority (an Independent Adult Protection Board) must be introduced on a statutory footing. The Independent Adult Protection Board must have a basis in law, must be independent of any government Department and must be properly resourced to effectively lead on adult protection matters across Northern Ireland.

While the detail of the Independent Adult Protection Board will require much consideration, the Commissioner would highlight the Safeguarding Board for Children in NI as an example of what can go wrong when such a body is established: 'From the outset, the Board spent too much time on the wrong issues and failed to deliver on its main statutory responsibilities concerning improved protection of children' (*A Review of the Safeguarding Board for Northern Ireland,* 2016, p.1). The Commissioner maintains that such an example should provide ample warning about the need to learn

from best practice and engage in meaningful consultation in order to get the Independent Adult Protection Board right from the start.

Functions of the board require clear definition. The main function should be to provide leadership and set direction for the safeguarding system across Northern Ireland and to respond in a timely manner to new and emerging concerns. This can also include information regarding multi-agency training, lessons learned from Case Management Reviews to drive improvements, the dissemination of Safeguarding policies and procedures and additional useful resources. It will also be important for the Board to collate all relevant data in relation to adult protection to identify trends and this data analysis together with any outcomes of improvements in policy and practice should form the basis of an Annual Report to the Assembly.

The Department of Health is the current sponsor for the Safeguarding Board for Children, with The Public Health Agency (PHA) acting as corporate host. The Commissioner advises that the appropriate sponsor for the Adult Protection Board should be outside of the Department of Health to promote true independence of its functions.

11. Do you agree with the introduction of Serious Case Reviews?

The Commissioner agrees with the introduction of Serious Case Reviews. In particular, as stated in the consultation document 'to establish whether there are lessons to be learned from a case about the way in which agencies and professionals work together; and to action change as a result'.

The Commissioner maintains that a Serious Case Reviews mechanism is an essential aspect of promoting a change of culture in adult protection from one marked by apportioning blame to one defined by learning, and acting on, lessons from serious cases.

The mechanisms for the procedures of the reviews needs to be clear and unambiguous. Timelines are essential for the provision of the reports and any recommendations.

Robust training will be required to support the introduction of the review process.

Case Study:

An older person was the victim of a serious sexual assault by a known family member while in Care Home setting. The alleged perpetrator was arrested and released on Police Bail which specifically provided for continued contact with the vulnerable victim. Health professionals did not challenge the bail condition due to lack of understanding of the criminal process and there was a complete breakdown in communication and failure to follow proper protocol by the relevant statutory agencies in the aftermath of the incident.

How would a Serious Case Review have assisted?

- Correct intervention would have protected an elderly, vulnerable and distraught victim from further distress and emotional abuse.
- Accepted and regulated protocols where duties and obligations are defined clearly, would serve to properly protect the victim.

13. Do you think there should be a new power to access an adult's financial records as part of an adult protection enquiry? If yes, which organisation(s) should be given this power?

The Commissioner supports increased powers to access an adult's financial records as part of an adult protection enquiry, if such measures would speed up and strengthen current investigative processes.

Financial abuse is an area of serious concern for the Commissioner who holds that in too many instances it is regarded as a personal or civil matter rather than a form of criminal behaviour. Occurrences of financial abuse are at significant levels here and appear to be increasing. A study conducted in 2016 by the Commissioner's office found that '21% of people aged 60 and over are affected by some level of financial abuse' (*Financial Abuse of Older People in Northern Ireland: The Unsettling Truth*, COPNI, p.6).

The Commissioner broadly supports increased powers to access records in cases of suspected abuse. A clear and unambiguous definition of 'financial abuse' will be required. A specific legislative reference to financial abuse in new legislation will help

support better recognition and identification of instances when financial abuse is occurring.

In cases where there is reasonable suspicion of financial abuse that has not yet reached the threshold for the initiation of police investigation, adult safeguarding practitioners should be able to access relevant financial records (with proper checks and balances). This would allow an assessment of the level of risk to the older person of whether financial abuse is occurring, and any appropriate interventions or investigations to follow as required. As with the powers of entry and private interview, this power should be predicated on the basis that consent would be sought in the first instance. The Commissioner considers that adult safeguarding professionals are the appropriate people to have this power and anticipates that they would only use this power when necessary.

Safeguarding practitioners have communicated to the Commissioner that financial institutions are keen to cooperate with them on suspicions of financial abuse, but they are restricted in terms of their ability to share data or to intervene due to limited legal powers.

Case Study:

A family member was restricting access to an older relative's account. This allegation was confirmed by the older person. Counter-allegations included a suggestion that considerable sums of monies had been disposed of as well as a long history of credit card fraud – all against the older person.

How would a power of access to financial records have assisted?

- The nominated authority would be able to immediately identify if: financial fraud / irregularity was in fact occurring.
- Bank records would pinpoint where and when the abuse was taking place.
- Perpetrators would be easily identifiable from the nature and type of transactions involved.

14. Do you agree that new offences of ill treatment and wilful neglect should be introduced?

The Commissioner supports the introduction of new offences of ill treatment and wilful neglect. The Commissioner was supportive of the introduction of similar measures with the Mental Capacity Act 2016 and strongly maintains that there should be comparable offences to protect people with capacity.

The Commissioner supports the introduction of 'care worker' and 'care provider' offences similar to those already in place across the UK. The investigation into Dunmurry Manor Care Home and COPNI's current caseload, indicate an urgent need to distinguish between two aspects of abuse experienced by those receiving care: i) ill treatment / neglect which is the result of a carer's behaviour/choices (personal abuse); and ii) ill treatment / neglect which arises from the care provider's behaviour/choices (structural abuse).

During the Dunmurry Manor investigation, while evidence of individual care worker ill treatment / neglect was identified, this occurred within an overall management structure and within corporate processes, which allowed and, in some respects, necessitated ill-treatment / neglect (such as under-resourcing and understaffing the home).

At a number of points during this investigation, incontrovertible evidence of ill-treatment / neglect was attributed to individual care workers when in fact responsibility lay partly or exclusively, at a corporate level (Summary, p.41). Robust well-drafted 'care worker' and 'care provider' offences would represent a significant tool in breaking down a 'blame culture' within care situations and precisely and legally affix responsibility for both the personal and structural aspects of care provision.

15. Are there any other new offences that should be considered?

The Commissioner considers that where someone commits a crime against an older person, including by way of their action or neglect, that this should be regarded as a statutory aggravating feature. In the Hate Crime Legislation in Northern Ireland review published in December 2020 Judge Marrinan recommends "However, having weighed

up all the submissions received including the expert evidence submitted to the review, I consider that there is sufficient evidence of hostility-based offences against the elderly to include age as a protected characteristic." This recommendation should be taken into account when drafting the Adult Protection Bill to ensure that there is reflection of any corresponding legislation being developed by the Department of Justice.

16. Finally, are there any other provisions that you would like to see included in the Adult Protection Bill?

The Commissioner has previously supported a power to ban a suspected 'abuser' from contacting an individual or attending a particular location.

The Commissioner recognises that the intention of both proposals may be achieved through the new Domestic Abuse Protection Notices (DAPNs) and Orders (DAPOs), and other elements of an Adult Protection Bill. Nevertheless, the Commissioner is eager that the intention underpinning earlier calls to ban suspected abusers and to promote protections for individuals at risk, appear in some form in this and other developing legislation.

In previous reports and in the Home Truths recommendations, the Commissioner has promoted the introduction of an 'individual Duty of Candour...in Northern Ireland for all personnel and organisations working across and in the system, which governs and delivers care'. The introduction of a statutory duty of candour was also one of the key recommendations from the Inquiry into Hyponatraemia-Related deaths. This duty would address the concerns that the Commissioner was frustrated by in the Dunmurry investigation where there was a lack of certainty that there had been full disclosure of evidence.