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REVIEW OF *IN SAFE HANDS*

A REVIEW OF THE WELSH ASSEMBLY GOVERNMENT'S GUIDANCE ON THE PROTECTION OF VULNERABLE ADULTS IN WALES

September 2010

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The responsibility for the contents of the review rests, of course, with the WIHSC Team.

THE REVIEW TEAM

The review was conducted by Julia Magill (Project Manager), Prof Marcus Longley (Project Director), Dr Rachel Davies, Rhobert Evans, Tony Garthwaite, Glyn Griffiths, Prof David Hands, Prof Ruth Northway, Marina Roberts, Amy Simpson, Becky Stackhouse, Pat White, Elizabeth Williams and Vicky Yeates all from the University of Glamorgan. The report was written by Julia Magill, Vicky Yeates and Marcus Longley.

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Summary of conclusions and recommendations

Introduction to the review

The first chapter sets out the overall aim of this review of *In Safe Hands*: *Implementing Adult Protection Procedures in Wales* (National Assembly for Wales 2000): to consider and assess the continuing effectiveness, appropriateness and robustness of the guidance, and to make recommendations about where improvements can be made.

Changes in demographics, significant legislative and regulatory change, policy developments and lessons learned over the nine years since publication have led to the need for a review.

The groundbreaking contribution of the guidance is acknowledged, but the overall conclusions of the review are that *In Safe Hands* is now:

- partially effective;
- in some important respects, no longer appropriate; and
- not sufficiently robust.

In light of these conclusions, the recommendations set out in Chapter 8 aim to build on the firm foundations established by *In Safe Hands*, to develop a legislative framework, policy and practice so that adults in vulnerable situations, the agencies who support them and the wider community can together:

- develop a culture in Wales that does not tolerate abuse;
- raise awareness about abuse;
- prevent abuse from happening wherever possible;
- where abuse does happen, support victims to:
  - stop abuse continuing;
  - access services they need, including advocacy and post-abuse support;
  - support over-stretched carers;
- deal effectively with perpetrators; and

- have improved access to justice.

The review process

The review has three sections:

SECTION 1 | SETTING THE SCENE (Chapters 1-2)
SECTION 2 | FINDINGS (Chapters 3-7)
SECTION 3 | CONCLUSIONS AND RECOMMENDATIONS (Chapter 8)

Introduction

The first chapter gives the background to the review and sets out its overall aim.

Terms of reference

Chapter 2 sets out the terms of reference for the review. It is centred on policy issues, including the role of legislation and guidance in safeguarding adults. The Care and Social Services Inspectorate Wales (CSSIW) is currently conducting a national inspection of adult protection. CSSIW's work is focusing on practice, rather than policy. WIHSC and CSSIW have worked in close partnership to ensure that both the inspection and this review are complementary, and to avoid duplication. The outcomes of both the inspection and this review will be reported to the Assembly Government's Adult Protection Project Board during 2010 to enable the Board to be in a position to advise Ministers about how consultation could be taken forward on overall policy relating to safeguarding adults.

Methodology

Our methodology involved a three-phase, multi-methods approach to the study.

Phase 1 comprised:

- Focus groups with older people, people with learning disabilities and people with mental health problems to ensure that their aspirations and concerns were incorporated from the start;

- Exploration of the safeguarding agenda through telephone interviews with officials at the Scottish Executive and the Department of Health and the Home Office;

- A review of the literature with the main focus being the UK since 2000, but also drawing on relevant European and international literature; and

- Scene-setting with Adult Protection Co-ordinators.

Informed by each of the elements in Phase 1, Phase 2 comprised:

- a survey of statutory stakeholders, including all local authorities, police, local health boards, and NHS Trusts in Wales; and

- qualitative field work, based on in-person and telephone interviewing.

In Phase 3:

- survey responses were followed up;

- local studies were undertaken in, Blaenau Gwent, Cardiff, Isle of Anglesey and Pembrokeshire;

- emerging conclusions and recommendations were tested through a stakeholder workshop; and

- a second round of focus groups with adults and their carers was held to test their reactions to emerging findings and proposed recommendations.

As well as ongoing dialogue with Adult Protection Co-ordinators in local authorities and the NHS throughout the review, the research team also took part in three meetings with PAVA Wales (Practitioner Alliance Against Abuse of Vulnerable Adults (Wales)), met the Welsh Assembly Government Adult Protection Project Board and was briefed by Gwent Police about lessons learned from Operation Jasmine (an inquiry involving issues connected with safeguarding adults).

Ethics

The involvement of adults and their carers in such a sensitive topic as adult protection clearly raises important ethical issues. The University of Glamorgan's Health, Sport and Science Faculty Ethics Committee confirmed that the project would meet its requirements for ethical approval. We also confirmed with the NHS National Research Ethics Service that the review was not subject to NRES procedures.

Findings

The use of a range of different methods to gather evidence gave a rich and detailed picture of current issues relating to safeguarding adults in Wales. Whilst differing perspectives and emphases were evident, there was a broad consensus about what the future development of policy should look like. The chapters in Section 2 discuss the findings from the following strands of the review:

- focus groups;
- literature review;
- survey;
- interviews and local studies; and
- stakeholder workshop.

Integrating key themes and messages from all of these strands in the review, has led us to the conclusions and recommendations to be found in Section 3 of this report.

Conclusions and recommendations

Overall conclusions

Taking account of the evidence from all of the various strands of the review, *In Safe Ha*nds can justifiably be seen as ground-breaking policy that has made an important contribution to adult protection in Wales. Nevertheless, in the fast developing legislative and policy environment between 2000 and 2009, our overall conclusions are that *In Safe Hands* is now:

- partially effective;
- in important aspects, no longer appropriate; and
- not sufficiently robust

Effectiveness

Some groups of people are referred more readily and there is more confidence about the support they receive than others. People with mental health problems, from BME communities, who misuse drugs or alcohol, or who are homeless appear to be disadvantaged. There are particular concerns about people in receipt of direct payments and those who fund their own care.

Some agencies work together and share information more effectively than others. Primary care, health services, the criminal justice system and financial institutions are not all working together with local authorities as well as they might.

Appropriateness

The title of the guidance *In Safe Hands* these days sounds out-dated - it implies that people are passively leaving their fate to others; and that people are in care and dependent on care workers. It does not reflect policy aspirations to co-produce services with empowered, fully engaged citizens.

People do not like being labelled as 'vulnerable'. People are not intrinsically vulnerable: some situations make people vulnerable. Vulnerability fluctuates over time as situations change. A new statutory definition is needed of people who are at risk of harm from abuse and who are not in a position to protect their own interests.

There should be more of an emphasis on prevention as well as protection and on post-abuse support. The phrase 'Safeguarding Adults' has a broader scope than 'adult protection' that better reflects this wider agenda and is the preferred term for this policy area.

Robustness

Interagency working and the regulatory system need to be strengthened, particularly in relation to institutional abuse.

Given these overall conclusions, we now consider the recommendations we would make in the context of the findings of our review to improve the system of safeguarding adults in Wales.

Recommendations

RECOMMENDATION 1: PRINCIPLES OF SAFEGUARDING

Safeguarding adults in Wales should be based on the following principles:

- the views and wishes of victims should guide how they are supported;
- the starting point must be to believe people who raise concerns about abuse;
- safeguarding should be based on consent;
- we should maintain the current legal position in Wales that adults with capacity have the right to refuse intervention even if this leaves them at risk of significant harm;
- the priority should be to stop abuse continuing whilst safeguarding procedures are followed;
- there is a crucial balance to be struck between autonomy and protection;
- people at risk from abuse should be involved in decision-making processes, including strategy meetings and case conferences, unless there are exceptional and compelling reasons not to do so;
- people should be supported with strategies to keep themselves safe; and
- safeguarding should be in the context of fully engaged citizenship, not restricted to social care, health services and the criminal justice system.

RECOMMENDATION 2: LEGISLATION

New legislation is required. The symbolism of legislation is important in fostering cultural change. Safeguarding adults at risk from abuse who cannot protect their own interests must have the same legislative status and priority as protecting children.

Legislation should include:

- defining people to whom policy for safeguarding adults applies as those over 18 years of age who are:
  - Not in a position to protect their own well-being, property, or other interests; AND

  - Are at risk of harm from abuse; AND
  - Because they are affected by disability, mental disorder, illness, or physical, or mental infirmity are more vulnerable to being harmed than adults who are not so affected; AND
  - That another person, or persons conduct is causing, (or likely to cause) the adult to be harmed.

- a statutory framework for interagency working, including a duty to investigate, a duty to co-operate and a duty to share information;
- a duty to consider advocacy support;
- a statutory framework for serious case review;
- a new offence of ill-treatment, or neglect of a person with capacity;
- new powers including power to:
  - enter premises to assess whether someone is at risk of abuse, or is being abused, to review /remove records and to arrange a medical examination;
  - remove an adult (with their consent) to a place of safety, even if others in the household disagree;
  - ban perpetrators from premises.
- a new offence of obstruction;
- sanctions in relation to offences by 'bodies corporate' (including statutory agencies) and individuals within them in cases of consent to, or collusion in abuse, or negligence.

In principle, banning a perpetrator should be considered preferable to removing a victim.

Inevitably, it will take time to get legislation in place. There is no reason, however to delay the other recommendations made as part of this review until legislation is in place. Implementing the other recommendations will mean that the preparatory work is in place to enable rapid, effective implementation of the legislation as soon as it reaches the statute books.

RECOMMENDATION 3: SANCTIONS

We asked as part of our survey, reported in Chapter 5, and in qualitative interviews whether specific sanctions should be available if corporate bodies failed to follow new guidance/legislation and this led to serious harm. The majority of respondents were in favour of robust accountability arrangements being in place including

disciplinary action, and organisational and individual fines being available. A substantial minority (47%) of survey respondents favoured imprisonment being an option in the most serious cases (para 263). In respect of sanctions, we recommend that there should be further consultation about the range and scope of possible sanctions to ensure an appropriate balance is found between accountability on the one hand, and, on the other hand the potential for sanctions to impact adversely on people wanting to work in the adult safeguarding field.

RECOMMENDATION 4: NATIONAL ARRANGEMENTS. GUIDANCE, POLICIES, PROCEDURES AND MONITORING

The National Adult Protection Project Board and National Adult Protection Advisory Boards should be disbanded and a single new national organisation should be created. This body should have an independent chair, expert in the adult safeguarding field and bring together adults with experience of safeguarding issues and experts in policy and practice in safeguarding (including the voluntary sector, local authorities, health, police and CPS) and related fields, including development agencies (SSIA, NPIA, NLIAH) regulation and health and safety. The new National Safeguarding Adults Group would have the following role:

- to advise the Welsh Assembly Government on policy to safeguard adults;
- to lead policy and practice development to safeguard adults in Wales, including ensuring related policies, such as commissioning guidelines, and direct payments have safeguarding built in;
- to inform and oversee the development and implementation of the legislative programme set out in recommendations 2 and 3;
- in partnership with CSSIW and HIW to be a repository for and to ensure the dissemination of good practice, (including from Serious Case Review and Homicide Review) throughout Wales;
- to build on the work of Adult Protection Co-ordinators, CSSIW and the Local Government Data Unit Wales, to develop outcome based monitoring arrangements based on nationally agreed data definitions;
- To ensure there is an integrated approach based on clear roles and responsibilities for safeguarding on the part of the National Safeguarding Adults Group, Safeguarding Adults Boards (see Recommendation 6) CSSIW, HIW, HMIC, the Older People's Commissioner for Wales and the Public Services Ombudsman;
- To oversee the development of a national competency based training programme and advise on the development of qualifications in safeguarding.

It is imperative that the proposed National Safeguarding Adults Group builds on the work of the current Regional Forums to develop and consult on interim national guidance, policies and procedures, until the new legislation is in place, followed by revised national guidance, policies and procedures once legislation is enacted.

RECOMMENDATION 5: CATEGORIES OF ABUSE

New national guidance should include the following categories of abuse:

- Physical (including chemical/medication abuse)
- Sexual
- Psychological
- Financial/Material
- Neglect
- Institutional

It should be clear that abuse by strangers comes within safeguarding policy.

Hate crimes (based on race, religion, disability, sexual orientation) should all be recognised as aggravating other offences, potentially leading to longer sentences in cases where perpetrators are successfully prosecuted.

Cases involving domestic abuse, or forced marriage require joint working between safeguarding teams and partners with responsibility for domestic abuse/forced marriages to ensure that an abused person's needs are addressed holistically and seamlessly.

RECOMMENDATION 6: SAFEGUARDING ADULTS BOARDS

Local authorities should be the lead agency in relation to safeguarding adults. New Safeguarding Adults Boards (SAB) should be formed, based on local authority boundaries, grouped in accordance with the principles set out in the Beecham Report: *Beyond Boundaries: Citizen-Centred Local Services for Wales* (Welsh Assembly Government 2006). (See also para 62, Chapter 4).This would give the Boards and the specialist Safeguarding Adult Teams (see Recommendation 7) that we propose should support them the critical mass they need to develop expert, robust safeguarding arrangements. Each Board should have a chair who is independent from local adult social services.

The proposed Safeguarding Adults Boards would be senior interagency bodies, supported by expert Safeguarding Adults Teams (SAT) who:

- ensure effective interagency working locally, based on national legislation, guidelines, policies and procedures;
- ensure that each of the Directors of Social Services from constituent local authorities can demonstrate that they are fulfilling their s.7 guidance responsibilities for safeguarding adults through the SAB and SAT;
- ensure there is an integrated approach and read across between adult safeguarding and related policies and activities;
- oversee a training needs analysis for safeguarding adults and the development of a consistent approach to training, based on a nationally devised training programme; and
- develop a consistent approach to data collection, based on nationally agreed data definitions.

The new Safeguarding Adults Boards could be based, for example, on local health board boundaries, so there would be 7; or based on Police / CPS boundaries in which case there would be 4.

There are pros and cons to each of these configurations that can be tested in consultation. For example, aligning with local health board boundaries would promote greater integration of health into safeguarding and would retain a degree of localness. Aligning with Police/CPS boundaries would reduce complexity in supporting victims to access justice.

RECOMMENDATION 7: SAFEGUARDING ADULTS TEAMS

Each of the proposed Safeguarding Adults Boards should have a specialist Safeguarding Adults Team who would lead the investigation and co-ordination of safeguarding adults for their area. The teams would be based on a model that integrates generic practice with the specialist team. Where an adult at risk of abuse has a social worker, their generic social worker would take part in all strategy discussions, strategy meetings and case conferences and would have an important role in post-abuse support. Safeguarding teams should include, or have access to specialist investigators with expertise in finance/audit and be able to call on Local Health Boards for expert investigators with health expertise.

Once a strategy discussion identifies a prima facie case of abuse, all investigations

would be led either by the police, or by an investigator who has been trained to PACE standards.

All lead investigators will be independent from the setting that is being investigated. Investigators will involve local services, including independent sector mangers/proprietors, in investigations and in decision-making processes (strategy discussions, meetings and case conferences) unless there are compelling reasons not to do so. (Principally that they are implicated in the abuse).

RECOMMENDATION 8: ACCESS TO JUSTICE

- Safeguarding Adult Teams and the police will ensure early involvement of the Crown Prosecution Service in cases where a crime may have been committed;
- Access to justice will be supported by the police and (where appropriate by Safeguarding Adult Team investigators trained to PACE standards);
- In all cases involving adults at risk, victims will be offered advocacy support[1] and special measures for court appearances - including the use of intermediaries if needed;
- Perpetrators will be offered advocacy support and special measures for court appearances, including the use of intermediaries if needed, if they are themselves adults at risk;
- 'Wrap around' (see para 417, Chapter 6) support based on the Safety Unit model for domestic abuse should be developed to support abused adults.
- A pilot scheme should be put in place to give abused adults access to special courts, on the model developed for Special Domestic Violence Courts.
- The CPS should adopt a culture supporting a 'positive prosecution policy' in cases of alleged abuse.

RECOMMENDATION 9: REGULATION

Guidance on the role of CSSIW should make explicit their role in improving the quality of regulated services (see para 388).

In the event that future case law establishes the existence of a common law duty of

[1] This does not refer to advocacy in the sense of legal representation but to advocates specialising in safeguarding adults.

care by care standards registration authorities towards individual service users, CSSIW should give guidance on the circumstances in which such a duty may arise (see para 395, Chapter 6). In the mean time, CSSIW should ensure that once it is aware of abuse in a regulated setting, CSSIW takes the appropriate steps available within its statutory powers to safeguard against the risk of further abuse.

In order to strengthen role of CSSIW in the prevention of abuse:

- day centres should be regulated by CSSIW;
- supported housing schemes should be assessed and regulated as residential care settings if that is how they are in fact operating;
- unannounced visits to regulated agencies and care settings should be the norm;
- notifications under Regulation 26 for domiciliary care: *Notification of serious injury and other incidents* and Regulation 38 for care homes: *Notification of death, illness and other events* should include serious pressure ulcers (Grade 3 and 4); and
- electronic recording of visits by domiciliary care workers should be a requirement;
- medically qualified proprietors/mangers should not be permitted to certify deaths arising in their own establishments; and
- the implementation of sanctions provided for under the Health and Social Care Act 2008 should proceed. Consideration should be given to the system of penalty points and fines being further developed to allow for the accumulation of penalty points to lead to automatic suspension of registration in the event of repeated failure to comply CSSIW/HIW requirements.

RECOMMENDATION 10: DIRECT PAYMENTS

Adults at risk of abuse should be carefully assessed in relation to whether direct payments will meet their needs. The support of local authorities, or disability coalitions through local authority Direct Payment support schemes in handling the employment aspects of direct payments including:

- Recruitment
- Checking references
- CRB /ISA checks
- Paying fees/salaries

- Making Tax and National Insurance payments

are useful in ensuring an adult at risk has the flexibility associated with direct payments in being able to choose how and when a service will be provided without being exposed to some of the risks.

We recommend that policy on Direct Payments should be changed so that it is not possible to make Direct Payments to a person who has not been CRB/ISA checked. (To do otherwise leaves adults at risk of abuse by a known abuser who is being paid with public money see para 323, Chapter 6).

Once Direct Payments are in place the arrangement should be reviewed by the local authority regularly (after the first 3 months and at least 6 monthly thereafter).

Arrangements should be made for regulated providers being paid through a Direct Payment to notify the relevant local authority if an adult is getting into arrears, to ensure that the arrangement is not putting the adult concerned under too much pressure and that they are not subject to financial abuse on the part of a third party.

RECOMMENDATION 11: SELF-FUNDERS

Regulated providers should notify proposed self-funders to the person concerned's local authority so that they can be offered assessment and regular review of their needs. Self-funders who are socially isolated, or who have lost links with their families should be offered advocacy support.

RECOMMENDATION 12: LOCAL HEALTH BOARDS AND NHS TRUSTS

Local Health Boards and NHS Trusts should ensure they have robust safeguarding arrangements, including:

- establishing specialist teams with the appropriate level of investigative skills and clinical expertise to contribute effectively to:
  - being a resource to staff within the LHB, or NHS Trust who have safeguarding concerns;
  - referring prima facie cases of abuse into safeguarding arrangements;
  - training others in safeguarding adults; and
  - local Safeguarding Adult Teams, including contributing to

reciprocal investigation arrangements to ensure independence in investigation;
- ensuring that incidents of abuse are conceptualised as abuse;
- investigating all incidences of serious pressure ulcers (Grade 3and 4) to assess whether they have resulted from neglect;
- ensuring that all staff in contact with adults at risk are CRB checked;
- ensuring that all staff are trained in safeguarding adults to a level commensurate with their role;

LHBs should:
- support general practice in putting CRB checks and appropriate training in place;
- facilitate engagement of primary care in screening for abuse, safeguarding procedures, and information sharing;
- introduce screening for adult abuse in Accident and Emergency Departments;
- ensure that settings providing continuing healthcare have the necessary staff and equipment to support adults at risk, (including those at risk from pressure ulcers); and
- nurse assessors should be trained as investigators to PACE standards and play an integral part in the Boards safeguarding arrangements.

RECOMMENDATION 13: RAISING AWARENESS

There should be a national publicity campaign aimed at raising awareness amongst the general public, including adults who may themselves be at risk of abuse, about:
- what abuse is
- being clear that they should not have to tolerate abuse directed at themselves; nor should they tolerate abuse of other people
- who they can contact if they have concerns about abuse
- a national phone number that they can ring if they have concerns

The campaign should be timed to happen after the implementation of new policies and procedures and in the run up to new legislation being implemented to ensure there is capacity in the system to deal effectively with concerns and to highlight the new arrangements.

RECOMMENDATION 14: DUTY TO REPORT ABUSE

Staff working with vulnerable adults should have a duty to report abuse. Such a duty to report could be:

- a responsibility to maintain a member of staff's registration;
- a condition of employment;
- a requirement by regulators that such a duty is reflected in the policies and procedures of regulated settings;
- enshrined in new legislation, (as in some other countries, including Canada – see para 68, Chapter 4).

There should be further consultation on each of these possible approaches.

Where reporting within organisations is problematic, concerns could be raised directly with safeguarding teams.

Whilst whistle-blowing policies should still be in place as a last resort, it was the general view that a change in culture was necessary based on a duty to report, rather than staff being seen as acting against their peers by taking it on themselves to act. This would take the "should I say something, or shouldn't I" dilemma away from staff.

RECOMMENDATION 15: RESOURCES

The implementation of a system to safeguard adults in line with the recommendations in this review will not be cost neutral – although we do not think that the level of resources required will be comparatively as high as in Scotland. (See paras 435-8, Chapter 6). Resourcing the proposed system is a question of priorities for the Welsh Assembly Government and its partners in safeguarding.

In order to identify the costs associated with these recommendations we recommend that local authorities, LHBs and the police in Wales should be asked to identify the resources associated with their safeguarding adults services including, as a minimum:

- staff
- non staff
- training

with effect from the financial year 2010/11 in order to identify the baseline spend.

Initiatives to support the implementation of new legislation, policies and procedures should be costed, taking into account resources that are already built in.

RECOMMENDATION 16: CONSULTATION AND DEVELOPMENT PROGRAMME

The review of *In Safe Hands* contains a wealth of information and ideas from contributors on a wide range of subjects. We could make many hundreds of detailed recommendations based on our findings for example on:

- institutional abuse
- financial abuse – especially in relation to adults with capacity;
- developing advocacy capacity;
- developing post-abuse support capacity in the voluntary and statutory sectors;
- information sharing
- commissioning
- training (including all of the groups set out in para 239, academic social work training, Coroners and others identified through training needs assessment.)
- data definition (for example, using 'substantiated' rather than 'proved' to improve accuracy of reporting).

However, our remit was principally to look at the policy level aspects of safeguarding and much about how the details of the report could be tackled will turn on the model for safeguarding that the Welsh Assembly Government decides to adopt. This will not be clear until all strands of the policy review, including:

- this review of *In Safe Hands;*
- CSSIW and HIW inspections of adult protection; and
- The work of the National Adult Protection Project Board

can be considered as a whole and a consultation exercise is carried out. We recommend that once the model for safeguarding adults is settled following full consultation, the proposed National Safeguarding Adults Group, (or equivalent) will work through the details of this review to create a development programme that ensures the rich detail of the review informs the future development of safeguarding policy.

SECTION 1 | SETTING THE SCENE

Chapter 1 | Introduction to the review

1. The overall aim of this review of *In Safe Hands*: *Implementing Adult Protection Procedures in Wales* (National Assembly for Wales 2000) has been to consider and assess the continuing effectiveness, appropriateness and robustness of the *In Safe Hands* guidance, and in the light of all the views, evidence and information gathered during the review to reach conclusions and make recommendations about where improvements can be made.

2. The publication of *In Safe Hands* in Wales and *No Secrets* in England (Department of Health, 2000) was rightly considered groundbreaking at the time in recognising that protection of the criminal law was not in itself sufficient to safeguard adults from abuse. The scope of the criminal law did not, for example, cover some kinds of neglect and poor practice. *In Safe Hands*, however, was not simply about the scope of the criminal law; it heralded the need for cultural change whereby:

> *". . . all vulnerable adult client groups are to be protected from abuse, [and] supported in seeking treatment and redress in the event that they have been abused".*
>
> (*In Safe Hands*, 2000)

3. *In Safe Hands* was the first formal recognition in policy terms that a multi-agency approach was required to fulfil the Welsh Assembly Government's policy aspirations to ensure that in relation to adults, there is an appropriate balance between independence on the one hand and protection from abuse on the other – and that safeguarding adults is everyone's business.

4. Nine years on from the publication of *In Safe Hands,* a number of factors led to the need for a review to ensure that the arrangements at both the national and local levels are effective, appropriate and robust. These include:

   - Demographic changes affecting particularly the increasing number of older people in the community and the greater life expectancy of people with learning disabilities;

   - Better information on prevalence;

- Lessons learned from a variety of sources;

- Significant legislative and regulatory changes including, for example, the Safeguarding Vulnerable Groups Act 2006, Mental Capacity Act 2005, the extension of the application of the Human Rights Act 1998 and the POVA scheme;

- Policy developments in Wales including supplementary guidance on financial abuse and in related topics such as direct payments, dignity, concerns about care homes, sharing information and the role of regulators;

- Policy developments elsewhere in the UK;

- The appointment of the Older People's Commissioner in Wales;

- The establishment of new regulatory and professional advisory bodies including Care and Social Services Inspectorate Wales (CSSIW), Health Inspectorate Wales (HIW), the Care Council for Wales (CCW) and Social Services Improvement Agency (SSIA); and

- Greater public awareness and less tolerance of adult abuse.

5. Generally, the findings of the review acknowledge the significant contribution that *In Safe Hands* has made in developing arrangements for safeguarding adults in Wales. Nevertheless, in a changing legislative and policy environment and in the context of cultural change over the last decade, overall, the conclusions that have been reached are that *In Safe Hands* is:

   - partially effective;
   - in some important respects, no longer appropriate; and
   - not sufficiently robust.

6. In light of these conclusions, the recommendations set out in this review aim to build on the firm foundations established by *In Safe Hands*, to develop a legislative framework, policy and practice so that adults in vulnerable situations, the agencies who support them and the wider community can together:

   - develop a culture in Wales that does not tolerate abuse;

- raise awareness about abuse;
- prevent abuse from happening wherever possible;
- where abuse does happen, support victims to:
  - stop abuse continuing;
  - access services they need, including advocacy and post-abuse support;
  - support over-stretched carers;
  - deal effectively with perpetrators; and
  - have improved access to justice.

A NOTE ON THE USE OF LANGUAGE

7. Issues of definition and the use of language are recurring themes throughout the review. In line with the conclusions of the review we are using the expression 'safeguarding adults' wherever possible for the policy area currently covered by *In Safe Hands* as this was the preferred term of contributors to the review. 'Safeguarding adults' was held to have a broader focus than 'adult protection', more readily being understood to encompass the wider role of society in tackling abuse, particularly in terms of prevention. However, the phrase 'adult protection' still features prominently in the report of the review because of its historical association with the *In Safe Hands* guidance.

8. Similarly wherever possible we do not use the terms 'vulnerable adult', or 'service user'. The preferred alternative is simply to refer to 'adults,' or 'people' and to describe their situations rather than labelling the adult, him, or herself.

ATTRIBUTION

9. In asking people to contribute to the review, we gave an assurance that whilst we would report their views and quote directly from them, where appropriate, this would be done in an unattributable way. This had the benefit of enabling people to speak very frankly to the review team and we are sure that the review has benefitted from this approach. Where we use quotation marks in the document around quotations from other documents, books, websites, or papers, these are fully referenced in the usual way. Where quotation marks appear around quotations that are not referenced, these are direct, verbatim quotations from participants. Where possible to do so without identifying individuals, we make clear from which sector particular perspectives have arisen giving an indication of the source in brackets following quotations.

REPORTING THE REVIEW

10. The aim of this report is to give an accessible account of the review. It includes an outline of the terms of reference, summarizes evidence from the various strands of the review and sets out conclusions and recommendations. We have written this report so that it can be read as a stand-alone document.

TERMS OF REFERENCE

11. The review was commissioned by the Welsh Assembly Government from the Welsh Institute for Health and Social Care at the University of Glamorgan and took place between May and October 2009.

12. The terms of reference agreed with the Welsh Assembly Government were as follows:

- The overall aim of the review is to consider and assess the continuing effectiveness, appropriateness and robustness of the *In Safe Hands* guidance and in the light of all the views, evidence and information that is gathered to reach conclusions and make recommendations about where improvements can be made.

Matters to be considered in the review include:

- the extent to which the original 'In Safe Hands' policy statements have been achieved;
- the continuing appropriateness of the definitions of a 'vulnerable adult' and 'abuse' used in the *In Safe Hands* guidance;
- the evidence for the effectiveness, appropriateness and robustness of local adult protection policies, procedures and guidance and evidence that such policies, procedures and guidance are reviewed and up dated on a regular basis;

- the evidence for active co-operation and information sharing between care managers, commissioners, care providers and adult protection teams;

- the clarity and understanding of each agency of their respective roles, responsibilities and relationships in adult protection;

- the evidence for the effectiveness of local interagency working, and for the active collaboration and partnership working including information sharing of all key agencies at all levels from operational to Chief Officer / Member level;

- evidence for the effectiveness of the local adult protection referrals pathways, sole or inter-agency consideration of adult protection cases, the decision making arrangements and follow up procedures including record keeping and maintaining the audit trail for decisions;

- evidence for the effectiveness of local adult protection monitoring and reporting arrangements, including monitoring outcomes;

- evidence for the effectiveness of preventative work, including the training of staff in adult protection matters and the extent to which commissioners take account of adult protection matters in contracting with service providers;

- evidence for identifying sharing and implementing good practice across Wales; and

- evidence for trends in adult abuse victim or perpetrator prevalence including any regional differences across Wales.

- In the light of all the assessed evidence to reach conclusions and make recommendations about where improvements could be made to the adult protection national guidance framework and/or local implementation arrangements including:

    - the scope and case for introducing a more unified adult protection process and documentation across Wales;

- the future role of the All Wales Adult Protection Advisory Group;

- the need for new legislation or other changes with particular reference to:
  - ◊ the arrangements applying to the protection of children to see if any of the arrangements that apply, including serious case review procedures, could usefully be applied to adults;
  - ◊ the case for establishing local adult protection registers;
  - ◊ the adult protection legal framework in Scotland;
  - ◊ the outcomes from the review of the '*No Secrets'* guidance in England;
  - ◊ the work of the WAG Adult Protection Project Board; and
  - ◊ an assessment of the resource implementation costs associated with any recommendation made.

(Adapted from *Specification for a Review*, Welsh Assembly Government 2009a)

13. The scope of this review is centred on policy issues, including the role of legislation and guidance in safeguarding adults. The Care and Social Services Inspectorate Wales (CSSIW) is currently conducting a national inspection of adult protection. CSSIW's work is focusing on practice, rather than policy. WIHSC and CSSIW have worked in close partnership to ensure that both the inspection and this review are complementary and to avoid duplication. The outcomes of both the inspection and this review will be reported to the Assembly Government's Adult Protection Project Board during 2010 to enable the Board to be in a position to advise Ministers about how consultation could be taken forward on overall policy relating to safeguarding adults.

METHODOLOGY

14. A three-phase, multi-methods approach to the study was adopted.

Phase 1 comprised:

- Focus groups with older people, people with learning disabilities and people with mental health problems to ensure that their aspirations and concerns were incorporated from the start;

- Exploration of the safeguarding agenda through telephone interviews with officials at the Scottish Executive and the Department of Health and the Home Office;

- A review of the literature with the main focus being the UK since 2000, but also drawing on relevant European and international literature; and

- Scene-setting with Adult Protection Co-ordinators.

Informed by each of the elements in Phase 1, Phase 2 comprised:

- a survey of statutory stakeholders, including all local authorities, police, local health boards, and NHS Trusts in Wales; and

- qualitative field work, based on in person and telephone interviewing.

In Phase 3:

- survey responses were followed up;

- local studies were undertaken in, Blaenau Gwent, Cardiff, Isle of Anglesey and Pembrokeshire;

- emerging conclusions and recommendations were tested through a stakeholder workshop held in Aberystwyth on 10 September 2009; and

- a second round of focus groups with adults and their carers was held to test their reactions to emerging findings and proposed recommendations.

15. As well as ongoing dialogue with Adult Protection Co-ordinators in local authorities and the NHS throughout the review, the research team also took part in three meetings with PAVA Wales (Practitioner Alliance Against Abuse of Vulnerable Adults (Wales)), met the Welsh Assembly Government Adult Protection Project Board and was briefed by Gwent Police about lessons learned from Operation Jasmine (an inquiry involving issues connected with safeguarding adults).

ETHICS

16. There are significant ethical issues involved in working with adults and their carers where there is risk of abuse, or there has been abuse. Our team had established links with adults and their carers in relation to older people, people with learning disabilities and people with mental health problems that enabled us to explore the issues from their perspective in an ethical way.

17. The project was discussed with the University of Glamorgan's Health, Sport and Science Faculty Ethics Committee (FEC) on 22 April 2009. Although the project is service evaluation, rather than research and does not require ethical approval in the way that a research project would, the involvement of adults and their carers in such a sensitive topic as adult protection meant that we wished to apply the same ethical standards as those that would be required for a research project. The FEC confirmed that the project would meet its requirements for ethical approval.

18. We also confirmed with the NHS National Research Ethics Service that the project falls within their definition of service evaluation, not research, and was not, therefore, subject to NRES procedures.

19. The use of a range of different methods to gather evidence gave a rich and detailed picture of current issues relating to safeguarding adults in Wales. Whilst differing perspectives and emphases were evident, there was a broad consensus about what the future development of policy should look like. The following chapters discuss the findings from the following strands of the review:

    - focus groups;
    - literature review;
    - survey;
    - interviews and local studies; and
    - stakeholder workshop.

20. Each of the chapters in Section 2 sets out the context for, and findings from, each of these strands of the review. The overall conclusions we have reached through our review are as a result of integrating key themes and messages from all of the strands in the review. Conclusions and recommendations based on our findings are to be found in Section 3 of this report.

21. Separate focus groups were held for people with learning disabilities, people with mental health problems and older people during the first phase of the review. This was so they could tell the review team from their own experience what issues were important to consider. Towards the end of the review, the focus groups were invited to meet again to test with them the emerging conclusions and recommendations.

PHASE 1 FOCUS GROUPS

22. The key themes from all of the first round of the focus groups were:

- the whole of society has a role in safeguarding adults;
- there is a crucial balance between autonomy and protection;
- prevention is important, including capacity building so that people can keep themselves safe;
- the use of the word 'abuse' makes the subject more difficult for people to feel comfortable talking about it than using the term 'safeguarding';
- People are not intrinsically vulnerable because they have mental health problems, learning disabilities, or are older. Vulnerability is situation dependent and varies over time. We should not label people as 'vulnerable adults';
- people need to know to whom they can report concerns;
- people are still not being believed when they disclose abuse;
- once abuse has been identified, the priority is to stop the abuse continuing whilst investigations and other procedures proceed;
- investigations should be independent;
- outcomes to be achieved in response to abuse should be based on the perspective of the victim of abuse;
- access to advocacy and post-abuse support is important;
- the perceived lack of access to justice will continue in the absence of successful prosecutions; and
- the experience of the operation of the *In Safe Hands* Guidance is better for some groups than others. Particular problems were raised by people who have mental health problems.

23. Whilst these were common themes from all three of the focus groups, there were also issues raised by each of the groups that were specific, or particularly

emphasised by them. The following sections look at the differing perspectives from each of the focus groups.

PERSPECTIVES OF PEOPLE WITH LEARNING DISABILITIES

24. Issues raised by those with learning disabilities during phase 1 of the review included:

- policies should be accessible and understandable, including the use of photographs and new media;
- bullying should be a recognised form of abuse;
- some abuse is subtle – for example people in wheelchairs being left out of activities;
- particular vigilance is needed for people with limited, or no, verbal communication;
- people with learning disabilities may not realise they are being abused, particularly when financial abuse is involved.

When abuse does take place the issues of concern were:

- knowing who to tell – family members, advocates and teachers were all seen as important intermediaries between the person with learning disabilities and the police, but could also be perpetrators;
- being believed;
- not being understood because of communication difficulties; and
- being kept informed throughout about what was happening.

25. Some of the people with learning disabilities who took part in the focus group had been involved in helping to train police officers and were, therefore, aware of some of the powers available to the police, for example the potential application of public order offences.

26. Where criminal offences had taken place, the group felt that perpetrators should be 'locked up'.

27. Most did not have direct experience of the courts but felt that measures like:
    - video-taping evidence;
    - officials and lawyers not wearing wigs and gowns;
    - telling people what would happen; and

- showing them around before the proceedings began;

would make the experience less daunting. One of those who had had experience of a court case observed:

> "The only time we've ever been involved in anything like that people with learning disabilities weren't believed anyway."

28. An important theme was that until people with learning disabilities saw successful prosecution of those abusing them, they would not be confident in policy on safeguarding adults and would not feel as though they were being valued as equal members of society.

29. The importance of post-abuse support was highlighted including access to counselling support and flexibility about changes to service provision.

PERSPECTIVES OF PEOPLE WITH MENTAL HEALTH PROBLEMS

30. People with mental health problems said that overall they would be more confident in raising abuse that was affecting someone else rather than abuse that was impacting on themselves. They acknowledged the complexities around patient-to-patient abuse and pointed out the perpetrators may themselves be being abused.

31. There were particular concerns about hospital admission:

> "You're vulnerable when you are not well. I have not been informed about [adult protection] policies and procedures. In an ideal world people [being admitted because of mental health problems] would be given this information".

Overall the group wanted their concerns to be believed, but this had not been their experience.

> "When you have a label of 'mental health' you are not taken seriously".

32. Members of the group expressed fearfulness related to past experiences. This accords with the recent findings of a Care Quality Commission survey of mental health inpatients in England that reported that fewer than half of mental health

patients “always” felt safe on their ward with 16% saying that “they did not feel safe at all” (Lomas 2009).

33. The group was sceptical about the role of the police and the courts, because of their experience of being disbelieved.

34. Of the three focus groups, those with mental health problems were the most mistrustful that their interests are being properly protected through current arrangements and were most concerned about perpetrators of abuse who were health, or social care staff.

PERSPECTIVES OF OLDER PEOPLE

35. The older people taking part had less experience of health and social services than those who had mental health problems, or who had learning disabilities. They were not aware of specific policies to protect adults.

36. Participants felt they would have to be very sure of the facts before intervening as they would not want to be seen as “interfering”.

37. This group saw keeping safe as a personal responsibility and the first port of call if an abusive situation arose would be other family members. Only then would health, or social care professionals, or the police be considered.

38. In situations where abuse had been raised, it was felt that both the abused person and alleged abuser should be kept informed at every stage.

39. Where, for example, an older person lived with a son, or daughter, who was abusing them, it should be possible to remove the abused person to a place of safety. Where it was an older person’s own home, then there should be the power to remove the son, or daughter.

40. There was an emphasis on community involvement as being an important safeguard.

> “Somebody should call on you, particularly if you are living alone”.

41. It was strongly felt that GPs and their practice teams had an important role in identifying people at risk of abuse and being a first point of contact. It was suggested that assistive technology could also play an important 'alert' role.

42. It was felt that the breakdown in community and 'good neighbours' compounded concerns for older adults living alone.

> "As neighbours and community have gone as a concept, why not have a 'neighbourhood worker'?"

43. All three of the focus groups welcomed the opportunity to take part in the review and to help shape its work from the outset.

PHASE 3 FOCUS GROUPS

44. Towards the end of the review, those who had taken part in the focus groups at the beginning of the review were given the opportunity to have feedback on emerging conclusions and recommendations and were asked for their views on them.

45. The reaction of those taking part supported the conclusions and recommendations the review had developed and highlighted support for new legislation including:
    - establishing a duty to investigate abuse[2];
    - establishing interagency duties to co-operate and share information, backed by sanctions;
    - power to enter premises;
    - power to remove an adult with capacity, with their consent, even if other members of the household disagree;
    - power to ban perpetrators;
    - a new offence of wilful neglect of an adult with capacity;
        - having all Wales policies and procedures;
        - making the reporting of abuse a duty for all health, and care staff in the independent and voluntary sectors as well as in statutory services;
        - having a principle of independence built into arrangements for investigating abuse;

[2] This new duty would apply to local authorities. The police already have a legal duty to investigate if abuse involves criminal acts, or omissions.

- putting the abused person's wishes at the centre (although agreeing that prosecution may sometimes need to proceed in the public interest even if the abused person did not want the perpetrator prosecuted);
- keeping people informed throughout [the importance of feedback was emphasised repeatedly at all stages of the focus groups deliberations];
- demonstrable access to justice, evidenced by abused people being believed and resulting in successful prosecution;
- moving away from the title *In Safe Hands* with a new title "reflecting the policy intention and being transparent, meaningful and communicable";
- no longer describing people as 'vulnerable adults';
- recognising institutional abuse as a distinct category of abuse; and
- good practice in employment arrangements including CRB and ISA checks, references and professional registration checks needing to be universally in place.

INTRODUCTION TO THE LITERATURE REVIEW

46. In reviewing the literature on adult protection, we concentrated on relevant reports from governments, health and social care organisations and 'think tanks' as well as peer-reviewed journal articles dating from after the publication of *In Safe Hands* in 2000. We also took an in depth look at the role of current guidance and legislation in the field of safeguarding adults, both in the UK and the wider world.

47. The main issues arising from our review of the literature are considered under the following headings:

- prevalence
- policy context including international and UK perspectives
- legislation and guidance

PREVALENCE

48. As the World Health Organisation has reported (2008) in many countries (India, Kenya, Singapore) elder abuse is a culturally challenging concept. India (1998) and Kenya have not had a tradition of acknowledging that elder abuse exists in their communities. In Singapore, decisions affecting members of a family are traditionally made by the family as a whole, not autonomously by individual family members Feedback from Black and Minority Ethnic Communities in the course of the *No Secrets* consultation (Department of Health 2008) in England suggests that accepting that such things happen is still an issue for some communities.

49. These cultural differences in conceptualizing abuse of older adults, let alone considering abuse of all adults in vulnerable situations, may explain in part the relative lack of availability of information about prevalence.

50. An important contribution to understanding abuse of older adults is to be found in influential research conducted by O'Keefe et al (2007). Although limited to adults outside care settings, and excluding those with dementia, this study exposed the scale of abuse and neglect of older people. Their estimates for Wales suggested that 6% of older people (over 65 years of age) had experienced

abuse. In 2007 this equated to around 32,000 people. They also commented on the paucity of mistreatment cases actually reaching the attention of Adult Protection services – which they estimated at 3%.

51. Studies also identify some of the reasons for the low level of reporting of such abuse amongst older people (Action on Elder Abuse 2004). These reasons include lack of access to trusted people, embarrassment particularly where the abuser is a family member, fear that the authorities will remove the victim and substitute institutional care, social isolation and mental health difficulties.

52. Investigations by the Healthcare Commission (2007a, 2007b and 2007c) and the Commission for Social Care and Inspection (2007) revealed a dispiriting picture of widespread institutional abuse which was prevalent in learning disabilities services in England. HIW concluded in its 2007 review in Wales people with learning disabilities: "... that people are well cared for in terms of fundamentals but lack stimulation."

53. In Wales, an ICM poll commissioned by Age Concern Cymru and Help the Aged in Wales in February 2009 revealed that 19% of adults polled had personal experience of an older person being mistreated; 5% of respondents reported coming across abuse of an older person in their own home; and 9% reported coming across such situations in care homes.

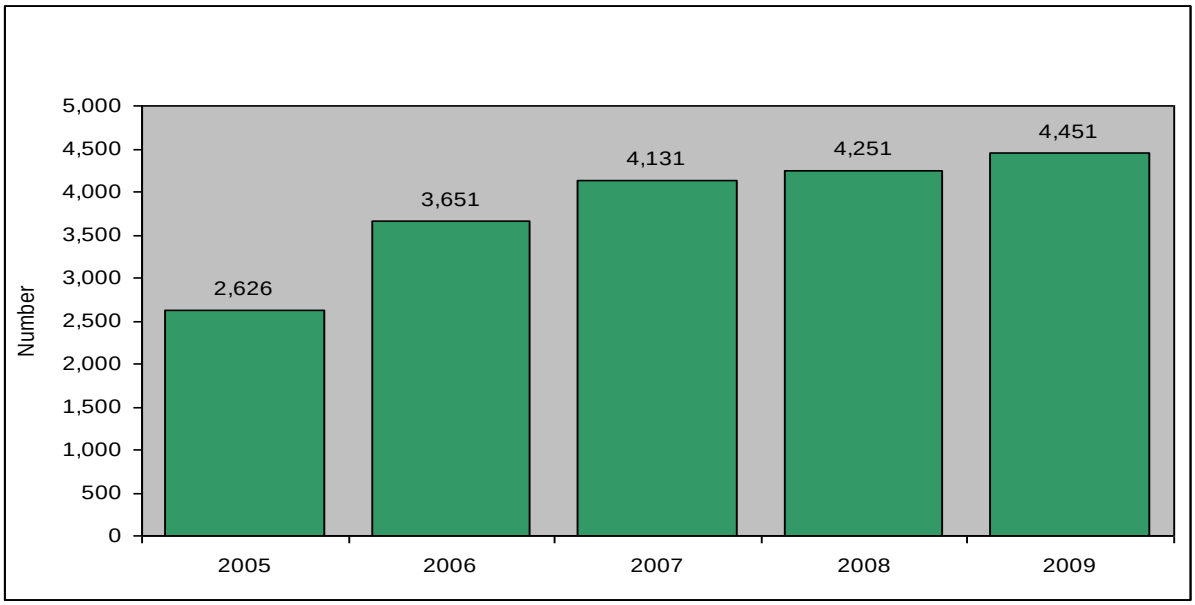
Data on abuse of adults in vulnerable situations.

54. In England, for the first time, the NHS Information Centre for Health and Social Care (2009) has initiated the collection of data relating to vulnerable adults for the period from 01 October 2009 – 31 March 2010. There is as yet no systematic data collection in Scotland. Wales has been recognised (CSCI 2008) as being in the vanguard in terms of information relating to vulnerable adults, with CSSIW publishing annual monitoring reports since 2004-05 based on data produced by all local authorities in Wales, as well as information about adult abuse in regulated services. Wales is therefore in a unique position in the UK to observe trends in relation to adult protection.

55. The picture in Wales based on the latest data for 2008-09 (due to be published in the CSSIW monitoring report for 2008-09 in the New Year, but made available to the review team by CSSIW and the Local Authority data Unit) is as follows:

The total number of completed referrals has increased from 4251 in 2007-08 to 4,451 in 2008-09 – an increase of 4.7%.

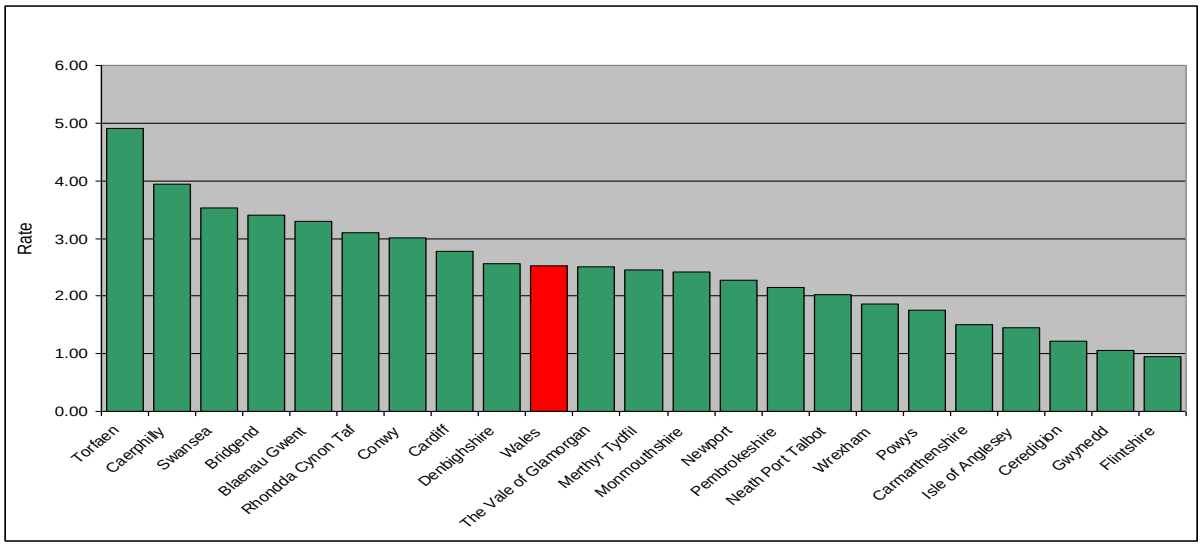
Figure 1 | Total number of completed adult protection referrals in Wales



(Source Local Government Data Unit –Wales 2009)

As in previous years there remains considerable variation in the rate of referrals received per 1000 population.

Figure 2 | Rate of referrals received per 1000 population



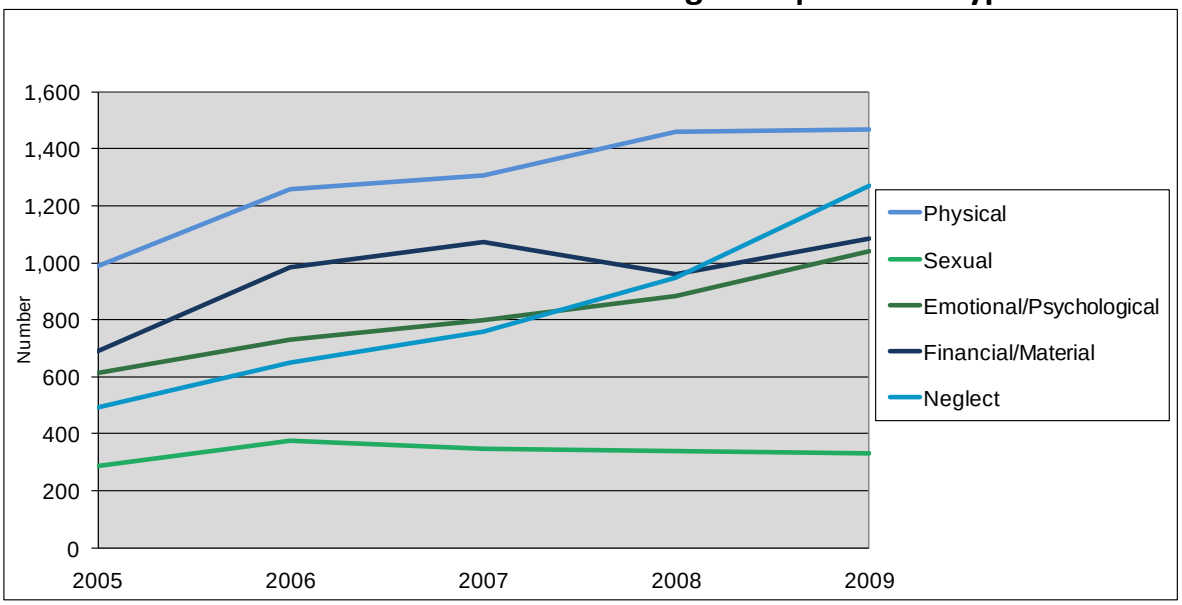
(Source Local Government Data Unit –Wales 2009)

The reasons that may lie behind the variation in referral rates appear from our field work to be linked to:

- the relative resources available to adult protection services;
- continuity in appointments to Adult Protection Co-ordinator posts;
- whether or not a specialist team is in place (referrals rates tend to be higher where there are such teams); and
- the number of referrals being generated by the health service.

Trends in types of abuse recorded are indicating a rise in the number of reported cases of neglect.

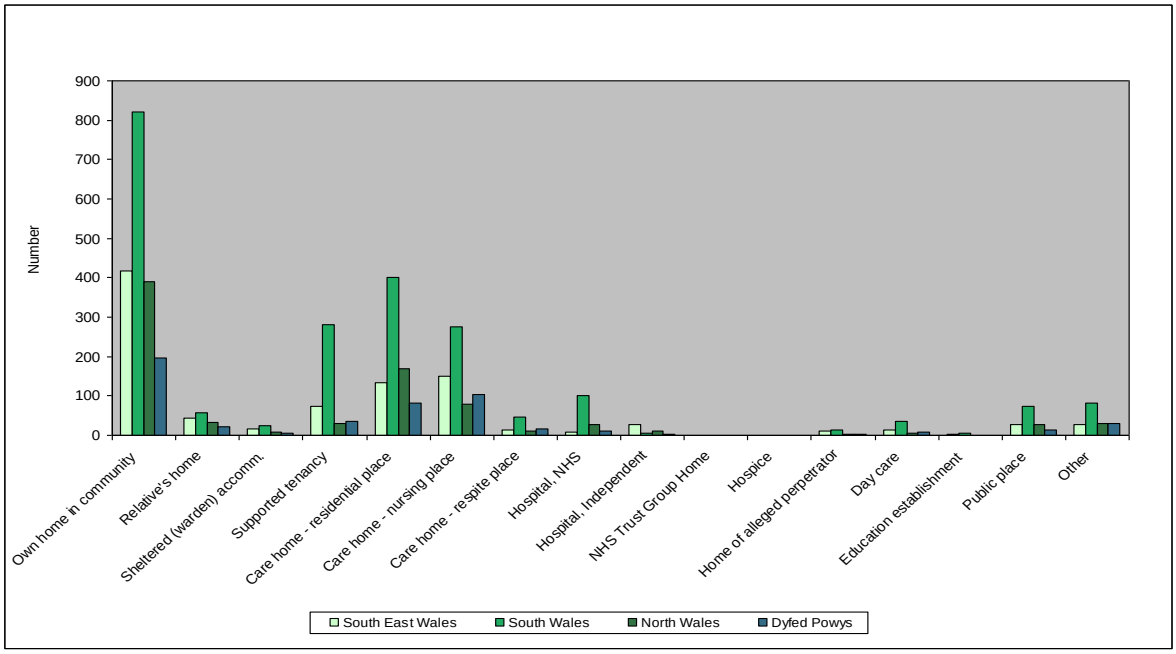
Figure 3 | Trend in types of abuse



(Source Local Government Data Unit –Wales 2009)

56. The location of abuse is in line with O'Keefe et al's 2007 study in that most reported abuse occurs in people's own homes:

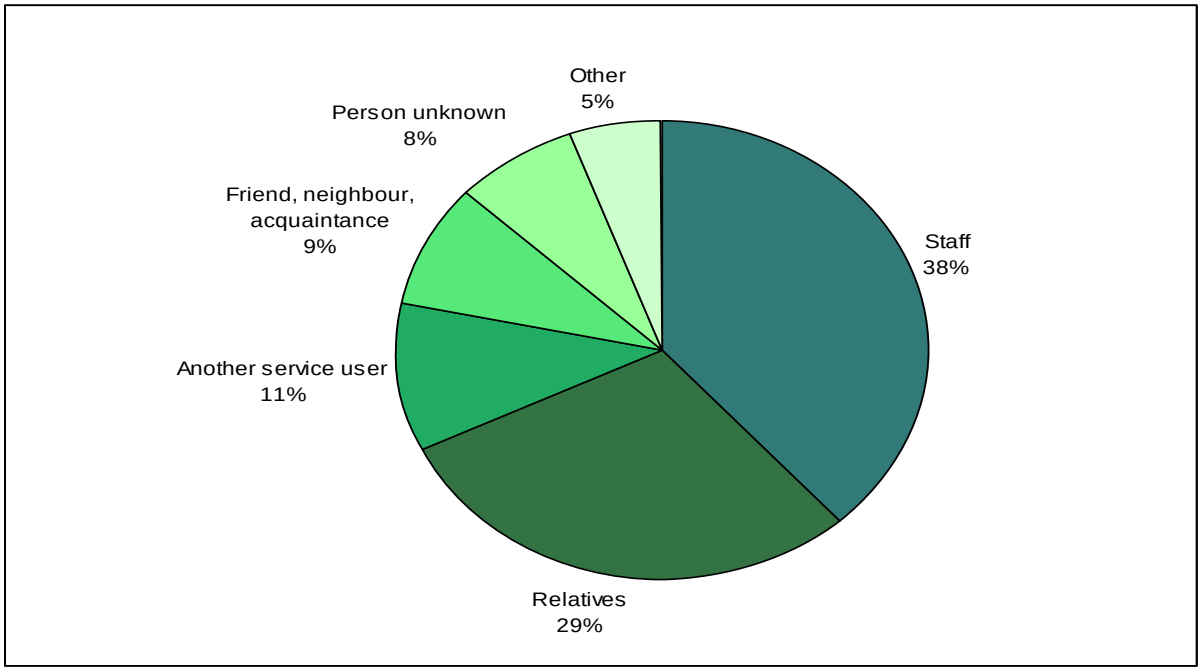
Figure 4 | Place where abuse occurred



(Source Local Government Data Unit –Wales 2009)

The proportion of those alleged **t**o be responsible for abuse is similar in March 2009 to the picture in March 2008, with staff being the largest proportion. This is a change from 2007 when relatives made up the largest group.

Figure 5 | Alleged perpetrators



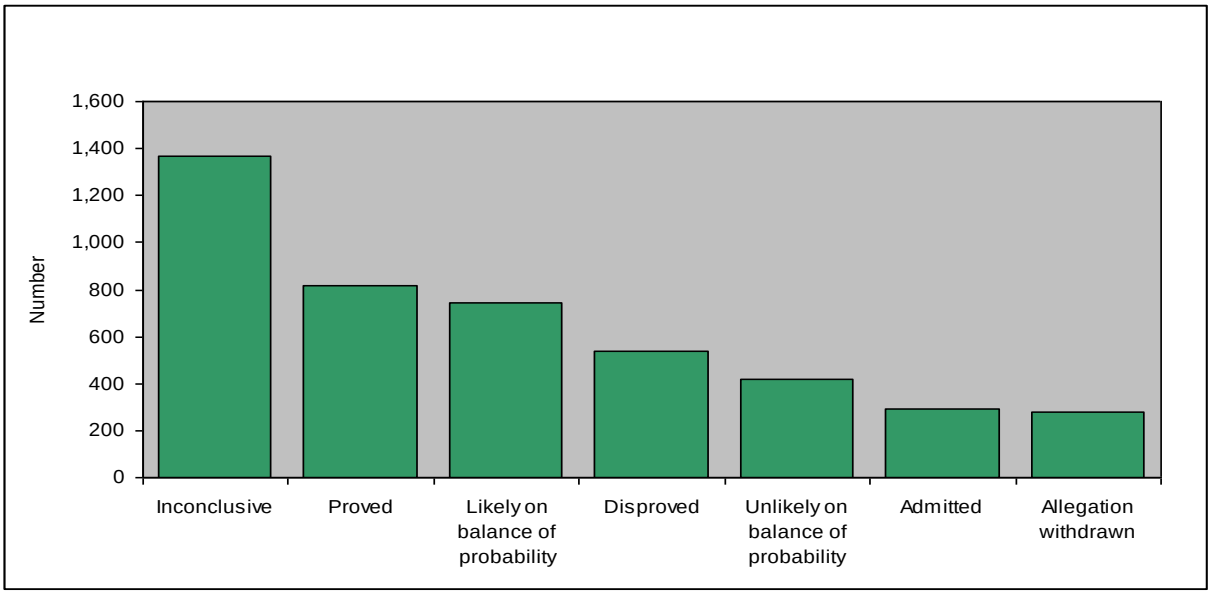
(Source Local Government Data Unit –Wales 2009)

Outcomes

57. As with previous years, the recorded outcome of most investigations into allegation of abuse is 'inconclusive'. Issues that emerged from our field work (see Chapter 6) that have a bearing on outcomes are:

- qualitative data concerning outcomes is needed as well as quantitative data to understand the background to the reported status of allegations;
- there is a reluctance to use the term 'proved'. Judgements are made on a balance of probability and there is wariness that such judgements may be subject to legal challenge. In England, the terms 'substantiated' and unsubstantiated are being used;
- the number of inconclusive outcomes is considered 'corrosive' to confidence in the system by victims of abuse.

Figure 6 | Status of allegation



(Source Local Government Data Unit –Wales 2009)

58. As in previous years, you are more likely to be referred because of concerns about abuse if you are a woman over 65 years of age than from any other group.

59. It is important to remind ourselves that despite the increase in reported abuse in Wales, prevalence studies estimate that around 32,000 older adults in Wales may experience abuse in any one year. Taking the 2660 older adults referred in 2008-09, this means that of the expected number of abused adults only around

8% are currently referred into adult protection procedures. The apparent disconnection between the number of people likely to be being abused compared with those formally referred into current adult protection procedures was an important aspect of the considerable debate in the review about to whom safeguarding procedures should apply.

Data definitions

60. Adult Protection Co-ordinators and the Local Government Data Unit Wales have been collaborating during 2009 to create a data dictionary to ensure that all co-ordinators are recording data against agreed definitions. There is acknowledged lack of consistency in the way that data definitions have been interpreted up to and including data referring to 2008-09. From 2009-10, there should be a consistent approach to data definition across Wales.

POLICY CONTEXT

61. There is a complex policy environment affecting safeguarding adults and important policy, legislative and regulatory changes that have taken place in the last nine years that have led to the current guidance in *In Safe Hands* being somewhat out of date. The implications of the Safeguarding Vulnerable Groups Act 2006, Mental Capacity Act 2005, the implementation of Deprivation of Liberty Safeguards, the extension of the application of the Human Rights Act 1998 and the transition of the Protection of Vulnerable Adults (POVA) scheme to the Independent Safeguarding Authority (ISA) Vetting and Barring Scheme all post-date *In Safe Hands* and need to be incorporated into updated guidance.

62. There are also important general policy developments in Wales in the context of *Making the Connections - Delivering Beyond the Boundaries* (Welsh Assembly Government 2006) and the development of integrated health bodies that make it imperative that a whole system perspective is taken in developing new guidance in relation to safeguarding adults and that any new guidance in this field also takes into account the priorities set out in other relevant policy areas, for example, (but not limited to): *Strategy for Older People in Wales* (Welsh Assembly Government 2003a), *Fulfilled Lives, Supportive Communities* (Welsh Assembly Government, 2007), *Designed for Life* (Welsh Assembly Government, 2005) *Designed to Improve Health and the Management of Chronic Conditions in Wales* (Welsh Assembly Government, 2007) Which all prioritize:

- Putting citizens first;
- Co-production of care with service users;
- Fostering effective collaboration;
- Leading and supporting change through new forms of local partnership and local agreements; and
- Accessible and responsive services delivered sustainably across organisational boundaries.

63. In developing policy on safeguarding adults in Wales, the emphasis that is needed on these principles is fundamental. Facilitating co-production in framing new legislation, policies and procedures, but also, crucially, in the way that individual cases of abuse are handled is an over-arching conclusion and informs the recommendations of this review.

INTERNATIONAL PERSPECTIVES

64. Countries such as Japan, Malta, South Africa and Canada have introduced national legislation in the field of elder abuse. Canada, in particular has been recognized internationally as a leader in raising public awareness of abuse of older adults and in developing innovative approaches to dealing with the issue (Gordon 2001).

65. Experience from around the world suggests that there is the need for both legislation to safeguard adults in vulnerable situations and effective supporting policies, procedures and practice. In *A Global Response to Elder Abuse and Neglect* (2008), the World Health Organisation reported a need to "sensitize governments" in response to its finding that:

> "Insufficient engagement on behalf of the government affects all participating countries, expressed by prevailing public policies relating to health care, social issues and finance that do not adequately cover or protect older people (**Australia, Brazil, Chile, Costa Rica, Kenya, Spain**)"
>
> (WHO 2008)

66. Experience in **Brazil** is that legislation in the absence of services on the ground is relatively ineffective in protecting vulnerable adults. Issues highlighted are typical of those that impact adversely on safeguarding adults in many countries including:

> "**lack** of:
>
> - training on elder abuse;
> - inter-professional communication and co-ordination;
> - protocols for homogeneous interventions;
> - Specific definitions and terminologies;
> - social support for care givers; and
> - circulation of information regarding the existing institutional resources"
>
> (WHO 2008)

67. In the **USA**, state-mandated programmes for adult protection have been in place since the passage of the Social Security Act 1974. In the intervening years most states have created laws and regulations aiming to create a co-ordinated, interdisciplinary system of social and health services to protect vulnerable adults (Otto 2000). In many states a legal requirement for local authorities to investigate reports of abuse, or neglect within 24 hours has been put in place. (Steigel and Van Cleave Klem 2005). There is now, however, seen to be the need have a federal legislative framework for Adult Protection Services. The National Council on Ageing is spearheading a campaign to support the passage of the Elder Justice Act currently (October 2009) being considered by the House of Representatives and the Senate.

> "This bipartisan legislation is the first and only comprehensive federal effort to address the tragedy of elder abuse, neglect and exploitation in our society. The authors of H.R. 2006 have applied the lessons learned in the fields of children's and women's abuse, neglect, and violence in an effort to combat crimes against seniors. By combining law enforcement, public health, and a social service approach to study, detect, treat, prosecute, and prevent elder abuse, neglect and exploitation this bill is very far-reaching and effective in its approach.
>
> The bill will provide the opportunity to conduct necessary research, provide training, respond to the needs of victims, and hold offenders accountable.

> The Act identifies measures that are cost effective, that have already worked, and that will help to contain the growing societal costs of elder abuse, including avoidable acute and long-term care resulting from abuse. Reports reveal that 500,000 to 5 million senior Americans will be victims of some form of abuse every year, causing illness, suffering, and premature death. The Elder Justice Act would, for the first time, provide much needed support to state and local entities, which are on the front lines in combating this largely unknown, but growing problem".
>
> (National Council on Ageing, October 2009)

68. Although **Canada** is rightly recognised as an international leader in tackling elder abuse, once legislation is in place it is not necessarily the end of the story. In Canada the federal Criminal Code is supplemented by state legislatures that have taken differing approaches to tackling elder abuse. The Ontario model is based on the provincial guardian and trustee service; the British Colombia model provides for numerous steps before court orders are considered, favouring voluntary responses (Canadian Network for the Prevention of Elder Abuse 2009). The Adult Protection Act 1989 applying to the Atlantic Provinces has been criticised (Gordon 2001, Harbison et al 1995) as being over-used in the absence of less draconian policy responses such as guardianship and appropriate use of mental health services. The provincial family court in Nova Scotia voiced concern over the premature use of the Act's extensive legislative powers. Over-use was considered to have been prompted in part because of the reporting of abuse being a legal duty for all citizens. This has led to calls (so far unheeded) to amend the legislation so that reporting would in future be mandatory only for relevant professionals, with a voluntary reporting system for the general public (Canadian Network for the Prevention of Elder Abuse 2009).

69. The limits of acceptability of what may be perceived as being draconian legislation is a debate that emerged in Wales during the review, particularly in considering the transferability, or otherwise into the Welsh context of legislation along the lines of the Adult Support and Protection (Scotland) Act 2007; the potential for creating a duty to report abuse; and the potential for legal sanctions in the event of serious harm resulting from the failure of statutory agencies to co-operate, or share information.

SCOTLAND

70. With the implementation of the Adult Support and Protection (Scotland) Act 2007, Scotland has pioneered the introduction of legislation in the UK to protect adults from harm. Testing the applicability of this legislation to Wales, the impact of the legislation so far in Scotland and the resources attached to it formed an important component of the review as a whole, and was considered at length through the survey, interviews, stakeholder workshop and focus groups. References to Scottish policy are made as they arise throughout the review. The details of the Scottish legislation are discussed later in this Chapter under the heading "Legislation and guidance".

71. The Adult Support and Protection Act (2007) was implemented with effect from November 2008. The Scottish Government and COSLA (Convention of Scottish Local Authorities) are currently researching the experience from the first year of the operation of the Act. A report is anticipated in the New Year (2010). Early indications are that the new powers set out in the Act have been used sparingly with 12 Orders having been made so far. It is thought to have made a real difference that adult protection services in Scotland have these powers:

> "up our sleeve"
>
> (Voluntary Sector -Scotland)

72. For example, the fact that a Banning Order could be sought has often proved decisive in achieving co-operation on the part of a perpetrator, without having to go to the extent of actually applying for an Order.

73. The costs associated with implementation have been:

- £500,000 for a national publicity campaign 'Act Against Harm' to raise awareness amongst members of the public about what abuse is and how to respond to abuse if they come across it. The campaign is advertising using posters, magazines, buses and a television advert:
  (see http://www.infoscotland.com/actagainstharm/);

- £8 million to support the first 6 months of the Act's implementation;

- £16 million to support the first full year of the Act's implementation (£15.6 million to local authorities and £400,000 to the police).

74. Tapering funding has been identified for the first three years of the Act's implementation. COSLA is in discussion with the Scottish Government about future funding arrangements.

75. This substantial investment is in the context that Scotland has, as one interviewee put it:

> "gone from virtually nothing to the gold standard in one go"
>
> (Voluntary Sector - Scotland)

76. The publicity campaign was piloted in Edinburgh and resulted in a noticeable rise in referrals from 239 in the six months prior to the pilot from June 2008 to November 2008 compared with 409 referrals from December 2008 to May 2009. It is interesting to note, however, that even the higher of these referral rates (2.05 per thousand of the adult population) is still lower than the referral rates of 15 out of 22 Welsh Authorities based on 2008/09 data (see Figure 2 above in the section on prevalence.) The lower referral rate for Edinburgh (1.2 per thousand of the adult population) before the campaign was lower than 20 out of 22 Welsh Authorities in 2008/09. This illustrates the lower base from which the Scots started.

77. The resources in Scotland have been needed to appoint adult protection teams, including co-ordinators and administrative support; to establish statutorily based Adult Protection Committees; and to train staff, including the staff of voluntary and independent sector providers.

78. All local authorities in Wales already have an adult protection co-ordinator, or equivalent in post; nearly half have more than one person, or a team in place. All local authorities in Wales are part of an Area Adult Protection Committee. The level of investment that might be needed to support the implementation of legislation in Wales needs to be judged in the context that these components of the safeguarding system are already in place - although it was widely reported by local authority contributors to the review that the investment in adult protection in Wales has been at the expense of care management and has amounted to:

> "smoke and mirrors "

ENGLAND

79. During the course of our review of *In Safe Hands, Safeguarding Adults -Report on the consultation on the review of 'No Secrets'* was published *(Department of Health, 2009).* There were over 12,000 participants who took part in the consultation and over 500 written responses. This report aimed to summarize the views of participants and of the written responses. The Department of Health has indicated that there will be a formal ministerial response to the consultation once there has been the opportunity to consider fully consultation responses.

80. As part of our review of *In Safe Hands* we took the opportunity to talk to colleagues in England in the Department of Health, the Home Office and the Ministry of Justice and also to take into consideration responses to the English Consultation from a wide range of voluntary and statutory organisations.

81. The main issues emerging from *Safeguarding Adults* were:

- Safeguarding must be built on empowerment – listening to the victim's voice.
- Everyone must help to empower individuals, but safeguarding decisions must be taken by the person concerned.
- Safeguarding adults is not like child protection.
- The participation/representation of people who lack capacity is important.
- People from black and minority ethnic (BME) backgrounds, particularly the older generations , 'had less understanding of what abuse meant or how to get help; and some had significant concerns about being able to get help in ways that were respectful and might help to keep their family honour intact.'
- Better leadership from central and local government, the NHS, regulators and police was needed with Safeguarding Adult Boards being put on a statutory basis.
- The balance between personalisation and safeguarding had yet to be properly worked through and lacked leadership.
- Safeguarding was under-developed and not 'owned' by the NHS.
- Housing providers wanted to play a bigger role in safeguarding.
- The police supported having statutory Safeguarding Adult Boards and wanted to see legislation creating a duty to co-operate and to share information between statutory agencies. They also wished to see national

guidance on safeguarding and a national database of Serious Case Reviews, as well as an integrated approach to inspection.

- In the context of reportedly few successful prosecutions, voluntary sector organisations thought crimes should be dealt with as crimes with supported access to the criminal justice system.
- There was widespread support for new legislation at consultation events and 68% of written responses argued for, or supported having new legislation.
- 90% of respondents wanted the definition of a 'vulnerable adult' in *No Secrets* to be revised. 'Person at risk' was a preferred term. [The *Safeguarding Adults* document itself follows the same course as the Scottish legislation and simply refers to 'adults']
- The Government's vision is of an inclusive society with opportunities and justice for all … a vision of a future for safeguarding those at risk from harm which is empowering and person centred, preventative and wide-ranging … the delivery of this vision will require strong multi-agency and inclusive partnership working.

82. Many of these themes recurred within the review of *In Safe Hands*, although there were some important differences. The support for new legislation in Wales was emphatic; and there was considerable concern that the current balance between choice and safeguarding was resulting in identifiable risk. There is particular concern in Wales that the risk of abuse for people receiving direct payments to purchase their own care and for people self-funding their care requires a more fully worked through policy response.

83. In addition to policy specifically relating to safeguarding adults, policy on domestic abuse and hate crime was discussed by the review team with English policy leads. There is a need to ensure that these various policy strands should be developed in an integrated way. From the perspective of an individual potentially faced with all of these issues in their life, the policy response should appear seamless.

LEGISLATION AND GUIDANCE

84. Through our review of the legal literature we now examine the current role of legislation and guidance on safeguarding adults and the arguments for and against new legislation and/or revised policy guidance in safeguarding adults from abuse and neglect in Wales.

85. The existing law on safeguarding adults is fragmented and complex. Law reform to protect vulnerable adults was first discussed at length during the Law Commission's examination in the early 1990s of decision-making on behalf of mentally incapacitated adults. In 1991 the Law Commission published its first Consultation Paper No 119 on *Mentally Incapacitated Adults and Decision-Making* (Law Commission 1991) which included discussion of vulnerable adults and adult protection. In 1992 the Commission issued three further Consultation Papers: *Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction* No 128 (Law Commission 1992a); *Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research* No 129 (Law Commission 1992b); and *Mentally Incapacitated and other Vulnerable Adults: Public Law Protection* (Law Commission 1992c). In 1995 the Law Commission (1995) published its final report, *Mental Incapacity* Law Com 231, and a draft Bill, which included in Part III provision for protecting vulnerable adults.

86. The Law Commission considered that existing adult protection powers under the Mental Health Act and National Assistance Act were draconian and as a result insufficiently used. They wanted to make provision, modelled to a considerable degree on child protection legislation, to ensure protection from abuse and neglect of 'people without capacity, and other vulnerable adults, constituting a broader group who may not be able to protect themselves from harm.' (Lord Chancellor's Department 1997, 8.1).

87. The Law Commission recommended a new duty for social services to investigate possible cases of neglect and abuse, short term powers to intervene to protect people believed to be at risk, and powers to prosecute those who seek to obstruct them in the exercise of their duty. It was the Law Commission who first suggested the definition of a vulnerable person as:

> "a person over 16 who is or may be in need of community care services by reason of mental disorder or other disability or age or illness; and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation".
>
> (Lord Chancellor's Department 1997, 8.7)

88. In the Commission's view 'harm' included not only ill-treatment (including sexual abuse and forms of ill-treatment which are not physical) but also the:

> 'impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development'
>
> (Lord Chancellor's Department 1997, 8.11)

89. The Lord Chancellor's Department 1997 Consultation Paper *Who Decides?: Making decisions on behalf of Mentally Incapacitated Adults* asked whether there was a need for new legislation providing public law protection for adults at risk. However, when the Lord Chancellor's Department eventually published *Making Decisions* (1999), its proposals for making decisions on behalf of mentally incapacitated adults, public law protection for vulnerable adults was omitted altogether. Ultimately the Law Commission's proposed Bill was largely enacted as the Mental Capacity Act 2005, but the legislation did not include the adult protection provisions of Part III of the Law Commission's Draft Bill.

90. There is inherent jurisdiction exercisable by the High Court in relation to the protection of vulnerable people as set out in Munby J's statement in *NS* v *MI* (2006) EWHC 1646:

> "The jurisdiction is to be invoked if, but only if, there is a demonstrated need to protect a vulnerable adult. And the court must be careful to ensure that in rescuing a vulnerable adult from one type of abuse it does not expose her to the risk of treatment at the hands of the State which, however well intentioned, can itself end up being abusive of her dignity, her happiness and indeed of her human rights. That said, the law must always be astute to protect the weak and helpless, not least in circumstances where, as often happens in such cases, the very people they need to be protected from are their own relatives, partners or friends".

91. Any legislation or policy guidance must, if it is to be compliant with the European Convention on Human Rights, (ECHR) address the difficult balancing exercise of providing protection to people in vulnerable situations against the risk of undermining that person's qualified right to authority over their own life.

'Section 7' Guidance

92. In 2000 England and Wales introduced policy guidance under s 7 of the Local Authority Social Services Act 1970 (*No Secrets* and *In Safe Hands*). Social services departments, were required to follow guidance unless they have a good reason

to act to the contrary (*R* v *Islington London Borough Council ex parte Rixon* [1998] 1 CCLR 119). The same does not apply to the other health, criminal justice and regulatory agencies involved. Local authorities were to 'play a coordinating role' in developing policies and procedures.

93. *In Safe Hands* defines "vulnerable adult" and "abuse." It also provides structure and content for the development of local inter - agency policies, procedures and joint protocols for safeguarding adults. The focus of *In Safe Hands* is largely on process.

DEFINITIONS OF 'VULNERABLE ADULT'

94. *In Safe Hands* applies to 'vulnerable adults', but there is a lack of consistency between this guidance, the Common Law and various statutes about how to define who is a 'vulnerable adult'.

The Definition used in *In Safe Hands*

95. *In Safe Hands* (para 7.2) defines a vulnerable adult as a person over 18

> "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

96. The concept of vulnerability used in the guidance has been criticized because it is limited to those who are in receipt of community care services. The House of Commons Health Committee in their investigation of elder abuse (2007 para 8) noted the criticism in evidence before them of the *No Secrets* and *In Safe Hands* definition:

> "as appearing to exclude those individuals who do not require community care services and who can care for themselves, because it is based on a health/social care model and assumes that the vulnerable person must be in need of external support".

The Common Law

97. The definition of vulnerability used in relation to the circumstances in which the

High Court could exercise its inherent jurisdiction in relation to vulnerable adults contains no such limitation. In *A Local Authority* v *MA NA and SA* ([2005] EWHC 2942 Fam at [55]), Munby J said that a vulnerable adult is someone who:

> "even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence; or (iii) for some other reason deprived of his capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent".

98. The position is further complicated by the fact that different statutes provide different definitions of vulnerability.

The Care Standards Act 2000

99. The Care Standards Act 2000 places a duty on persons who provide care for vulnerable adults to report to the Secretary of State for Health any worker who has been dismissed or disciplined or moved on account of conduct which has harmed a vulnerable adult or placed them at risk. Part VII of the 2000 Act provides a process whereby the worker may be placed on a list maintained by the Secretary of State of persons who are unsuitable to work in care settings, whether that be with children or adults. Under s 80(6) of the 2000 Act "vulnerable adult" is defined according to the setting the person is in. It means—

> (a) an adult to whom accommodation and nursing or personal care are provided in a care home;
>
> (b) an adult to whom personal care is provided in their own home under arrangements made by a domiciliary care agency; or
>
> (c) an adult to whom prescribed services are provided by an independent hospital, independent clinic, independent medical agency or National Health Service body.

The 2000 Act s 80(7) defines persons who provide care for vulnerable adults as—

> (a) any person who carries on a care home;

(b) any person who carries on a domiciliary care agency;

(c) any person who carries on an independent hospital, an independent clinic or an independent medical agency, which provides prescribed services; and

(d) a National Health Service body which provides prescribed services.

Youth Justice and Criminal Evidence Act 1999

100. Chapter 1 of Part II of the Youth Justice and Criminal Evidence Act 1999 provides for special measures directions in case of vulnerable and intimidated witnesses. Section 16 of the 1999 Act provides that an adult witness is eligible for assistance if the court considers that the quality of evidence given by the witness is likely to be diminished by reason of the fact

(a) that the witness—

(i) suffers from mental disorder within the meaning of the [1983 c. 20.] Mental Health Act 1983, or

(ii) otherwise has a significant impairment of intelligence and social functioning; or

(b) that the witness has a physical disability or is suffering from a physical disorder.

Safeguarding Vulnerable Groups Act 2006

101. The Safeguarding Vulnerable Groups Act 2006 seeks to bar unsuitable individuals not just on the basis of referrals but also at the earliest possible opportunity as part of a centralised vetting process to which all those working closely with children and/or vulnerable adults will be subject. Section 59 of the 2006 Act defines a vulnerable adult as someone who is over 18 and—

(a) is in residential accommodation,

(b) is in sheltered housing,

(c) receives domiciliary care,

(d) receives any form of health care,

(e) is detained in lawful custody,

(f) is by virtue of an order of a court under supervision by a person exercising functions for the purposes of Part 1 of the Criminal Justice and Court Services Act 2000

(g) receives a welfare service of a prescribed description,

(h) receives any service or participates in any activity provided specifically for persons with disabilities or who are expectant mothers,

(i) a direct payment is made to him (or to another on his behalf) in pursuance of arrangements under section 57 of the Health and Social Care Act 2001, or

(j) he requires assistance in the conduct of his own affairs :

102. The Association of Directors of Adult Social Services (ADASS) (2005) argue that the concept of 'vulnerable person' should be replaced with 'adult at risk'. The appeal of this is that it shifts the focus of responsibility for the acts or omissions of others rather than locating the cause of abuse with the victim. ADASS suggest a revised definition - an adult at risk is:

> "one who is or may be eligible for community care services and whose independence and well being are at risk due to abuse or neglect".

103. This definition does not clash with the Commons Health Committee for it would include (ADASS, 2005, p.5),

> "those people who are assessed as being able to purchase all or part of their community care services but whose need – in relation to safeguarding – is for access to mainstream services such as the police... The emphasis is now on supporting adults to access services of their own choosing, rather than 'stepping in to provide protection'".

This revised approach is reflective of the move towards the greater use of direct payments and the personalisation agenda.

104. In relation to definitions and terminology *Safeguarding Adults* records the following findings (2009, para 13):

"90% of respondents to the Consultation wanted the *No Secrets* definition of a 'vulnerable adult' revised and there was much support for replacing the term 'vulnerable adult' with 'person at risk.' Other terminology of concern to some respondents was the use of 'abuse' and 'perpetrator' when referring to the spouses of older people with dementia when what was required was more support for the carers."

The Law Commission commends the approach adopted in the Safeguarding Vulnerable Adults Act 2006, which defines vulnerability:
"purely through the situation an adult is placed [in]"

(*Law Commission 2008)*

105. Such an approach is adopted by the Adult Support and Protection (Scotland) Act 2007 which defines 'adults at risk' in s.4 as adults who:

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

(b) are at risk of harm, and

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

106. Section 4(2) goes on to provide that "An adult is at risk of harm for the purposes of subsection (1) if—

(a) another person's conduct is causing (or is likely to cause) the adult to be harmed, or

(b) the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm."

107. The term 'vulnerable' is regarded by some groups as disempowering and patronizing. The language of law can be most influential in shaping attitudes and responses. The Scottish definition makes no reference to community services and also adopts a comparative approach to vulnerability – that is, it asks whether a person is more susceptible to abuse than a person who is not affected by disability, mental disorder, illness or physical or mental infirmity.

The definition of abuse

108. *In Safe Hands* para 7.4 defines abuse as follows: - 'Abuse is a violation of an individual's human and civil rights by any other person or persons.'

- **physical abuse**: including hitting, slapping, over or misuse of medication, undue restraint, or inappropriate sanctions
- **sexual abuse:** including rape and sexual assault or sexual acts to which the vulnerable adult has not or could not consent and/or was pressured into consenting
- **psychological: abuse** including threats of harm or abandonment, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks
- **financial or material abuse:** including theft, fraud, pressure around wills, property or inheritance, misuse or misappropriation of benefits
- **neglect:** including failure to access medical care or services, negligence in the face of risk-taking, failure to give prescribed medication, poor nutrition or lack of heating.

109. The House of Commons Health Committee in their investigation of elder abuse (2007 para 14) recommended as follows:

> "We recommend that the … definition of elder abuse should be expanded to include those individuals who do not require community care services, for example older people living in their own homes without the support of health and social care services, and those who can take care of themselves. We recommend that all government departments and statutory agencies, independent bodies, charities and organisations working within the area of care for older people apply this definition of elder abuse to promote consistency and conformity throughout government and the health and social care sector".

110. Furthermore, any suggestion that there should be a distinction between the types of abuse carried out by a person in a position of trust or power and those committed by a stranger has not found favour with many of the respondents to the *No Secrets* consultation. This is because many people would be unable to distinguish between the two, for example, because of learning difficulties. Also sexual abusers, financial exploiters, unscrupulous neighbours would not be covered. Any distinction of this kind would be particularly problematical, even

unworkable in the context of the move towards self directed care. ADASS have also incorporated their plea for greater clarity of terminology and language within their 7 point plan for better safeguarding arrangements *Personalisation and Safeguarding* (ADASS 2007, para 6).

111. Most of the forms of abuse defined in *In Safe Hands* are criminal offences. *In Safe Hands* (para 7.8) states that where instances of abuse constitute a criminal offence vulnerable adults are entitled to the protection of the law in the same way as any other member of the public. In addition, statutory offences have been created which specifically protect those who may be incapacitated in various ways, for example, s.44 of the Mental Capacity Act 2005 which makes it an offence to ill treat or neglect an incapacitated person.

    "… Accordingly, when complaints about alleged abuse suggest that a criminal offence may have been committed it is imperative that reference should be made to the police as a matter of urgency. Criminal investigation by the police takes priority over all other lines of enquiry".

112. The Crown Prosecution Service has published policy guidance on how it approaches crimes against older people including the type of support or special measures available for victims and witnesses of crime (Crimes Against Older People – CPS Prosecution Policy 2008) such as screens and video links. The crimes that affect older people are listed by the CPS in an appendix to its policy document. The extensive list of offences is very specific - from assault and ill-treatment to theft and fraud, as well as deprivation of contact and harassment - and is usefully annotated with the relevant legislation.

113. The CPS policy introduces no new sanctions and essentially draws together and clarifies what should already be good practice for all vulnerable adults. However, the focus on the principle of the more serious the offence:

    "... the more likely we are to prosecute in the public interest, even if the victim says they do not wish us to do so".

    is described by the CPS as promising and sends out a clear message that the government is taking more notice of adult/elder abuse and introducing some dignity into proceedings.

Primary legislation, or guidance?

114. A key question for the review has been whether it would be better to introduce primary legislation, or to up-date guidance, or both and whether Wales should introduce its own statutory provisions?

115. The United Nations Convention on Disability Rights, ratified by the UK government in 2008 will provide a lens through which any new laws will be monitored for compliance with the Convention via Governmental periodical reports and a complaints system whereby individuals can register alleged violations (*United Nations, Convention on the Rights of Persons with Disabilities and Optional Protocol 2006).* Article 16 of this Convention makes specific reference to "Protection from Abuse and Exploitation". The fact that we do not, as yet, have comprehensive statutory measures to safeguard vulnerable adults (or adults at risk) may be regarded as untenable in terms of compliance with international law (Flynn and Brown 2009*).*

116. Moreover, the idea that independent living should be regarded as a human right is gaining momentum at both international and European levels (Parker and Clements 2008). This clearly has implications for the law and policy on adult protection/safeguarding. Commentators argue there should be a clear presumption in favour of independent living as opposed to institutional care and new legislation is required to support and facilitate this trend (Clements (2007) *The Need for New Legislation*) Legislators with their eye on future trends should factor this in to any new legislation and policy.

117. With particular reference to elder abuse, the UN General Assembly on 6th July 2009 made the following statement:

> 'Member States may wish to address the important issues of neglect, abuse and violence against older persons by initiating a nationwide review about the situation with regard to these three issues. Additionally, Member States may wish to design more effective prevention strategies, as well as stronger laws and policies to address these problems and their underlying factors.'

The challenges facing the law making process

118. Any attempt to introduce a new legislative code will have to contend with the fact that the law already regulates this area through a wide range of mechanisms including statute law, secondary legislation, common law, and

guidance. Adult protection or safeguarding adults is an area which has attracted much attention both from the legislature the courts and Government Departments. However, as Mandelstam (2009) has commented, the nature of adult protection is so ill defined in terms of both law and practice it is difficult to construct clear boundaries around what is currently an embryonic yet fast growing field. In his view (2009) the absence of dedicated comprehensive legislation such as exists in child protection adds to the problem of establishing or defining the contours of adult protection/safeguarding adults.

119. This prompts the question whether clear boundaries might be established by consolidation or codification of safeguarding laws. The Law Society's Mental Health and Disability Committee, (The Law Society, 2009) has suggested that in light of the legislative changes arising from the Mental Health Act 2007 and the Mental Capacity Act 2005, review of the existing legal framework for safeguarding adults is now overdue, as it currently,

> "does not provide a co-ordinated framework of legal protection for adults at risk of abuse or neglect".

120. Codification and consolidation would be a complex task, given that the law relevant to vulnerable people spans a vast array of legal categories including, but not limited to, the following:

i. social care and NHS functions
ii. mental health legislation
iii. mental capacity legislation
iv. s 47 of the National Assistance Act 1948
v. the regulatory arrangements for care providers
vi. the vetting and barring system for those working in the field
vii. information disclosure and confidentiality
viii. environmental health
ix. tort law including negligence, battery and false imprisonment,
x. the availability of occupation orders and non molestation orders under the Family Law Act 1996 and its provision (not yet brought into force) under s 60 for third parties to act on behalf of victims of domestic violence
xi. criminal law including theft, fraud, assault, sexual offences, manslaughter, and hate crimes

xii. offences such as sexual offences with people whose capacity to consent is impaired by mental disorder, ill-treatment or wilful neglect of people with a mental disorder or mental incapacity, and hate crimes
xiii. whether the criminal process is properly adapted to enable vulnerable people to give evidence in court.

121. As Bowen (2006) notes, in addition to the complex web of primary legislation and common law there is a huge mass of case law, regulations, directions and soft law in the form of guidance and circulars,

> "none of which is readily available except to those who are skilled in knowing where to look for it".

122. Laws exist to intervene in cases of abuse but they are to be found in a diverse range of sources, and guidance directs practitioners to the relevant provisions.

123. The Law Commission (2008) in its Adult Social Care Scoping Report has drawn a boundary between adult social care law and the law relating to safeguarding adults. The Commission recognizes there are aspects of the law relating to safeguarding which are in need of review but does not envisage it will be part of the grand consolidating reform advocated for adult social care law. This delineation is not without its difficulties. In practice there will inevitably be a significant overlap which may require a number of specific interventions, by health, social care or the police. (Kalaga and Kingston 2007)

124. Whether it is necessary to draw up new legislation in the field of adult protection/safeguarding adults or even to draw up revised guidance requires clear answers to three key questions. The first is a question of definition and language:

- How do we provide a definition of vulnerable adults or adults at risk which will provide effective protection for those adults who are in need of safeguarding, but in a way which is not stigmatizing?
- The second key question is "which laws already apply?" As the above list shows, some laws are specifically targeted to protect vulnerable adults. In other cases the adult may be relying on general criminal law or tort law, and a key question will be ensuring that general law and legal process is ideally adapted to provide protection for groups who are vulnerable or at risk.
- The final question is whether a codified statute could provide effective

legal protection by bringing together registration requirements and specific offences to protect vulnerable people, whilst at the same time providing special rules in relation to information sharing, whistle-blowing, and criminal and civil processes, which will enable vulnerable adults to enjoy effective protection of their legal rights?

125. Before proceeding to consider these issues it is important to sound a cautionary note. Manthorpe et al (2008) have argued persuasively that the creation of even the most immaculately drafted legislation will not necessarily reduce abuse and neglect without the other vital ingredients of greater resources and skills enhancement for practitioners. They also comment (Manthorpe et al 2008) that services with thresholds and eligibility criteria which are very high often result in 'professionals having to undertake more rationing or gatekeeping.'

126. Kalaga and Kingston were commissioned by the Scottish Executive to review the literature relating to interventions that are available for adults 'at risk' of abuse and harm (Kalaga and Kingston 2007). A key aim of the review was to reveal which interventions actually work. However, this endeavour was hampered by the absence of 'evidence based practice' in situations involving adult abuse. The report examines the various types of intervention – billed as primary, secondary or tertiary – yet concludes there is no one 'magic bullet.' Whilst acknowledging the huge challenge posed by the continuing prevalence of abuse of vulnerable adults in our society, the report pays tribute to the contribution played by support, inter-agency cooperation, training and education. The report was however confident that Scotland will lead the way the rest of the UK in this field with their Adult Support and Protection (Scotland) Act 2007.

127. Other recent research has highlighted the need to place greater emphasis on issues relating to implementation in order to achieve more effective outcomes (Ash 2009).

Lobbying for legislation: safeguarding adults alliance

128. In January 2009 a coalition of over 700 organisations and individuals formed the **Safeguarding Adults Alliance** as part of a campaign to urge the Government to put adult protection in England and Wales and Northern Ireland on a statutory basis. The Alliance consisted of core organizations such as Action on Elder Abuse, Mencap, the Alzheimer's Society, 53 associated member organizations and 621 individuals. A number of statutory organizations have also lent support including the Health Care Commission, The Law Society, and The Commission for

Social Care Inspection in England (CSCI). Originally, it had been expected that MIND would join, but they declined to do so because of serious concerns about any new legislation. The reason cited by Anna Bird - Mind's policy and communication manager – was that although Mind supported the Alliance's call for a statutory duty on agencies to cooperate and share information, it was more circumspect about giving professionals, including social workers, powers to enter people's homes if they had evidence that a vulnerable adult was at risk. This is one of the key goals of a number of proponents of legislation, including Action on Elder Abuse.

So should there be legislation and or new guidance?

129. For many organizations, this question about whether there should be legislation or new guidance goes to the heart of the matter. Various organizations are fully committed to the notion we need new legislation (Williams 2009).
(and see http://www.elderabuse.org.uk/Mainpages/Campaigns.htm)

130. The central aim of the Safeguarding Adults Alliance has been to campaign for new legislation and the view has been expressed that the issue of legislation was not given sufficient prominence in the consultation on *No Secrets*. Action on Elder Abuse (2009a, pp3-4) are highly critical of the failure to address the point that strategically targeted legislation offers the opportunity for the Government to reflect the priority that should be given to the rights of victims of crime and abuse. They contend that consideration of legislation was to have been a particular focus of the Review of *No Secrets*, and that it has failed to do so:

> "consideration of legislation needs to be based upon a strategic analysis of the value of legislation in comparison with guidance, and the lessons learned in other related fields. Legislation is not just about new laws, it is also about societal messages on particular issues and the extent to which the dynamics of abuse require a unique legislative approach".

131. Action on Elder Abuse state that the lessons should have been learned from the Domestic Violence, Crimes and Victims Act 2004 where the Government adopted a targeted approach to the problem. With the 2004 Act the Government recognized that existing criminal law by itself had proved insufficient and that the abuse of partners in a domestic arena required action greater than simple accessibility to criminal law. The 2004 Act, according to Action on Elder Abuse, indicated a clear recognition that, while legal remedies

may already exist, they required an additional strategic response to the realities of victims and the abuse they experienced, coupled to a societal message. (Home Office Website Home Office (2009)) Action on Elder Abuse could find no evidence that these factors had been considered either:

> "by the consultation document itself or in the consultation events undertaken by CSIP on behalf of the DH".

132. *Safeguarding Adults* records that more than two thirds of respondents (68%) supported new legislation. Of those who responded to the legislation question, 21% did not support new legislation, and 11% were undecided or made other suggestions.

133. One of the most trenchant responses was from PAVAUK who said:

> "Yes it is necessary. It would help by imposing sanctions on people who either abuse vulnerable adults or don't cooperate with local safeguarding procedures. Legislation is also necessary because it makes the moral stance that society does not accept and will not tolerate or condone the abuse of vulnerable adults".

134. Flynn and Brown (2009) are firmly in favour of legislation, especially in light of Article 16 of the UN Convention on the Rights of Persons with Disabilities. They suggest that the safeguarding responsibilities should reach beyond Local Authorities to the NHS, banks, building societies and housing providers.

135. The Law Society too unequivocally favour legislation. They state that, as an interim measure, there should be 'updated and refreshed' guidance which should be one document for all agencies. However, this should be pending the introduction of consolidating legislation which addresses the problems arising from the 'diverse and difficult' nature of existing guidance and legislation.

136. The Association of Directors of Adult Social Services (ADASS) in England endorses the need for a legislative framework to support the work of keeping people safe with the provision of powers and duties as part of a 'national approach' to the protection of vulnerable people. With regard to the criminal justice system, ADASS suggest that,

> "Legislation, codes of practice and guidance that support safeguarding and

require compliance, embedded in the inspection process from Her Majesty's Inspectorate of Constabulary (HMIC) would ensure the police are encouraged towards better integration".

137. The issue of placing Adult Safeguarding Boards/Adult Protection Committees on a statutory basis - in a manner which mirrors child protection safeguarding boards - is closely linked to the questions of whether there should be a duty to cooperate and a duty to commission and contribute to serious case reviews (SCRs). Placing such Boards/Committees on a statutory footing would clarify how they are constituted, what roles members should adopt, and would establish lines of accountability and a clear duty on agencies to share information.

138. A Commission for Social Care Inspection study has found gaps in how councils and care providers handle adult safeguarding. The study, using 23 inspections, found that only half of local adult safeguarding boards were working effectively. (Samuel 2008)

139. Recent research lends powerful support to the view that Committees should be placed on a statutory footing and there should be concomitant legal duty to contribute to SCRs (Flynn and Brown 2009). Significantly, 92% of respondents to the *No Secrets* Consultation supported placing Committees on a statutory footing. The main reasons cited were: better multi agency working, better attendance at hearings, nationally agreed protocols and procedures, greater consistency in performance, and possibly improved funding.

140. In essence, giving such Committees a statutory basis could ensure senior staff would be at the helm. The addition of sanctions and accountability would help raise the profile of safeguarding and the disparate approaches of different agencies could be better addressed with a view to lessons being disseminated more effectively. Notably, both the Health Care Commission and the CSCI were strong advocates of this proposal. PAVAUK helpfully suggested that a statutory footing should, 'include the ability to commission multi agency learning forums at a less formal level.'

141. ADASS contribute strongly on the governance issue. ADASS (2009) supports Safeguarding Adult Boards (or Committees) being placed on a statutory footing to:

'address matters of variation in terms of the structure and role of boards and thus their functioning across the country. Legislation setting out clear roles and responsibilities would remove this inconsistency'.

142. ADASS are very clear that if legislation were to set out clearly both the role of the Board and of the organisations that are required to participate this would effect change and improvement.

143. ADASS state that the work of statutory Boards should be reinforced with a duty to cooperate, and clear governance arrangements and lines of accountability to both its partners but also to government. Equally important is for the Chair of the Board to be an independent person from outside Adult Social Care in order to provide both critical challenge and hold to account the service charged with protection of the vulnerable.

144. The Scottish legislation creates statutory Boards and even specifies office holders. In terms of profile and accountability raising this send out a strong message that compliance and involvement is non negotiable.

The pros and cons of new legislation as reported in the response to the consultation on *No Secrets*

145. *Safeguarding Adults* (Department of Health 2009) summarised arguments from contributors to the consultation both for and against new legislation:

FOR LEGISLATION

- Arrangements for safeguarding children are on a statutory basis and so should those for adults be.
- Legislation would make safeguarding a higher priority, both in terms of commitment and resources.
- Similar powers should be available to those in Scotland.
- The choice and personalisation agenda needs to be balanced with the safeguarding agenda.

AGAINST LEGISLATION

- Adult safeguarding has achieved much without legislation.

- Legislation may produce the hugely bureaucratic process driven system which typifies child protection and the new Deprivation of Liberty Safeguards.
- Legislation would not necessarily lead to adult safeguarding becoming more of a priority.
- Some would like to see the Scottish legislation evaluated prior to legislating in England.
- The new Scottish powers – there was concern expressed about the new orders giving councils a right to enter and power to remove even someone with capacity who is refusing intervention.
- Choice and safeguarding – whilst there was significant support for balancing choice with safeguarding, some respondents were unsure about whether legislation might at this stage be ahead of the debate in society about the balance between choice and safeguarding.
- There is already ample legislation in existence – it should be better adhered to. Many abuses are already crimes – they should be prosecuted.
- New legislation may encourage a risk averse approach rather than support one of appropriate risk taking. Organisations may limit their efforts to compliance with legislative requirements. This may hinder imaginative working practices.
- The problem is one of profile. New law will not solve this - public awareness campaigns would be more effective.
- The main aim is to achieve better inter agency working through more effective cooperation. This is more likely to be achieved through an incentive scheme rather than new law.
- The key to effective safeguarding lies in empowerment of citizens and new law cannot deliver on this.

146. As reported in subsequent chapters of our review, the evidence from Wales yielded a different critique on the pros and cons of legislation and guidance. Evidence from Wales arguably results in a more nuanced position. For example, our conclusions would agree that empowerment of citizens is fundamental to effective safeguarding, but disagrees that the law has no role to play. On the contrary, we conclude that symbolic legislation is necessary to help promote cultural change.

147. We now turn to considering the issues concerning various specific powers and duties associated with legislation to safeguard adults.

Should there be a duty to cooperate?

148. In contrast to Scotland, in Wales there is no statutory duty on agencies to cooperate in investigations of adult abuse. The Scottish legislation imposes a duty on public bodies such as health, the police and the Care Commission to cooperate with a council making inquiries. Furthermore, where a public body knows or believes an adult is at risk and that action needs to be taken to protect that person, then the facts or circumstances must be reported to the relevant council. The Scottish Act includes the duty to make inquiries, to investigate in given circumstances and it gives powers to officials to enter premises to pursue inquiries. The carrying out of medical examinations and examination of records which is allowed under the Act – clearly legislation which has a strong interventionist ethos

149. Whilst there are examples of good collaborative practice springing up in England and Wales, there are still gaps and inconsistencies. Respondents to the *No Secrets* consultation were asked to consider whether imposing a statutory duty to cooperate would improve practice and if so how that should be enforced?

150. Of the respondents to the *No Secrets* consultation, 86% felt there should be a wider duty to cooperate on **all** agencies involved in commissioning, purchasing and provision of social and health care services and the criminal justice system. There was unanimous support from the three main partners: social care, police and the NHS. PAVA commented that this should be extended to GPs and pharmacists and enforcement would be through legislation and the regulation and inspection processes.

151. The Law Society's Mental Health and Disability Committee (2009) commented that Local Authorities should have a named individual with the statutory responsibility to enforce cooperation of other agencies. However, the Committee were more circumspect about the exact manner in which this duty should be enforced and measured, stating that the agencies involved are, "better placed to describe how this duty would be enforced and how it would improve outcomes".

152. This partially echoes the comments of the CSCI who commented that enforcement could be via self assessment, performance management objectives and/or the use of performance indicators by regulatory bodies. Whatever standards are used to promote safeguarding they should be "consolidated, clear

and robust" and linked to other guidance (Health Care Commission 2009)

153. ADASS in their response are quite clear that the work of statutory safeguarding boards would be enhanced by a duty to co operate.

154. The duty to cooperate is clearly linked to the issue of whether there is a duty to act on alerts and to share information. This is not posed as a specific question to respondents in the English Consultation. It is however, raised as an issue in the explanation to Ch 8 of the *No Secrets Consultation Document*. Unlike in Scotland, there is no statutory duty placed on local authorities in England and Wales to investigate cases of abuse (as is the case in child protection). Instead the legal basis for intervention is through a circuitous mix of common law and local authority guidance.

Duty to report / whistle-blowing

155. With regard to whistle-blowing or reporting, there is no common law duty on employees to whistle-blow. The Public Interest Disclosure Act 1998 does not create a duty to report but provides redress and protection for employees who suffer reprisals as a result of whistle-blowing within their employment. The organisation, Public Concern at Work, (PCaW 2009) have expressed their opposition to any proposal to impose a legal duty on employees to whistle-blow. The organization referred to the 'mistake' made by the Government 2004 when it extended liability in health and safety legislation for workplace accidents to employees who failed to report health and safety concerns. The legislation was, in their view deeply flawed in how it approached the issue of legal duties and resulted in an amendment to the legislation in 2006.

156. The main arguments opposing a legal duty to report, according to PCaW, are:

- It may undermine good workplace cultures. Nervous or suspicious individuals may over report to ensure individual exoneration.

- It could lead to a chilling effect where staff wait until they have irrefutable evidence before coming forward.

- It would lead to the need to ensure consistency – employers would have to invest precious time and resources in investigations of employees who knew of a risk but did not report.

- It could lead to complex legal arguments such as employers being vicariously liable for non reporting employees despite having no awareness of the risk at the time. This would lead to an increase in litigation and the growth of a blame culture.

- A duty to report would inevitably involve a duty to cooperate and employees may hang back from reporting if they feel it would lead to involvement in difficult internal inquiries.

157. The clear recommendation of PCaW is that no duties be imposed on employees or employers, but the existing framework for good practice for employers and protection for whistle-blowers be further promoted. It suggests the Department of Health introduce a policy for whistle-blowing arrangements to assist in the protection of vulnerable adults. PCaW suggest the approach of the Combined Code on Corporate Governance with respect to whistle-blowing arrangements. See ICAEW Guidance for Audit Committees – http://www.icaew.com/inder.cfm/route/118068/icaew_ga/pdf

158. During our review, the issue of whistle-blowing was a key concern from discussions with Adult Protection Co-ordinators, PAVA and a number of interviewees. The Welsh perspective on whistle-blowing is discussed in Chapter 6.

Recent case law and the duty to act

159. The existence of a common law duty of care owed by statutory agencies towards vulnerable adults has recently been considered by the Court of Appeal in April 2009. It was held that a local authority owed no duty of care in relation to its failure to transfer the couple concerned to temporary emergency housing before they were sexually and physically assaulted by local youths, even though it was aware the couple were at risk. The local authority had been actively trying to re-house them and was carrying out its statutory duties under the National Assistance Act 1948 and the Housing Act 1996, which did not give rise to a common law duty of care. This judgement by the Court of Appeal overturned the judgment of the High Court in May 2008 which had decided that the Council did owe a common law duty of care in these circumstances.

160. The House of Lords in the case of *Jain v Trent HA* (2009) concluded that care standards registration authorities did not owe a duty of care to the proprietors of a care home when exercising its statutory powers to apply for an urgent cancellation of registration. During the course of the judgment it was suggested that care standards registration authorities might owe a duty of care towards the residents of care homes. This is likely to be probed in further litigation.

161. In Re Z [2004] where a woman who was suffering from an incurable illness and wished to go to Switzerland for assisted suicide, it was held that the local authority owed Mrs Z duties under section 29 of the National Assistance Act 1948, the National Health Service Act 1977 and the NHS & Community Care Act 1990 and that they were obliged to take into account the guidance in "No Secrets" and to treat Mrs Z as a vulnerable adult. It was held that in a case such as this, the local authority incurred a number of duties, including : to investigate; to assess her competence; if competent to give all reasonable assistance to support her decision making and give effect to her best interests; to consider invoking the jurisdiction of the High Court; to alert the police if appropriate.

162. In another recent case (R ota Watts v Wolverhampton City Council – October 2009) the Court of Appeal commented that "the duty not to cause harm to individuals is not in fact a public law duty. It is a common duty of care which is owed by every person or body to individuals for whose wellbeing they are responsible". Such a duty would be owed by all providers of care, whether public or private.

The positive duty under Article 3 of the European Convention on Human Rights

163. The positive duty under Article 3 of the European Convention on Human Rights requires states to provide effective protection of vulnerable people against torture or inhuman or degrading treatment (*A* v *United Kingdom (human rights: punishment of child) 1998).* Ill-treatment of mentally disordered people and sexual abuse amount to inhuman and degrading treatment and states have a duty to provide effective protection via the criminal law. Article 3 carries with it a positive obligation on a state to provide protection through its legal system against a person suffering ill-treatment amounting to inhuman or degrading treatment at the hands of third parties. In *Z* v *United Kingdom (2001)* the European Court of Human Rights held that Article 3 had been violated because, whilst the local authority had been aware of serious ill-treatment of children

over a number of years they had failed to take any effective action. States had a duty, the Court held, to take measures to provide effective protection, in particular of children and other vulnerable persons. One aspect of the positive duty is the provision of a legal system for bringing to justice those who commit acts of violence against others. Another is the duty to investigate when the state has reasonable grounds to believe that there may be abuse breaching Article 3 or Article 8.

The positive duty under Article 8

164. In *X and Y* v *the Netherlands* (1985) the European court held that the positive obligation under Article 8 was breached where Dutch criminal law did not provide redress in respect of sexual abuse of a person with learning difficulties. One reason for this was a requirement of Dutch law that the victim must complain and that no one could act as her representative for the purposes of the criminal proceedings. The Court held that (1985, para 27):

> "This is a case where fundamental values and essential aspects of private life are at stake. Effective deterrence is indispensable in this area and it can be achieved only by criminal-law provisions; indeed, it is by such provisions that the matter is normally regulated".

165. States must therefore take steps to ensure that people with mental disorder are not denied the protection afforded by the criminal justice system to the citizenry in general. This can entail ensuring that existing criminal procedures do not operate to the detriment of mentally disordered victims, adapting criminal procedure to ensure that people with mental health problems are better able to give evidence, or the provision of special offences such as ill-treatment or willful neglect and specific sexual offences which apply where the victim has a mental disorder.

Power to enter premises

166. A more controversial question is whether there should be a new power to enter to investigate abuse in addition to those already available to the police and social services under s 17 of the Police and Criminal Evidence Act, under s 47 of the National Assistance Act 1948, or under s 135 of the Mental Health Act 1983. This question also raises wider issues such as who should exercise this power, what are the boundaries between the social care and police roles, and whether

such a power should be exercisable only on a magistrate's warrant or whether a senior police officer should be able to authorise entry.

167. There are numerous pieces of legislation which empower individuals and organizations to make interventions but it is not always clear how the various statutes work together. The existing legislation uses different terminology and definitions, raising concerns that existing powers and duties may be insufficient, too fragmented and not clear enough to fully discharge an effective safeguarding role.

168. The response to this question in the *No Secrets Consultation* differed markedly according to whether the individual has capacity or not. 60% of respondents felt there should be a statutory power to enter in circumstances where the individual lacked capacity. This figure dropped to a mere 22% where the individuals had capacity and were refusing.

169. Conferring power on professionals (police, social workers, nurses) to enter a person's home where there are concerns inevitably invokes concerns about balancing autonomy and risk and carries human rights implications. A person's Article 8 rights to respect for their home, their privacy and their family life would be engaged in circumstances where a professional is entering their home for the purposes of assessment, removal, or barring. Any interference with these rights must be justified under Art 8(2) of the ECHR as a proportionate response which is strictly necessary for the person's own health.

170. A related issue is whether the police need additional powers. At present police officers are able to enter premises under s. 17(1)(e) of the Police and Criminal Evidence Act 1984 (PACE) to save life or limb or to prevent serious damage to property. However, many safeguarding issues may fall short of this very high threshold. To lower the threshold justifying entry (perhaps to where there are reasonable grounds to believe that a vulnerable adult on the premises is being subjected to abuse) would require amendment of s.17 of PACE. A commonly held view on this point is expressed clearly by the CSCI in its response (2009) to the consultation.

> "there are complex ethical and human rights issues involved. The text in the consultation document does not provide a sufficient basis to determine this. We would expect the police to be able to enter premises under existing powers where there is information that a crime has been committed".

171. Extensive powers of entry are contained in s.135 of the Mental Health Act 1983 enabling a constable, under a warrant issued by the magistrates court, to enter, if need be by force, if there are reasonable grounds to suspect that a person on the premises is suffering from mental disorder and has been or is being, ill treated or kept otherwise than under proper control, or being unable to care for himself, is living alone. There is a power to remove that person to a place of safety for up to 72 hours if thought fit. Interestingly, this section does not specify whose decision this is. Richard Jones suggests it is the policeman's role to gain entry and to ensure the safety of the Approved Mental Health Practitioner (AMHP) and doctor. It is for the AMHP and doctor to make a decision on whether removal is necessary (Jones 2008 p.507). This reflects the view of Baroness Hale in *Ward v Commissioner of Police for the Metropolis* [2005] UKHL 32.

172. The point here is that mental disorder is broadly defined as any **'disorder or disability of the mind'**, which would probably apply to many vulnerable adults, other than those whose disabilities are physical in nature. The threshold for a person living with someone else is that they must be being ill-treated or being kept otherwise than under proper control. The breadth of scope of s 135 is one of the reasons why MIND is hesitant about seeking new powers.

173. The Law Society too express hesitancy, stating that, *"any new powers need to be very carefully considered"*. This cautionary note is sounded because any legislation would have to be Convention compliant. The Law Society emphasise the fact that if the adult lacks capacity the Court of Protection can authorise removal (and therefore entry) and some vulnerable adults will come under the inherent jurisdiction of the High Court. Little mention is made of this in the Consultation exercise.

174. Flynn and Brown argue the extreme position that

> "Powers are necessary but not sufficient because they are discretionary. There should be a duty to enter premises which only applies to police and social workers…. that duty should be enacted if there is reasonable cause to suspect that a person is suffering, or likely to suffer harm or exploitation."

175. A counterweight to this view is provided by MIND (2009) who consider that

"extending the powers of care workers to give access to people's homes against their wishes is a step too far".

176. Mind's policy and campaign manager, Anna Bird, expressed the concerns members have about the language around vulnerability and protection. She explained that it suggests they are passive and takes away their fundamental right to have control over their own lives. Mind's conclusions were that an extension of the powers of coercion would blur the line between law enforcement and care provision –social workers are advisors not enforcers.

Should this power apply to adults with mental capacity who may be self neglecting or self harming?

177. This category of people pose particular ethical problems for health and social care practice. Section 135 of the Mental Health Act 1983 enables entry in situations where a person is believed to be suffering from mental disorder and, being unable to care for himself, is living alone . The new definition of mental disorder is wide enough to encompass mental illnesses of old age, learning difficulties, and personality disorder. So what about a capable person who is self-neglecting, or self-harming who would be unable to care for himself if living alone, and would not be under proper care or control if living with someone else? The CSCI succinctly state that to extend powers would:

"inappropriately extend the safeguarding adults remit".

Should there be a power to remove adults who have capacity and do not consent? Should force be used?

178. This question from the consultation on the review of *No Secrets* poses real ethical and practical dilemmas as to where the boundary should be drawn between legitimate safeguarding practice and citizens' entitlement to respect for their autonomous decisions. Unsurprisingly, respondents to the *No Secrets* consultation were unenthusiastic in their support. Only 13% of respondents agreed that it should be possible to remove an adult without their consent. In relation to the question of the use of force, only 12% agreed this would be acceptable.

179. PAVAUK amongst others condemned the wording of the question describing it as 'inappropriate'. They drew attention to the need to distinguish between the

situation where a person lacks capacity and/or they are putting others at risk of serious harm, in which case force can be used under mental health legislation and where the person has capacity, is not putting any one at risk. In this case force should not be used. The CSCI felt there was insufficient evidence for an extension of the existing powers which allow access to merely assess and discuss options. There is a real risk that such a power may serve the interests of the perpetrator and be counterproductive.

180. Flynn and Brown acknowledge the point made by the Law Commission (Consultation Paper 130) that there is an absence of a half way house between leaving a person alone and removing them. They propose a system where social services should be able to apply for an order of limited duration which would involve daily contact with services. This is analogous to child assessment orders and although paternalistic in nature, falls short of outright removal. In essence it would operate like a 'watching brief' intervention. Flynn and Brown also state that refusal of help should not be regarded as an "immutable position". Whilst refusing help may be evidence of impairment or it may be evidence of a condition which means the person requires assistance in decision making, for example, autism. Refusal may also be the result of pressure or influence from a carer therefore should not be taken at face value. There is also the difficult ethical and legal dimension to the scenario where a person chooses to stay in an abusive relationship. In difficult situations involving issues of capacity and decision making, input from advocacy services could be beneficial.

If removal is countenanced, where to, why and for how long?

181. This question in the *No Secrets* consultation attracted a range of views but the consensus was removal should be treated very seriously. It is recognized that there are already powers under s.47 of the National Assistance Act 1948 to remove a person to a suitable hospital or other place. Research carried out in the 1980's revealed this Act was rarely used by some authorities and not at all by others (Nair and Mayberry) and it was quite inappropriate that such ancient legislation should be used in such a sporadic and unreported fashion (Muir:1990)

182. The Law Commission have raised the point in their Adult Care Scoping Report about the compatibility of detentions under s.47 with the ECHR (para 4.301). Under s.47 there is the possibility of removal for a lengthy period of time as a result of a hearing at which the person may not be present on the authority of

limited medical evidence. This may engage Art 5 ECHR requirement that a detention on the ground of unsoundness of mind must be based on objective medical opinion (Winterwerp v Netherlands) Also anyone deprived of their liberty shall under Article 5(4), be entitled to speedy review of that detention. The provisions in s.47 may not be sufficient and the UK Government may find itself vulnerable on this point (HL v UK 2005)

183. Furthermore, removing a person with capacity from their home without their consent potentially offends Art 8 of the Convention.

184. In reality people without capacity would be dealt with under the deprivation of liberty safeguards pursuant to the Mental Capacity Act 2005.

185. Respondents to the Consultation typically recorded caution on this issue. PAVAUK said the question was "too woolly" but if removal was a real probability, the warrant should record full details relating to why removal was being considered, where it would be to, and the duration – suggested as being for no more than 7 days.

Legal principles

186. Some of the most compelling arguments for legislation are that it would provide a clear legal basis for adult safeguarding, that clear legal duties and powers would lead to the commitment of resources, and that the legislation could include principles which would demonstrate the importance attached by society to protecting vulnerable adults. The complexities of safeguarding lack clarity because of the absence of any overarching principles which could assist agencies and practitioners in their work. Adult protection does not benefit from a set of statutory principles equivalent to those which guide the law and practice of child protection (the Children Act 1989) and adoption (the Adoption and Children Act 2002). The use of principles is becoming increasingly popular in other jurisdictions such as Scotland, Canada and Australia. Both strategic and operational objectives may be better served by the existence of strong, clear guiding principles which are accessible to all. The Mental Capacity Act 2005 with its statutory principles is regarded as something of a flagship in this regard. Section 1 of the Mental Capacity Act 2005 sets out five statutory principles. They are:

A person must be assumed to have capacity unless it is established that they

lack capacity.

A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

187. The Mental Capacity Act Code (Department of Constitutional Affairs, 2007, p 19) describes the role of principles, as being to state:

"the values that underpin the legal requirements in the Act. The Act is intended to be enabling and supportive of people who lack capacity, not restricting or controlling of their lives. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so."

188. The **Adult Support and Protection (Scotland) Act 2007** is based on principles set out in ss 1 and 2. Section 1 outlines the 'general principle on intervention in an adult's affairs' which is that 'a person may intervene, or authorise an intervention, only if satisfied that the intervention—

(a) will provide benefit to the adult which could not reasonably be provided without intervening in the adult's affairs, and

(b) is, of the range of options likely to fulfill the object of the intervention, the least restrictive to the adult's freedom.'

189. Section 1 'applies for the purposes of section 2 only.' Section 2 lists a further set of principles for performing functions under Part 1 of the Scottish Act, including the 'general principle on intervention in an adult's affairs'. Section 2 places a

duty on any 'public body or office-holder performing a function under this Part in relation to an adult, if relevant, to have regard to the following: —

(a) the general principle on intervention in an adult's affairs,

(b) the adult's ascertainable wishes and feelings (past and present),

(c) any views of—

(i) the adult's nearest relative,

(ii) any primary carer, guardian or attorney of the adult, and

(iii) any other person who has an interest in the adult's well-being or property,

which are known to the public body or office-holder,

(d) the importance of—

(i) the adult participating as fully as possible in the performance of the function, and

(ii) providing the adult with such information and support as is necessary to enable the adult to so participate,

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

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

The position in England: *Reform Issues - the Wider Context and Implications for Wales*

190. The Law Commission's ambitious review of the entire field of adult social care law led to the conclusion there is a pressing need for reform because the legal landscape is complex, confusing and voluminous. There are areas of law which are outdated and often based on discriminatory concepts with insufficient consideration given to human rights concerns and principles of equality.

(Scoping Report para 2.58) These comments apply no less to the law regarding safeguarding adults. A reform agenda of this area would seek to achieve the following aims:

Simplification

191. A clear and cohesive legal framework which would facilitate all stakeholders in understanding their entitlements and responsibilities. Law which is complex and obscure may deter professionals from acting as they may be unsure of their legal ground. It will also be inaccessible to many citizens - especially those who lack the financial, emotional, intellectual, or educational resources to challenge the current legislative regime (Clements 2007).

192. There is a crucial constitutional principle at stake here. In his seminal lecture on the Rule of Law, Lord Bingham stated that to satisfy the requirements of the modern state, law should be 'accessible....intelligible, clear and predictable' (Bingham LJ: 2006)

193. The same issues were addressed by Lord Justice Thomas in Cardiff Law School's Annual Lectures in his examination of devolution in its wider context (Thomas LJ 2008). He emphasised issues that arise in ensuring that the rule of law prevails through a clear understanding of the position of the framework within which laws are made, enacting laws that are capable of being applied and understood and thereby the provision of effective access to justice.

194. His was a timely and relevant reminder that devolution has presented both challenges and opportunities in the law making arena. Grafting additional provisions upon existing UK statutes could achieve some recognition of the Welsh legal and policy dimension. A decision to take the initiative beyond mere revision of policy guidance would require political drive commensurate to the challenge. The Welsh Assembly Government would need to commit the requisite resources and expertise to ensure the success of such a high profile development.

Consistency and transparency

195. Safeguarding of adults is bedevilled by inconsistency and overlapping laws. Greater legal clarity could be achieved were the law to be consolidated or codified, particularly if the improved law were to incorporate clear statutory

principles. This would achieve a clear steer as to the guiding principles and philosophies which should inform this most sensitive area.

Modernisation

196. Should the Welsh Assembly Government consider any significant legislative development of its own it should pay heed to the need to enshrine principles which eradicate discriminatory and stigmatizing concepts that unfortunately persist in the current law. The European Framework Directive gives a very clear steer on the parameters within which any future legislative efforts must operate. It may not be sufficient to claim that the existing Disability Discrimination Act 1995 and the Human Rights Act 1998 are satisfied.

Conclusion

197. Any consideration of the statutory regime must focus on producing law which is simple, accessible, fair, modern and cost effective. The specific types of law reform specified in the Law Commission Act 1965 are the removal of anomalies, repeal of obsolete and unnecessary enactments, consolidation and the simplification and modernization of the law (scoping report para 3.11)

198. The Law Commission intend publishing their report on the *No Secrets* consultation in January 2010. It is also their intention to draft a Bill consolidating the law relating to adult social care. There will be section of this Bill allocated to the safeguarding of adults at risk/vulnerable people.

199. They are also assessing the implications of s.7 of the Local Authority Social Services Act 1970. There is real concern that existing policy guidance does not give sufficient force in law and this could render the Government open to challenge under the Human Rights Act.

Support for new legislation in Wales

200. There appears to be very strong support in Wales for new legislation and updated policy. The ICM poll (2009) based on a random sample of 1330 people from all age groups in Wales, commissioned by Age Concern Cymru and Help the Aged in Wales found that 93% believed there should be legal protection to safeguard vulnerable adults in Wales, similar to that which exists in Scotland. Many respondents to our survey, and nearly all of the contributors to the

fieldwork for the review *of In safe Hands* expressed their wish for clear law with modern terminology/definitions, better inter agency working, a higher profile for safeguarding matters, statutory duties to cooperate and share information, a duty to investigate and clarification of duties to act on alerts. Where there is less enthusiasm for an extension of powers is with regard to vulnerable people with capacity who may be refusing help. Clearly, this is a most sensitive area. It will involve achieving a very delicate balance between the state's obligation under Art 3 of ECHR (to protect citizens from inhuman and degrading treatment) and respect for the individual's right for privacy and self determination under Art 8 of ECHR.

201. The Law Commission are watching potential developments in Wales with keen interest and were represented at the review's Stakeholder Workshop. Reform of the law relating to vulnerable people has been on the reform agenda for almost 20 years. Scotland has already seized the nettle. The Scottish Act draws considerably on the model provided by the English Law Commission in Part III of its Draft Incapacity Bill (Law Commission 1995). Both would provide an excellent starting point for the drafting of Welsh legislation if this is the route that Wales takes.

202. Consideration of the various methods by which the Welsh Assembly Government may enact its own legislation for the protection of vulnerable adults raises major policy and procedural issues. If new legislation is to be put in place, the timescales involved argue for new guidance to be put in place in advance to make improvements that do not rely on legislation and to prepare for the implementation of new legislation as soon as it can be enacted.

BACKGROUND TO THE SURVEY FINDINGS

203. On 14 July 2009 an online questionnaire was forwarded to statutory partners in Wales with a principal role in adult protection, namely:

- All local authorities
- All NHS trusts
- All local health boards
- Police leads of the regional adult protection forums

204. The questionnaire was in two parts. Part one surveyed information about adult protection services within organisations and about interagency working in their localities. Part two sought opinions about the future direction that policy on adult protection should take. The closing date for submission of completed questionnaires was 11 August 2009.

205. WIHSC and the Care and Social Services Inspectorate Wales (CSSIW) worked closely together to ensure that this survey did not duplicate requests for data/information from local authorities and other stakeholders; so the questions posed did not seek prevalence data, nor did CSSIW issue a separate survey as part of its national inspection of adult protection.

206. The results of the survey were followed up during our fieldwork, including in qualitative interviews, the local studies, the stakeholder workshop and phase 3 focus groups. When insights gained later in the study help to explain survey findings these are included in the discussion in this Chapter on survey findings.

OVERALL RESPONSE

207. The survey was forwarded to 57 organizations in Wales.

208. We received 36 responses, an overall response rate of 63%. This can be considered a good response, especially in view of the length and complexity of the questionnaire. Of these the response was as follows:

- 22 (100%) of local authorities
- 4 (44%) of NHS trusts

- 7 (32%) of local health boards
- 3 (75%) of police services

209. The rather lower response rate on the part of NHS organisations than on the part of local authorities and the police was an interesting diagnostic in itself. The details of the survey and qualitative interviewing indicated that the engagement of the health service in safeguarding adults is considered to be patchy – highly effective in some parts of Wales, but less effective in other areas. Other factors that were put to us as playing a part were:

    - The questionnaire was sent to the Chief Executive of each health organisation. Communications within NHS organisations, particularly those that did not have their own adult protection co-ordinator, team, or equivalent seems to have been problematic; and
    - The survey coincided with reorganisation of the NHS in Wales over the summer of 2009.

SURVEY RESULTS

210. Because the population size for the survey (n= 57) was limited by the number of relevant statutory organisations in Wales and because the organisations surveyed were not a random sample, results from the survey shown as percentages, or as numbers of respondents are descriptive rather than generalisable.

211. The survey was lengthy and very detailed, so this report reflects only key findings.

PART ONE RESULTS: LOCAL AND INTERAGENCY WORKING

MONITORING AND REVIEW OF LOCAL POLICIES PROCEDURES AND PRACTICE

212. We asked how frequently a number of policies and procedures were monitored for day to day management purposes; and how often they were reviewed to consider whether they needed to be revised, or replaced. We also asked who was involved in monitoring and reviewing policies and procedures and how policies and procedures were working in practice. The policies we asked about were:

- Adult protection
- Complaints
- Whistle-blowing
- Induction
- Disciplinary
- Grievance
- Unified assessment
- Risk assessment.

213. Whilst these policies and procedures were each separately reported to be fairly effective on the whole, the results showed a lack of consistency in the frequency of monitoring and review of these policies and in who was involved in monitoring and review of policies and practice both within organisations and across Wales. This would suggest that information from each of these sources is not necessarily being brought together systematically to look at the implications for safeguarding adults. This proposition was borne out in our field work. One of the issues that frequently emerges in Serious Case Reviews involving serious harm to children, or adults is that there was information known between and within various organisations, but it was not brought together in a consistent way – so no one had all of the pieces of the jigsaw together.

214. We have come across instances of good practice where some authorities are systematically bringing intelligence together from a wide range of sources including:

    - adult protection and other policies that have a bearing on adult protection;
    - commissioning
    - contract monitoring
    - the regulators and
    - partner agencies.

    This should become the rule, not the exception.

REFERRAL AND RESPONSIVENESS

215. Questions about how effective local policies and procedures were in:

- identifying people who needed to be referred into adult protection arrangements; and
- how effective arrangements were once people had been referred

showed that there was more confidence about arrangements for some groups of people than others. Over 80% of respondents thought that services were fairly effective, or highly effective in identifying people that needed to be referred into adult protection services and in their arrangements after they had been referred for the following groups:

- Adults with physical disabilities
- Adults with sensory disabilities
- Adults with long term health problems
- Older adults
- Adults with mental health problems other than dementia
- Adults with dementia
- Adults with learning disabilities

216. In a minority of cases, however, identifying those in need of referral or services were recorded as fairly ineffective, or (in the case of homeless adults) highly ineffective. Those where more than 10% of respondents recorded that referral was fairly, or highly ineffective, or where respondents did not know were as follows:

Adults with mental health problems other than dementia

	Number of responses	% of responses
Fairly ineffective	4	11%

Adults from Black and Minority Ethnic Communities (18-64 years)

	Number of responses	% of responses
Fairly ineffective	10	28%
Don't know	11	31%

Adults from Black and Minority Ethnic Communities (65 + years)

	Number of responses	% of responses
Fairly ineffective	11	31%

Adults who misuse substances

	Number of responses	% of responses
Fairly ineffective	10	28%

Homeless adults

	Number of responses	% of responses
Fairly ineffective	10	28%
Highly ineffective	2	6%
Don't know	4	11%

Post-referral, the effectiveness of services for these groups is shown as improving somewhat, but of the groups tested in the survey they remain relatively the most disadvantaged in the current arrangements.

217. Our fieldwork has tended to support these findings, but with the caveat that people with mental health problems and learning disabilities under-report abuse because they do not think they will be believed. In this context, the perception of statutory agencies about effectiveness in identifying people in need of referral may be under-estimating the number of those in need from these groups. Interviewees suggested that some groups not specifically included in the survey were particularly marginalised; for example people who were from BME communities and who also had mental health problems; and older people from Lesbian, Gay, Bisexual and Transgender communities.

218. It is important to note that the local authority areas in Wales with the largest BME communities were on the whole more confident their referral and post-referral arrangements were at least fairly effective than those authorities with smaller BME communities - although, our fieldwork suggested that disclosure from within BME communities was culturally very challenging. In focus group work with BME communities as part of the *No Secrets* consultation, even acknowledging that abuse could take place was a difficulty. Accessing safeguarding systems was also considered problematic in some cases because of perceived issues connected with immigration status.

219. The incorporation into the definition of 'vulnerable adult' in *In Safe Hands* that they must be someone:

> "who is or may be in need of community care services"

may partly explain that there is relatively less confidence about the effectiveness of services for people who are in vulnerable situations and at risk of abuse, but who are less commonly receiving community care services than for example older people, such as substance misusers and homeless people.

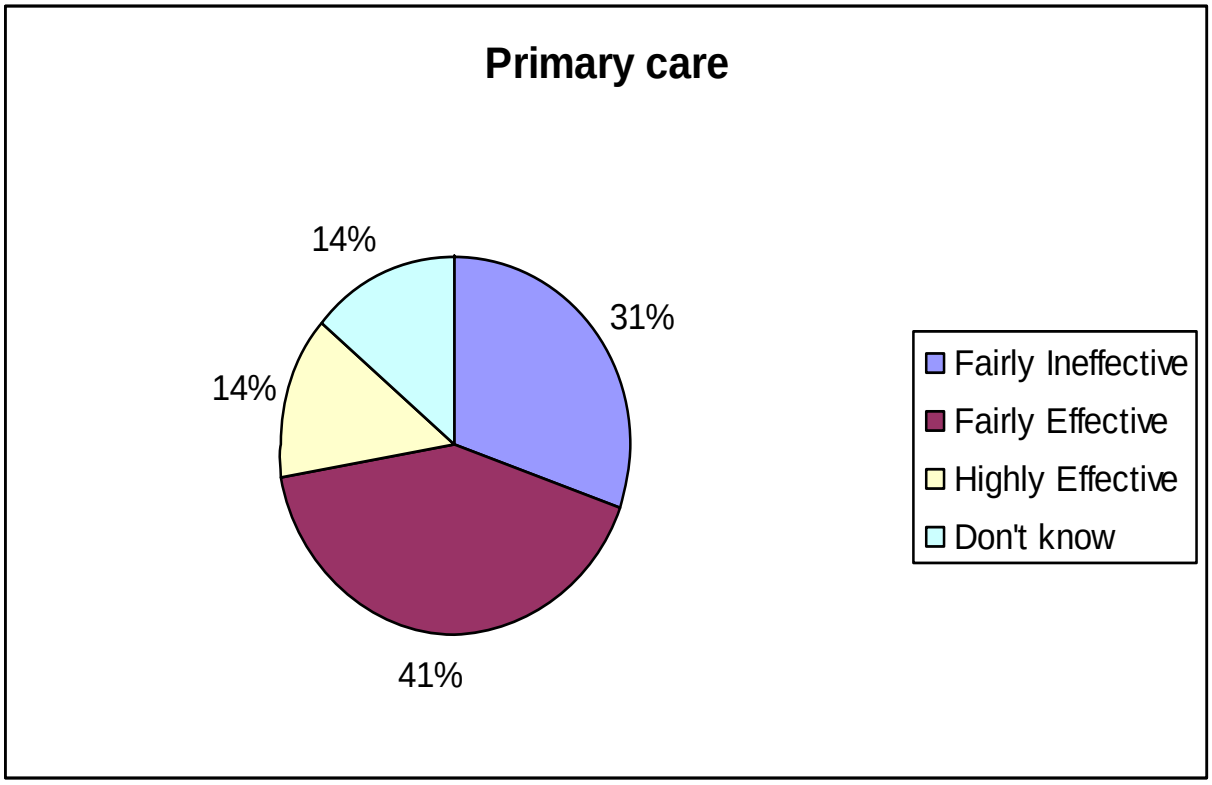
INTERAGENCY WORKING

220. Interagency working between local authority social services and the following interagency partners was viewed as fairly effective, or highly effective by the majority of respondents:

- the police
- NHS trusts
- local health boards
- community health services
- local authority housing
- adjacent local authorities
- voluntary sector care providers
- private sector care providers
- local adult protection committees
- regional adult protection forums
- All Wales Adult Protection Advisory Group
- Local Safeguarding Children Boards
- CSSIW (3 respondents (8%) recorded fairly ineffective relationships between social services and CSSIW)
- The population served

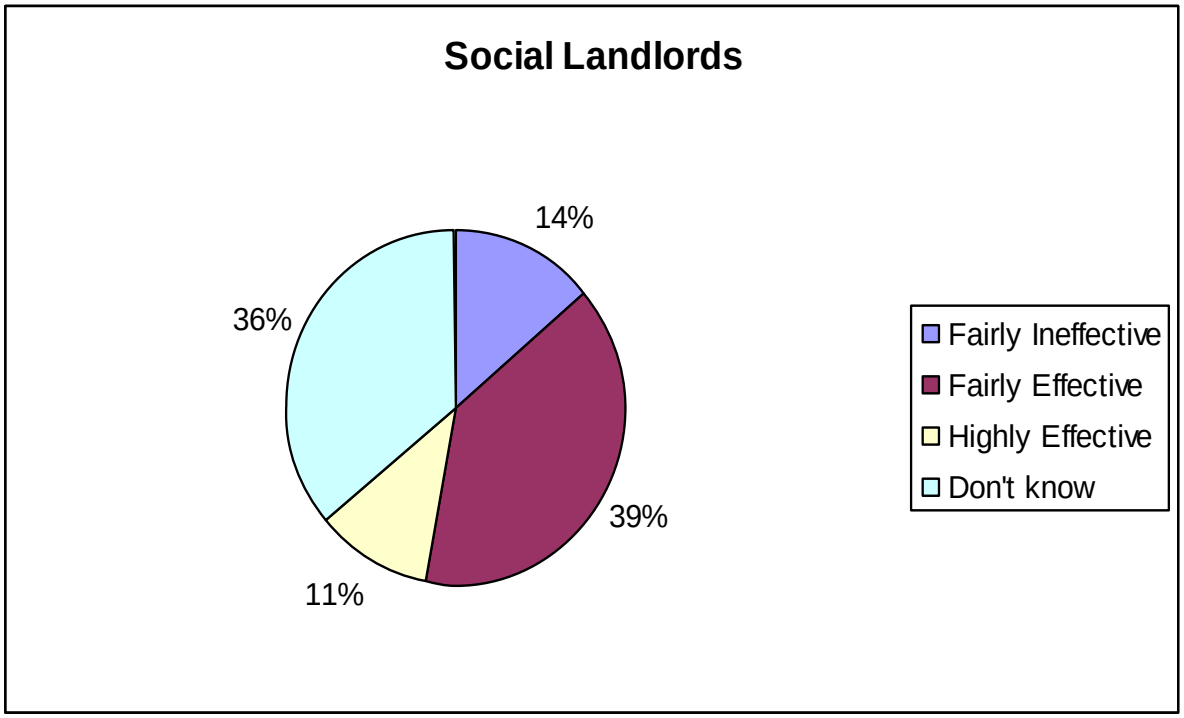
There was a more mixed picture in other cases:

Figure 7 | Primary Care



221. Our fieldwork confirmed that whilst in some parts of Wales, relationships with primary care were highly effective, more commonly, concerns were expressed about:
    - whether primary care was screening for abuse (screening in primary care is advocated by the World Health Organisation (2008) as a vital safeguard for victims who may not be linked in to other services);
    - whether primary care practitioners were considering whether adults had symptoms that could be attributed to abuse;
    - whether practitioners were fully aware about and acting on the fact that information sharing with interagency partners is legitimate in cases of suspected, or actual abuse; and
    - practitioners often did not commit to being fully engaged in adult protection arrangements, including taking part in strategy discussions, strategy meetings and case conferences.

Figure 8 | Social Landlords



222. There is some evidence of developing relationships between adult protection and housing providers in Wales, including initiatives such as assessing the vulnerability of tenants prior to a tenancy being taken up. The need to take into account safeguards for people at risk when transferring housing stock to social landlords has also been flagged.

223. It is not uncommon for housing officers to make adult protection referrals. Care and repair have also made referrals in to adult protection procedures and it is important for their staff as well as staff from local authority housing departments (including trades) to have awareness training. Pooling information is important in the context that an adult regarded as being at risk by social services, may be being flagged as 'a nuisance' to housing officers. There are examples of housing officers being on Adult Protection Committees.

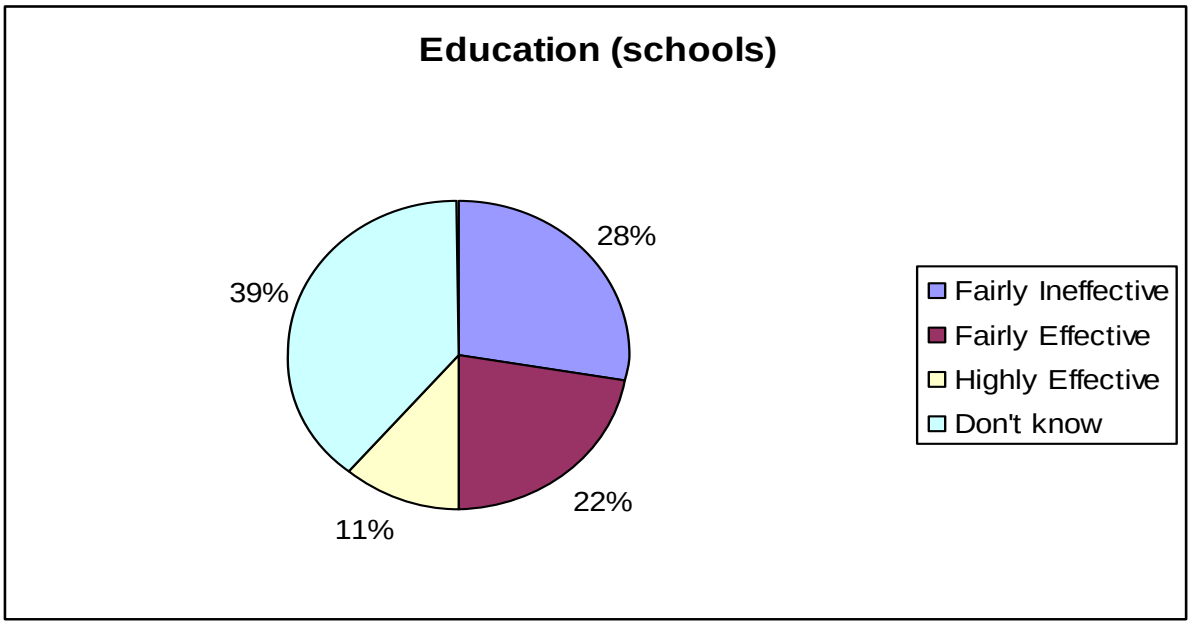
Education

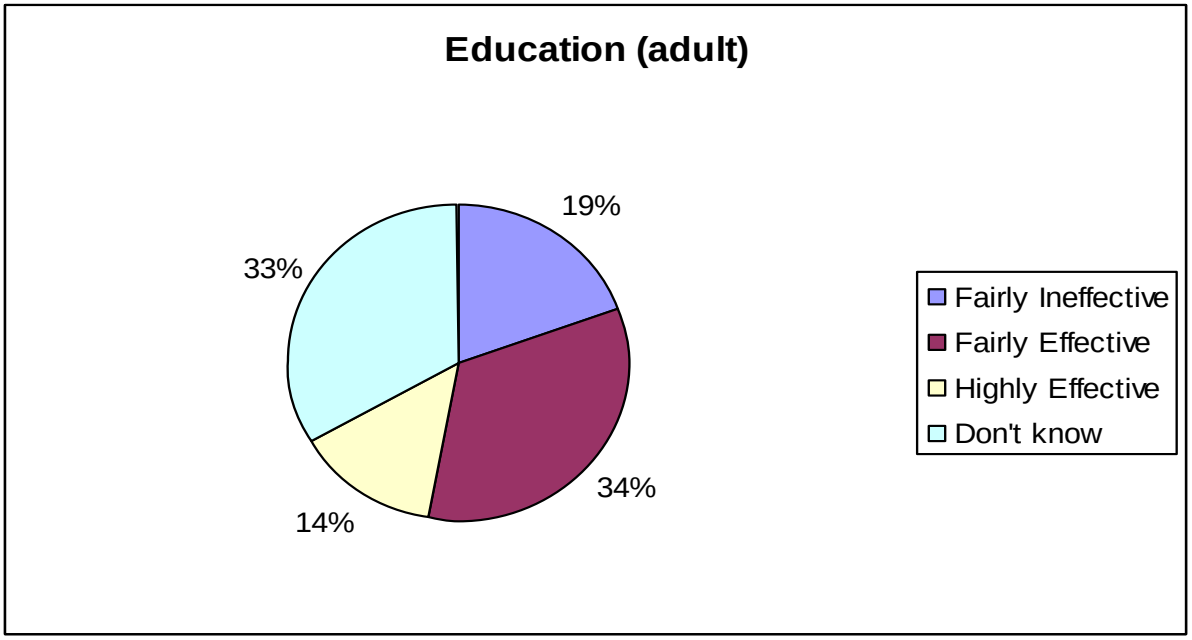
224. An important concern underlying relationships with education was in managing the transition from children's services to services for adults more effectively. It was also the case that some people who have special needs may stay in Special Schools beyond the age of 18 years. Representation from adult services on Local Safeguarding Children's Boards has been found to contribute to managing

these transitions better. The change in accessibility to services at 18 may increase risk, for example because of not necessarily being able to continue to access respite care.

225. Links between adult protection and adult education were considered somewhat better than the links with school-age education.

Figure 9 | Education

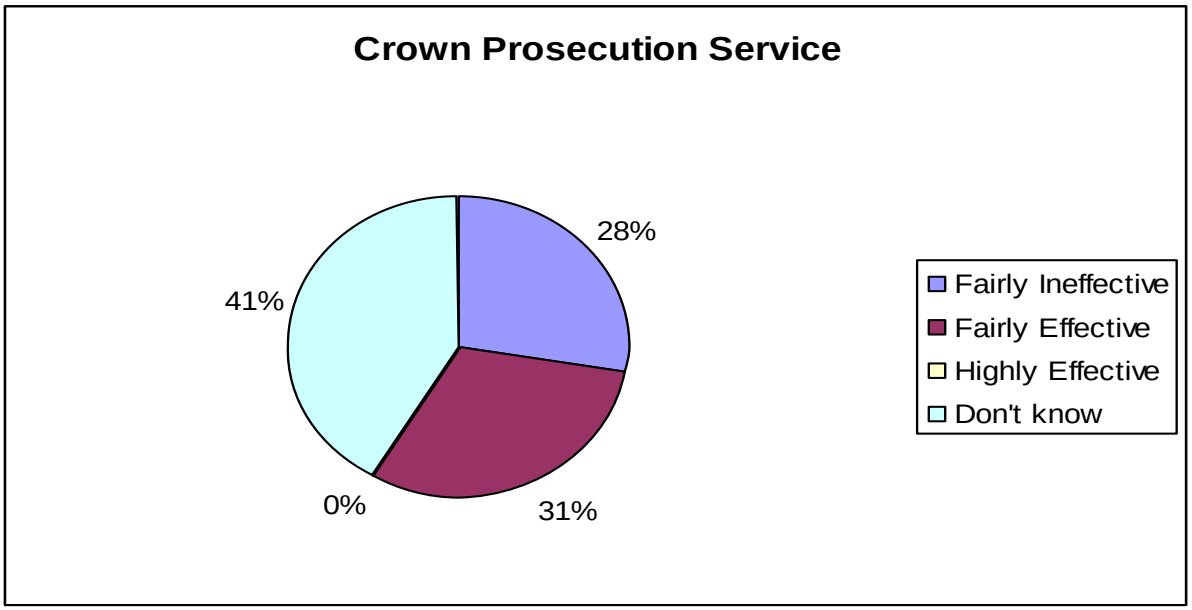


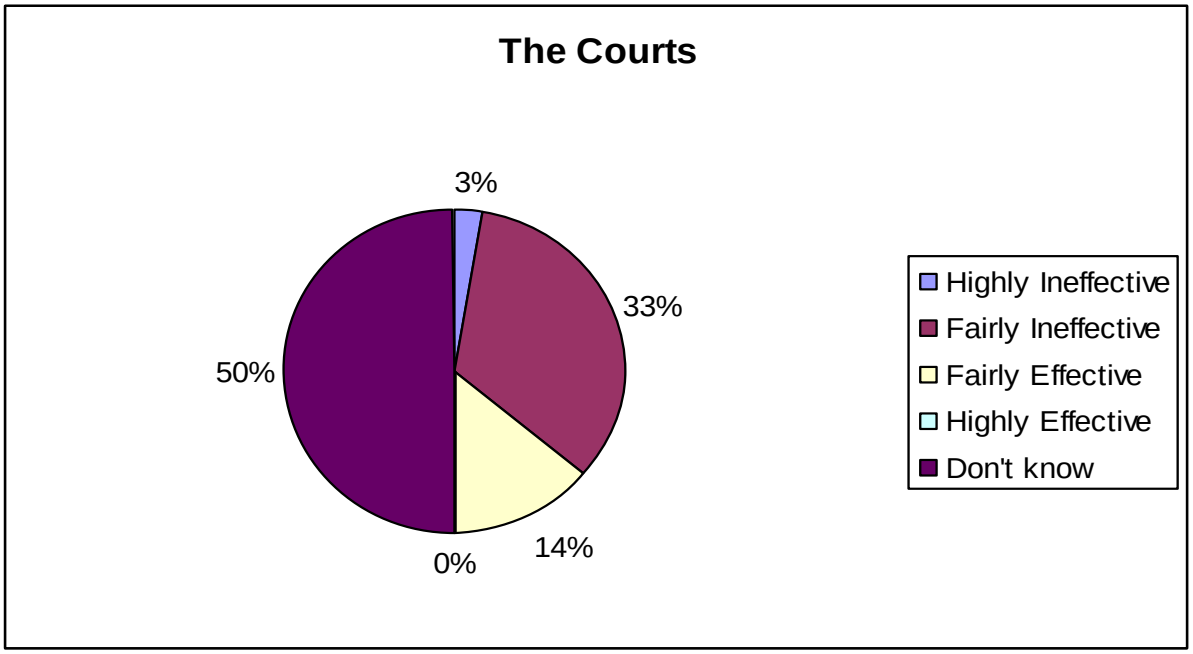


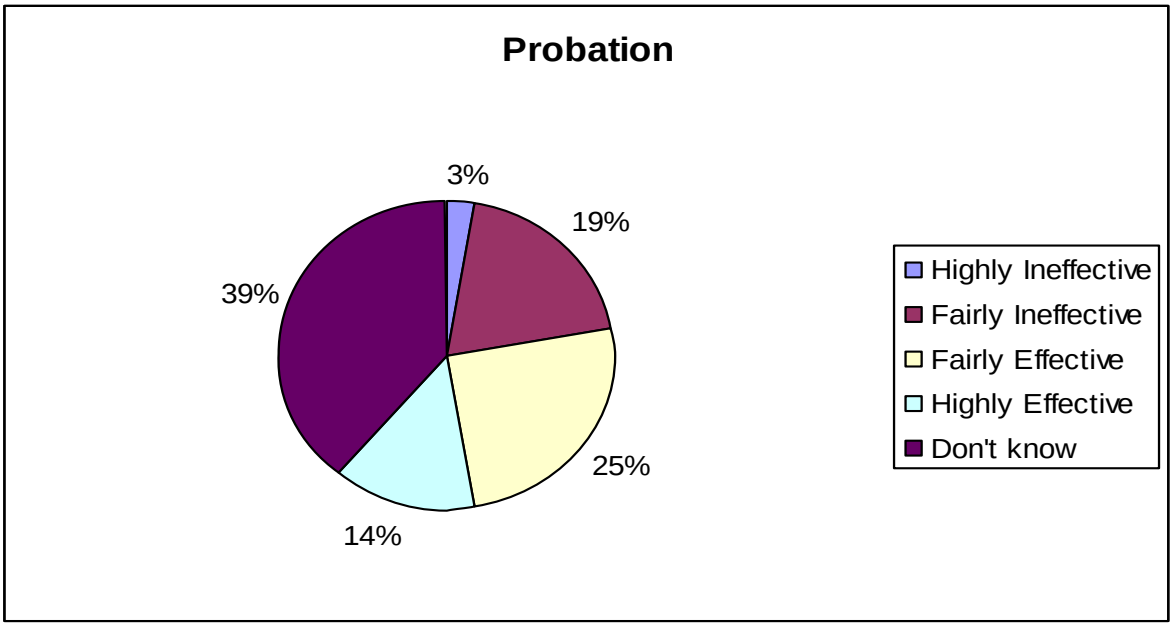
Criminal Justice System

226. In the context of the concerns from the focus groups about lack of access to justice, it is interesting that survey responses reinforce that there is work to be done in engaging adult protection with the CPS, the Courts and the probation service, as illustrated in the following three charts:

Figure 10 | Criminal Justice System







227. Respondents were also asked about the links between adult protection and:

- arrangements for public protection (MAPPA)
- multi-agency risk assessment conferences (MARAC)
- services dealing with domestic abuse

There was a mixed picture with up to 25% of respondents reporting fairly, or highly ineffective arrangements, compared with up to 30% reporting highly effective arrangements.

Adult Protection Committees: Seniority

228. A recurring issue from the fieldwork was that it was sometimes problematic to engage people of sufficient seniority to attend Adult Protection Committees, and for people who did attend to be sufficiently senior to commit their own organisation to courses of action. In the survey 20% of respondents said that ensuring people of sufficient authority attended was fairly ineffective, or highly ineffective. 47% reported their arrangements to be fairly effective.

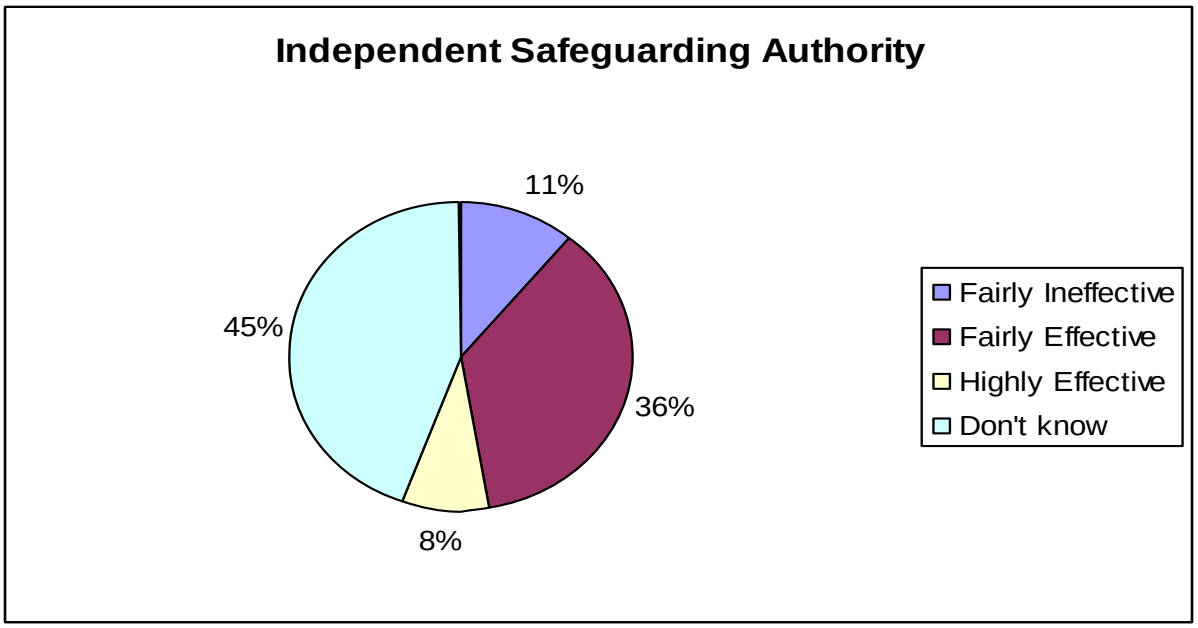
Independent Safeguarding Authority (ISA)

229. The ISA is a key component in safeguarding arrangements in England, Wales and Northern Ireland. There is a rolling implementation programme in response to the Safeguarding Vulnerable Adults Act 2006. The ISA already has responsibility for maintaining lists of people barred from working with vulnerable adults,

which replace the Protection of Vulnerable Adults (POVA) scheme. In due course those working with vulnerable adults (except in private arrangements not involving employees of companies, or voluntary sector organisations) will have to be registered with the ISA. That the relationship with the ISA is unknown by 45% of respondents reflects the newness of these arrangements.

There is further discussion of the ISA in Chapter 6.

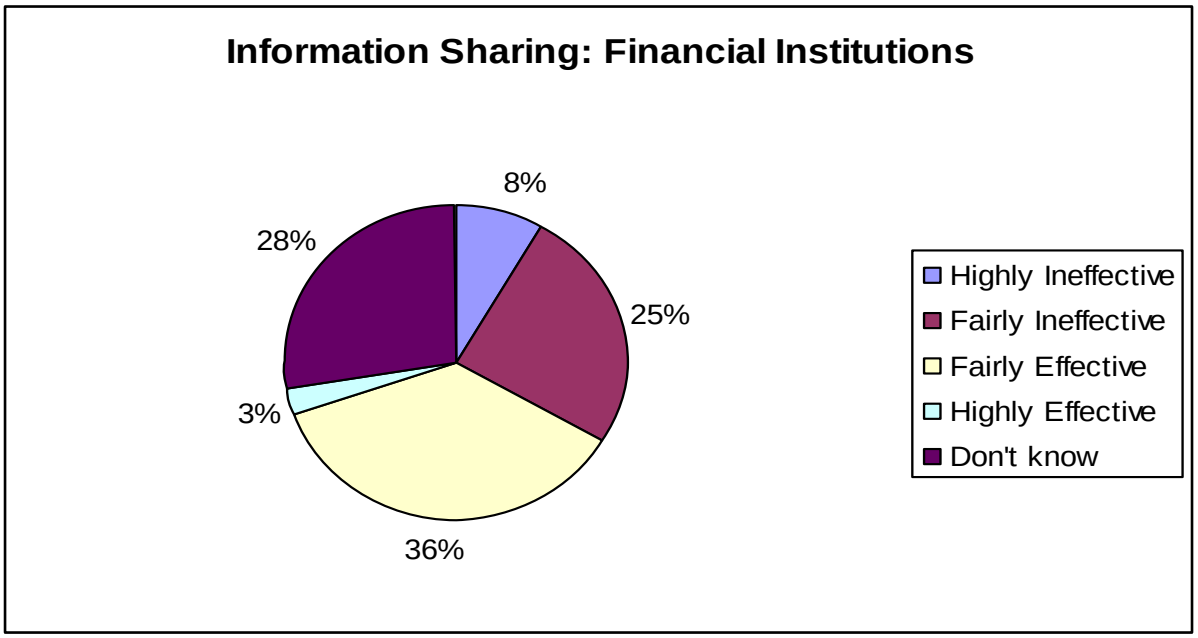
Figure 11 | Independent Safeguarding Authority



INFORMATION SHARING

230. The pattern of responses in relation to the effectiveness, or otherwise of information sharing more or less mirrored the results on the overall relationship between social services and other organisations. We asked specifically about information sharing in relation to banks, building societies and other financial institutions to prevent or deal with suspected, or actual financial abuse:

Figure 12 | Information Sharing: Financial Institutions



That 61% of respondents recorded information sharing with financial institutions as fairly, or highly ineffective, or they did not know is part of a pattern of wider concerns about financial abuse – a theme to which we return in Chapter 6.

231. Taking action required as a result of shared information was considered to be fairly, or highly effective by 89% of respondents.

Feedback

232. Giving feedback when action results from information sharing, including to the person originating the referral was reported as:

- 3% highly ineffective
- 17% fairly ineffective
- 50% fairly effective
- 19% highly effective

233. Lack of feedback to victims of abuse at all stages and lack of feedback to independent care providers, were consistent criticisms from other strands of the review.

LEARNING LESSONS AND SERIOUS CASE REVIEW

234. The arrangements for sharing good practice and learning lessons from:

- Disclosure
- Complaints
- Whistle-blowing

were reported to be fairly, or highly effective by 86% of respondents. 14% reported arrangements to be fairly, or highly ineffective.

235. Whilst most (81%) thought there was clarity about when a serious case review should be undertaken, 20% thought that there was not. A small minority (8%) thought that learning the lessons from Serious Case Review was fairly, or highly ineffective. The majority (53% thought current arrangements were fairly effective.)

WORKFORCE

236. 64% of respondents had either a full time or part time adult protection co-ordinator, but 47 % had no adult protection team.

28% had one administrative member of staff to support adult protection work. 53% had 2 or more administrative support staff.

47% had an adult protection champion.

All local authorities have a full time or part time co-ordinator, or equivalent and all 4 police services have an adult protection lead. Such posts are apparently less common in the health service.

TRAINING

237. The delivery of awareness training and specialised adult protection training varied considerably both in terms of frequency of training opportunities and which groups are currently offered training. Most training seems to be offered either annually, or on 2-5 year rolling programmes, It is noteworthy, however, some respondents recorded certain groups as **never** having had awareness training:

- 6% of respondents never gave frontline staff awareness training
- 14% of respondents never gave administrative staff awareness training

238. Whilst specialised training was recorded as **never** being offered to the following groups:

- 19 % of respondents never gave senior managers involved in policy development specialised training
- 14% of respondents never gave senior managers involved in managing adult protection service delivery specialised training
- 14% of respondents never gave frontline staff specialised training
- 17% of respondents never gave 'designated managers'[3] specialised training
- 25% of respondents never gave administrative staff specialised training

239. Some, but not all local authority adult protection services were recorded as offering training to the following groups, at least on an ad hoc basis :

- Voluntary sector providers
- Private sector providers
- Court diversion scheme staff
- Police officers
- Probation service
- Housing (Local authority)
- Housing social landlords
- Commissioning staff local authority
- Commissioning health
- Health service staff (NHS Trusts)
- Personal assistants to people using direct payments
- Multi-agency training in adult protection

[3] Non specialist staff who may investigate abuse and chair strategy meetings/case conferences

PART TWO RESULTS: POLICY, LEGISLATION AND GUIDANCE

IN SAFE HANDS

240. Overall, 83% of respondents considered *In Safe Hands* to be fairly effective in protecting adults from abuse. Within this:

- 47% thought *In Safe Hands* to be fairly (44%), or highly (3%) ineffective in supporting vulnerable adults in seeking redress.
- 25% thought *In Safe Hands* fairly ineffective in supporting those abused to access treatment.
- 14% thought *In Safe Hands* to be highly effective in supporting over-stretched carers - whereas 17% thought it fairly ineffective.
- 14% thought *In Safe Hands* to be highly effective in taking action against perpetrators - whereas 17% thought it fairly ineffective.
- 19% thought *In Safe Hands* highly effective in having a consistent approach irrespective of concerns being raised through complaints, regulation, whistle-blowing, or disclosure – whereas 11% thought it fairly ineffective.
- 19% thought information sharing between agencies was highly effective – whereas 11% thought it fairly ineffective.

241. Free text comments suggest that some of the factors in rating the policy as fairly effective, rather than highly effective are:

- it needs to be updated; and
- there is not enough emphasis on prevention and addressing underlying causes of abuse.

DEFINITIONS

242. For the sections on definitions and guidance/legislation respondents were asked in relation to a series of statements do you:

- Strongly disagree

- Tend to disagree
- Tend to agree
- Strongly agree
- Don't know ?

243. The main findings were as follows:

"The current definition of 'vulnerable adult' should continue to be used"

64% agreed (53% tended to agree, 11% strongly agreed)

33% disagreed

"The definition of 'vulnerable adult' should be broadened to cover all vulnerable adults, whether or not they are in need of community care services"

56% disagreed (36% tended to disagree, 19% strongly disagreed)

45% agreed (28% tended to agree, 17% strongly agreed)

244. The statutory agencies began from the perspective that to widen the current definition could lead to services being overwhelmed. Findings later in the survey on using the label 'vulnerable' and the possibility of creating a new definition de-coupled from community care services (tested at the stakeholder workshop) led to changing perspectives on these two statements.

"It is disempowering, or demeaning to describe an adult as 'vulnerable'"

53 % disagreed

42% agreed

"A person's vulnerability varies over time depending on the circumstances they are in and a person should not necessarily be described as 'vulnerable' because of characteristics such as age, illness and mental, or other disability"

75% agreed (33% strongly agreed)

"A needs-based approach should be put in place to respond to circumstances where it is necessary to prevent or protect against abuse, instead of describing an individual subject to abuse as 'vulnerable'"

69% agreed

245. These statements on vulnerability challenge labelling a person as vulnerable. The second statement was more nuanced than the first in retaining the concept of vulnerability, but relating it to situations rather than labelling the person. The third looks at the circumstances that may lead to abuse.

246. Feedback from the focus groups, voluntary sector organisations, interviewees and the stakeholder workshop led to the conclusion that we should stop labelling people as intrinsically vulnerable.

247. We asked about using various terms to describe the policy currently called 'adult protection' *In Safe Hands*. The phrases considered were:

- Adult protection
- Protection of vulnerable adults
- Safeguarding adults
- Protection of adults at risk
- Keeping people safe

248. The favoured phrase was 'safeguarding adults'.

81% agreed (42% strongly agreed)

249. One of the consistent criticisms of current policy is that it does not pay enough attention to the root causes of abuse and does not have enough emphasis on prevention. 'Safeguarding' was felt to be conceptually broader than 'adult protection' including encompassing prevention.

THE SCOPE OF SAFEGUARDING POLICY

250. 90% strongly agreed that the following forms of abuse should be included in safeguarding policy:

- **Physical**
- **Sexual**
- **Psychological**
- **Financial**
- **Neglect**

251. 81% strongly agreed that the following forms of abuse should also be included:

- **Material**
- **Institutional**

61% strongly agreed **racially motivated** abuse should be included

75% agreed **stranger abuse** should be included (of which 44% strongly agreed)

69% agreed to including **forced marriage** (of which 36% strongly agreed)

69% agreed to including **hate crimes** (of which 50 % strongly agreed)

72% agreed to including **domestic abuse** (of which 44% strongly agreed).

252. Some free text commentaries suggested that **chemical/medication abuse** should be a separately identified category of abuse. In relation to people with dementia, comments accorded with the recommendations subsequently published in the Banerjee Report (For summary see NHS Choices 2009) that:

- People with dementia should receive antipsychotics only when they really need them.
- Reducing the use of antipsychotics in people with dementia should be a priority for the NHS.
- Care home staff are given a curriculum to develop skills in non-pharmacological treatment of behavioural disorder in dementia.
- Care homes could be assessed based on their use of antipsychotic medications and the availability of staff who are skilled in non-pharmacological management of behavioural and psychological symptoms in dementia.
- Psychological therapy resources should be made available for people with dementia and their carers.

- Further research should be carried out, including studies of non-pharmacological methods of treating behavioural problems in dementia and of alternative pharmacological treatments.

253. Forced marriage was reported in our fieldwork to be a particular problem for people with mental health problems, or learning disabilities. West Midlands Police have reported that 25% of orders in their area relating to forced marriages have involved people with learning disabilities or mental health problems being forced into marriages for reasons connected with citizenship.

254. 64% agreed that where **crimes** have been committed safeguarding policy should refer to crimes as crimes, not as forms of abuse. (19% strongly disagreed with that proposition).

GUIDANCE AND LEGISLATION

255. The section of the survey on guidance and legislation tested views about the potential role of guidance and legislation and, if there were to be new legislation what that legislation should cover. We were interested to test four different strands of possible legislation:

- Symbolic
- Interagency working
- Sanctions
- New powers

Symbolic legislation

256. This is based on the premise that sometimes in the life of a nation, the need to create cultural change requires the symbolism of legislation. (for example, legislation on Racial and Sexual Discrimination). It was put to us by Action on Elder Abuse and many other interviewees in the voluntary and statutory sectors that there is legislation to protect children and animals in the UK, but not to protect victims of abuse who are adults at risk. Legislation would send a powerful signal that abuse is not to be tolerated.

Interagency working

257. We tested whether there should be a statutory framework for interagency working including:

- A statutory basis to Adult Protection Committees and Regional Forums
- A duty to investigate
- A duty to co-operate
- A duty to share information
- A statutory basis to Serious Case Review

Sanctions

258. The survey went out at a time when the failings of the statutory agencies in the case of Peter Connelly were being widely reported. Even though child protection is on a statutory footing, where things have gone badly wrong there has been a repeating cycle of common failings which legislation has not been sufficient to solve (Laming 2009). It is already the case that where a death occurs as a result of failures in work-related settings a range of criminal offences may apply including corporate, or individual manslaughter. The Health and Safety Executive, the Police and the CPS work together and follow a protocol of investigation in relation to work related deaths ensuring that offences under health and safety legislation are considered where there have been failings in health and safety management. In Scotland, s 50 of the Adult Support and Protection Act 2007 deals with offences by bodies corporate (applying, for example to businesses and local authorities). Where it is proved that an offence under the Act was committed with the consent or connivance of, or was attributable to any neglect on the part of, for example, a Director of a company, or a member, or officer of a local authority:

> "that person as well as the body corporate, partnership or, as the case may be, unincorporated association is guilty of the offence and is liable to be proceeded against and punished accordingly"
>
> (s 50 (1))

We tested whether the kinds of sanctions that back up health and safety and the Scottish legislation might have a part to play in ratcheting up the priority given to safeguarding adults and hold agencies to account in the event of serious failings leading to death, or serious injury.

New Powers

259. We tested whether the kinds of powers found in the Adult Support and

Protection (Scotland) Act 2007 should be available in Wales and the principles on which such legislation might be based.

GUIDANCE OR LEGISLATION …

260. Key findings from the section on Guidance and legislation were as follows:

"Adult protection policy and procedures should be based on revised guidance, not new legislation

89% disagreed (33% strongly disagreed)

"New guidance should refer to [codify] existing legislation rather than creating new laws"

75% disagreed (19% strongly disagreed)

"Both updated guidance and new legislation is required in order to protect adults effectively"

89% agreed

"If protection of adults is to be prioritized in the same way as the protection of children it too needs to be based on legislation"

92% agreed (67% strongly agreed)

These responses taken together send out a very clear signal of support for new legislation together with updated guidance. This view mirrors that of the Law Society, ADASS, and the Safeguarding Adults Alliance.

WHAT SHOULD LEGISLATION INCLUDE?

261. The next set of statements tested what should be included in new legislation:

"Guidance on adult protection should be underpinned by a statutory framework that includes a duty for statutory bodies to co-operate and a duty for them to share information"

94% agreed (75% strongly agreed)

"Adult protection registers should be put in place (similar to the arrangements for child protection)

58% agreed (25% strongly agreed)

33% disagreed (11% strongly disagreed)

The other strands of the review tended to emphasise that:

- Adults are not the same as children
- Vulnerability fluctuates over time and is not intrinsic
- It would not be practical, even if it were desirable to keep up-to-date registers of adults at risk.

This more tentative response no doubt reflects, in part, misgivings about treating adults in the same way as children. This accords with responses to *No Secrets* that revealed a line of thought which declared a system designed to cater for a group who could not consent i.e. young children was inappropriate for safeguarding adults who were entitled to respect for adult focused values-consent, autonomy, dignity, empowerment, choice and control.

"There should be a statutory definition of adult at risk"

89% agreed (47% strongly agreed)

"There should be a duty for local authorities to make inquiries if they believe an adult to be at risk of abuse"

97% agreed (67% strongly agreed)

This would be an important change. Currently the local authority role is to **co-ordinate** an interagency response to adult protection – no organisation currently has a **duty** to investigate.

"There should be a duty for local authorities to consider the importance of advocacy support"

97% agreed (56% strongly agreed)

In our fieldwork, this was thought to be an important innovation particularly by the focus groups, voluntary sector organisations and those working in the

criminal justice system.

"Serious Case Review should have a statutory basis"

92% agreed (61% strongly agreed)

"Local Adult Protection Committees should be statutory bodies"

86% agreed (44% strongly agreed)

"Regional Adult Protection Forums should be statutory bodies"

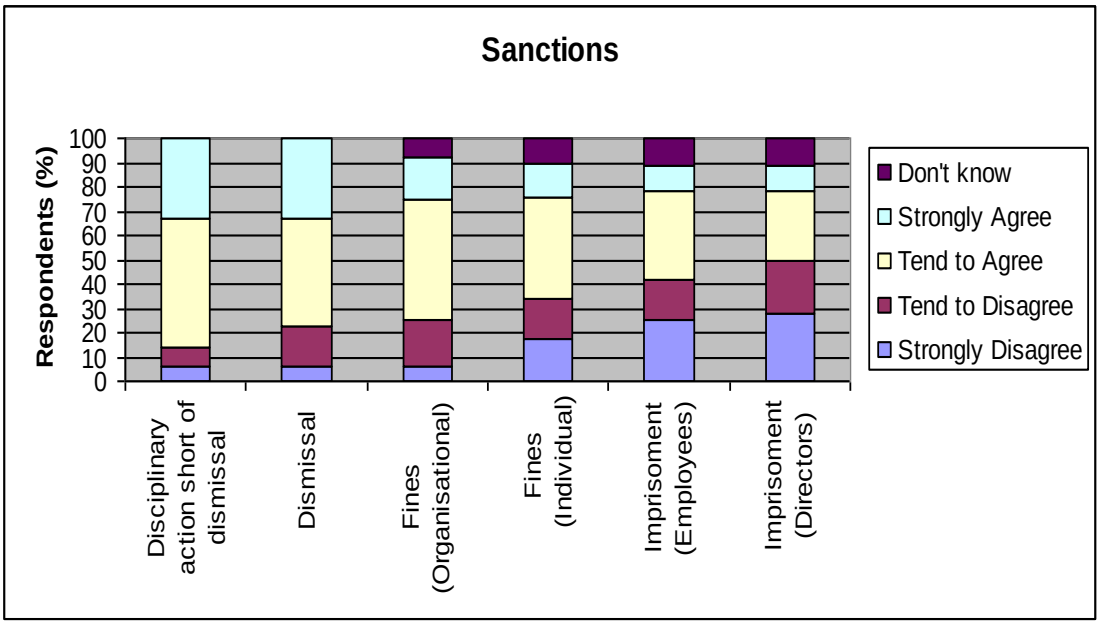
64% agreed (28% strongly agreed)

SANCTIONS

262. The issue of sanctions did not featured in the *No Secrets* consultation and therefore the findings in Wales cannot be compared to the responses in England. However, there seems to be strong support in Wales for sanctions such as disciplinary action, dismissal and to lesser extent organizational fines. Opinion is more divided over imposing fines and imprisonment on individuals and indeed about the possibility of imprisoning directors.

"Should sanctions be available if there is a failure to follow new guidance/legislation (for example leading to serious injury of a vulnerable adult)?"

Figure 13 | Sanctions



263. Figure 7 illustrates the majority of respondents were in favour of disciplinary action and individual and organisational fines as options for sanctions in the event of organisational failures in relation to adult protection. There was a 42:47% split in favour of the option to imprison employees and a 50:39% split against the option to imprison directors. These findings are telling given that the survey was completed by statutory bodies themselves. Qualitative interviewees and the focus groups were in favour of more robust accountability arrangements being in place. There was, however, thought to be an important balance needed between accountability on the one hand, but not having such draconian sanctions in the background that working in the field of adult protection became unattractive.

PRINCIPLES UNDERPINNING NEW POWERS

264. The package of questions and statements in the Welsh survey concerning the issue of new powers was phrased somewhat differently from those in the Consultation on *No Secrets*. The questions were tailored in a way that respondents were required to think more in terms of 'intervention' and the sorts of powers which may or may not be required to facilitate intervention.

265. The concept of 'intervention' is broader in scope than merely listing powers of entry and removal - it is an approach which is reflected in the Scottish legislation.

266. The next few statements explored some of the principles on which legislation could be built:

"Any intervention to protect adults should be the least restrictive possible to their freedom"

92% agreed (58% strongly agreed)

"Intervention to protect adults should occur where an adult LACKING CAPACITY could not be protected without intervention"

97% agreed (61% strongly agreed)

"Intervention to protect adults should occur where an adult WITH CAPACITY could not be protected without intervention and is being unduly pressurised not to consent to protection"

92% agreed (33% strongly agreed)

"An Adult WITH CAPACITY should have the right to refuse intervention even if such refusal puts them at risk of serious harm"

86% agreed (36% strongly agreed)

267. A limitation of surveys is that complex questions cannot be discussed in detail. We used other aspects of the review including the focus groups, interviewing and the workshop to explore this issue in much more depth. The principle that an adult with capacity should have the right to refuse intervention was seen as fundamental in these other strands of the review. This potentially takes Wales in a somewhat different direction from the Scottish legislation. For example, whilst we have concluded (see Chapter 8) that new powers to enter premises for various purposes would make an important contribution to more effective safeguarding, opinion in our review as a whole is that the Scottish powers to remove an adult with capacity without their consent in cases where they are being subjected to undue pressure to refuse consent, is a step too far. We propose that in the Welsh context in such circumstances we should continue to make every effort to support the adult concerned in making their decision, including discussing the pressure they were under. Responses to the following statements should be considered in this context.

NEW POWERS

268. The following statements explore issues around powers of entry and removal.

> **"There should be a right for a local authority officer to visit premises to investigate records, arrange a medical examination, or assess a person believed to be at risk with a warrant from a magistrate, accompanied by a police officer and, where appropriate, a health professional"**
>
> 78% agreed (42% strongly agreed)
>
> **"There should be a right for a local authority officer to visit premises to remove a person believed to be at risk with a warrant from a magistrate, accompanied by a police officer and, where appropriate, a health professional"**
>
> 75% agreed (42% strongly agreed)

269. To accord with the principle that adults with capacity have the right to refuse intervention, removal would only be possible with the consent of the adult at risk of harm. The need for this power might arise when an adult wishes to leave, (perhaps planning to return after assessment, or to leave to live in a different setting) but is being pressurised not to, or prevented from doing so by other people in the household.

270. The requirement to have a warrant from a magistrate to exercise powers to visit premises, or to remove an adult was favoured over having such powers based on being authorised by a senior police officer.

PERPETRATORS

> **"Banning Orders should be available to exclude an alleged perpetrator from premises where an adult at risk is residing"**
>
> 95% agreed (56% strongly agreed)
>
> **"There should be an offence of obstruction if an alleged perpetrator, or any other person attempts to prevent the removal of an adult at risk to a place of safety"**

89% agreed (50% strongly agreed).

NEGLECT

"It should be an offence to ill-treat, or neglect an adult with capacity"

92% agreed (61% strongly agreed)

271. It is already an offence to ill-treat, or neglect an adult who lacks capacity under s 44 of the Mental Capacity Act 2005. Taking into account all of the strands of the review the need for a parallel offence to s 44 (1) (a) of the Mental Capacity Act in relation to adults **with capacity** is thought to be essential.

KEY POINTS FROM THE SURVEY

272. The survey has resulted into some important insights in relation to adult protection amongst statutory organisations in Wales. It has some limitations in that adult protection is a complex policy area and there may well have been differences in the way that contributors interpreted a complex series of questions. Nevertheless, the response, for example, to the many issues around legislation, was so overwhelmingly in favour, that it is possible to draw conclusions from the overall results of the survey. Key issues include:

- There is a lack of consistency in the frequency and monitoring and review of adult protection and related policies.

- There is variability in the resources allocated to adult protection work in terms of whether organisations have:
  - Adult protection co-ordinators
  - Adult protection teams
  - Administrative staff to support adult protection processes

- There is considerable variability in the approach to training including:
  - Who is trained
  - How frequently they are trained
  - The level to which people are trained

- Some groups of people, (older people and learning disabled people) are

better served by the current arrangement than others, for example:
  - People with mental health problems
  - People from BME communities
  - Substance misusers
  - Homeless people

- Interagency working is regarded as fairly effective, but there is less confidence in relation to:
  - Primary care
  - Social landlords
  - Education
  - The criminal justice system

- Overall *In Safe Hands* is regarded as fairly effective, There are concerns about how effective current arrangements are in:
  - Supporting adults to seek redress
  - Supporting people to access treatment
  - Supporting carers
  - And taking action against deliberate perpetrators

- The preferred phrase to describe this policy area is 'safeguarding adults'

- In addition to the current types of abuse covered by *In Safe Hands* there should be a new category of 'institutional abuse'

- Both new legislation and new guidance are needed. There should be four aspects to new legislation:

  - Symbolism
  - Interagency working
  - Sanctions
  - New powers

- There should be a new offence of ill-treatment, or neglect of an adult with capacity.

273. The importance of the qualitative strands of the review, centred on being able to explore highly complex issues in areas not covered by the survey and to discuss issues that were tested through the survey in much more depth. The

findings from the qualitative strands of the review are considered in the next chapter (Chapter 6).

FIELDWORK

274. The fieldwork conducted as part of the review had three main components:

- Interviews
- Local studies
- Meetings and conferences

Interviews

275. A 'purposive sample' of interviewees was agreed with the Welsh Assembly Government. By purposive, we mean that we thought about in advance the perspectives that would be important to seek in relation to understanding the effectiveness, appropriateness and robustness of *In Safe Hands* and sought to interview representatives from specific organisations. We also agreed that we would interview organisations beyond the purposive sample that were signalled to us during the course of the research (this is known as 'snowball sampling'). It is important to note that our review is not in itself a consultation exercise. The purpose of the interviews was to seek evidence about *In Safe Hands* and to make recommendations accordingly. A key recommendation (see Chapter 8) is that recommendations from this review inform a comprehensive consultation on the future development of Welsh Assembly Government policy on safeguarding adults.

Local studies

276. We wanted to explore experience of *In Safe Hands* at the local level. We were asked by the Welsh Assembly Government to select authorities to ensure that a range of attributes were considered including:

- Rural/urban
- Valley communities
- Welsh speaking communities
- Relatively small
- Relatively large
- One from each Regional Adult Protection Forum (based on Police Authority boundaries)

- One from each of the four CSSIW regions

277. In discussion with the Welsh Assembly Government and CSSIW (to ensure there was no duplication with the CSSIW national inspection of adult protection) we conducted local studies of adult protection in:

    - Blaenau Gwent
    - Cardiff
    - Isle of Anglesey
    - Pembrokeshire

Meetings and conferences

278. The review team met with adult protection co-ordinators in April 2009. During the course of the review the team was also represented at 3 meetings of PAVA Wales, a meeting of the Welsh Assembly Government Adult Protection Project Board and has drawn on a verbatim transcript of the Age Alliance and Help the Aged Wales Conference - *Elder Abuse: It has to stop – act now!* held in Flintshire in June 2009.

REPORTING FIELDWORK

279. We undertook a thematic review of the data collected through the fieldwork and this chapter reports the main themes that emerged. As we set out under the heading 'attribution' in Chapter 1, our findings from the fieldwork have been written in a way that does not attribute particular comments to individual contributors. The assurance we gave that we would not identify individuals with particular comments, or perspectives enabled people to be very frank; the review team is confident that facilitating frank discussion of views has been of tremendous benefit to the review. Where possible to do so without identifying individuals, we make clear from which sector particular perspectives have arisen and give an indication of the source in brackets following quotations.

280. A list of the organisations from which contributions were drawn is shown in Appendix 1.

VICTIMS' PERSPECTIVE

281. Contributors from all organisations echoed the views of the focus groups that the starting point for safeguarding procedures must be from the perspective of victims of abuse, with each incident assessed in its own context. Outcomes sought by victims should be central to creating an appropriate response. The priority of victims will often be to maintain relationships, particularly within their own families. Safeguarding procedures must not end up being:

> "almost as abusive as the original abuse"
>
> (Civil Service)

Where, however, victims seek prosecution of an abuser, then they should be supported in accessing justice. In this context, the adversarial nature of the criminal justice system is problematic. Police and other agencies need to adopt the principles of problem-solving approaches (including problem-solving policing) when working with adults at risk from abuse.

Fundamental to victims of abuse is that the abuse stops.

CITIZENSHIP AND COMMUNITY

282. It is thought that the level of awareness amongst the general population in Wales about adult abuse is very low. The Scottish advertising campaign *'Act against harm'* was thought to be an excellent example of how to raise awareness amongst the general public and could be a model that Wales could follow. The response to the Edinburgh pilot for this campaign saw almost a doubling in adult protection referrals (see para 76 in Chapter 4). People need to know:

- What abuse is
- With whom they can raise concerns

283. In order to tackle the root causes of abuse, making a reality of Welsh Assembly Government policy aspirations to empower people to be fully engaged citizens set out in, for example, *Fulfilled Lives, Supportive Communities* (Welsh Assembly Government, 2007) and *Strategy for Older People in Wales* (Welsh Assembly government 2003) is an important preventative safeguard in its own right.

People who are engaged in the community and are visible to the wider community are less likely to become victims of abuse.

284. In the way that care is provided, particularly for people living alone, care plans should guard against creating:

> "institutions of one [bearing in mind that] people who can't tell make good victims"
>
> (PAVA Wales)

Small Communities

285. There are particular difficulties for adults at risk and people in their families, or wider community who may be concerned about abuse, but who live in small communities. Reporting a care-worker, for example, is daunting if the people managing the company for whom the person works and their colleagues all live in the same small community as the abused person. Safeguarding procedures need to be sensitive enough to respond effectively in safeguarding people in the context of maintaining relationships in their community.

COMMUNITY FOCUSED PREVENTION

286. For people with no, or limited, family contact and understanding the reality that neighbours may not know and look out for each other, means that voluntary, third sector and other agencies have a part to play in keeping people socially connected. Initiatives undertaken, co-ordinated by local authorities, in implementing the *Strategy for Older People in Wales* potentially have an important role. Mental health and learning disability voluntary sector organisations highlighted the isolation that can be part of living in any community, (perhaps especially cities) and that neighbours may be even less likely to know, look out for and engage with people who are learning disabled, or who have mental health problems than with older people living alone. The Serious Case Review (raised with us many times during the course of our review) following the tragic death of Stephen Hoskins illustrates how much risk can be involved where a socially isolated person tolerates abuse to try to keep 'friends'.

Health, Social services and care staff

287. Whether or not specialist safeguarding teams for adults are set up, most prevention and protection on the part of health and care services will depend on front line staff. In terms of prevention this argues for all staff who come in direct contact with adults at risk from abuse need to be trained to:

- be alert to the possibility of abuse;
- recognise the potential signs of abuse;
- know the policies and procedures to safeguard adults for their organisation;
- refer suspected cases of abuse in line with policies and procedures;
- follow up their referral so that they can be confident the necessary action is being taken; and
- take part in safeguarding procedures including strategy discussions, meetings and case conferences.

288. The World Health Organisation advocates screening for abuse to be undertaken by primary care practitioners (WHO 2008).

289. Screening for domestic abuse is already routine in accident and emergency and maternity services. Screening for adults at risk of abuse should also become routine.

Assistive Technology

290. A number of contributors highlighted the preventative role that assistive technology can play for people at risk from abuse. A learning disability voluntary sector organisation highlighted that assistive technology reduces emphasis on face to face contact and is a good route to balancing risk and independence.

291. In certain exceptional circumstances CSSIW, with the permission of the abused person, could conduct covert surveillance of care workers suspected of abuse – assistive technology could have a part to play here too in obtaining evidence. It should be emphasised that, in normal circumstances, CSSIW's powers of inspection are used overtly and that covert surveillance would only be considered in wholly exceptional circumstances where there was no other viable option. Although CSSIW has the power to act alone in undertaking surveillance,

to guard against perpetuating risk and to ensure compliance with the requirements of human rights and investigatory powers legislation, (Regulation of Investigatory Powers Act 2000) this type of investigation should, wherever possible be co-ordinated with other agencies, including the police and CPS through safeguarding procedures.

Community Policing

292. Community policing is in itself an important preventative measure in safeguarding adults through building relationships with adults who may be at risk, the communities in which they live and other agencies. Flexibility, such as conducting interviews at a person's home, rather than in police stations may help to build confidence on the part of an abused person to seek access to justice.

293. As is the case with domestic abuse, the police 'flagging' properties where incidents have previously been reported for urgent response should new incidents arise is a good approach that is already in place in some parts of Wales.

WHO TO CONTACT?

294. As part of the awareness raising campaign in Scotland the general public have been given a single telephone number to ring. Through this number they are directed to their local adult at risk team. Having a high profile telephone number to ring would be a useful contribution in making it easier to report abuse.

295. High prominence information about how to access advice and support on safeguarding could be incorporated onto the home pages of local authority and other agencies web-sites.

296. One of the local authorities in Wales has introduced a credit card sized card for all their staff with a phone number for child protection issues. This could readily be adapted for staff, or the public, to have easy access to contact numbers for concerns related to safeguarding adults as well as children.

WHISTLE-BLOWING

297. The question of how and with whom to raise concerns about abuse is not only an issue for the general public, but was also a major concern for staff from a wide range of organisations. In the ordinary run of things, staff should be trained about the course of action they need to take on becoming aware of potential, or actual abuse and follow their organisation's safeguarding procedures. When, however, managers to whom abuse should be reported do not take action, or are implicated in the abuse, or a staff member is under considerable peer pressure not to report their concerns, what then? In theory, a staff member could then follow their organisation's whistle-blowing policy, or even in some circumstances raise their concerns outside their own organisation. In an interesting innovation, raising concerns outside an organisation has become policy on the part of one care provider (Southern Cross Healthcare) who has arranged for staff to be able to raise concerns directly with Action on Elder Abuse as part of its formal whistle-blowing arrangements. Once the whistle has been blown, The Public Interest Disclosure Act 1998 would then protect the staff member from being victimised for 'blowing the whistle'.

298. That is the theory. The evidence to the review was, however, that there is very little confidence in whistle-blowing policies. Health and social care professionals consistently reported that the reality of whistle-blowing was that lack of support and victimisation followed. Financial compensation from an Employment Tribunal would not compensate for the loss of a career. The striking off of Margaret Hayward was referred to many times – even though it was fully acknowledged that the approach she had taken was highly questionable in secretly filming poor practice in a way that breached patient confidentiality. The damage that that case has done in further undermining confidence (even in the context of her subsequent re-instatement) should not be under-estimated.

> "I don't know anyone who has put their head above the parapet and not lived to regret it".
>
> (PAVA Wales meeting)

299. That Wales is indeed not immune from these problems is evidenced in the recent report of the Public Services Ombudsman for Wales on his investigation of a complaint against Carmarthenshire Council (September 2009). The report included the following recommendation in relation to a member of staff who did not have a good experience after blowing the whistle:

> "To remedy the injustice to Ms West I recommend that the Council provide her with a clear apology for its failure properly to investigate her complaints and its failure to offer her the support she was due, and make her a payment of £500 in recognition of the stress and unhappiness caused to her by its deeply flawed handling of the information she provided."

300. The term 'whistle-blowing' was itself seen very negatively. We had many comments along the lines of:

> "whistle-blowing is seen as 'snitching' – it needs to be re-cast as duty of care"
>
> (PAVA Wales meeting)

Duty to report

301. Particularly in the context of moves towards the registration of care-workers with the Care Council for Wales and the development of a code of conduct for care-workers like those applying to other staff groups, the consensus view was that it would be easier for staff to report concerns if they had a duty to do so. A number of contributors drew parallels with domestic violence whereby a decision by the CPS to prosecute an abuser took the onus off the person being abused to make a decision themselves about whether or not to seek prosecution:

> "Making it a duty to report concerns would mean that staff would not have a 'should I, or shouldn't I' decision to make about stepping outside their peer group"
>
> (Nurse Academic)

302. Such a duty to report could be:

- a responsibility to maintain a member of staff's registration;
- a condition of employment;
- a requirement by regulators that such a duty is reflected in the policies and procedures of regulated settings;
- be enshrined in new legislation, (as in some other countries, including Canada – see para 68, Chapter 4).

303. Where reporting within organisations was problematic, concerns could be raised directly with safeguarding teams.

Confidentiality

304. A factor in the Carmarthenshire case was the apparently common mistaken belief by whistle-blowers that their confidentiality can be fully protected. In cases that result in prosecution, or where a person is referred to the Independent Safeguarding Authority with a view to being barred from working with vulnerable adults, the alleged perpetrator has the right to disclosure of the evidence on which the prosecution or barring is based. Even where a whistle-blower is not named in such evidence, the context of their allegation will often mean that they are identifiable. That whistle-blowing in reality seems to offer very little protection to whistle-blowers was another factor in contributors seeking to make other ways of reporting abuse more effective.

DEFINITIONS

305. There was a strong consensus, as in other strands of the review that we should avoid defining groups of adults as intrinsically 'vulnerable' and recognise that vulnerability varies depending on the circumstances at the time. Whilst all adults are likely to be vulnerable at times in their lives, it was important to differentiate adults to whom safeguarding policy should apply from the general population by creating a definition that is targeted to those in need of support because they are not in a position to protect their own interests. This approach would account in part for the disparity amongst the number of predicted cases in prevalence data being very much higher than those that are referred in to safeguarding procedures. (See para 59, Chapter 4)

Adults are not children

306. In balancing autonomy with safeguarding it is fundamental that the difference between the needs of children at risk and adults at risk are fully recognised. In particular, the idea of creating 'adult protection registers' along the lines of child protection registers was not thought to be appropriate. Neither was this thought to be practicable in relation to adults. An important concept is that vulnerability is fluctuating. As situations change, vulnerability and the level of risk of abuse faced by a particular adult will change. It would not be a practical proposition to move people onto and off a register to capture these shifts.

THRESHOLDS

307. There has been some attempt to develop guidance on the thresholds at which, for example, poor practice crosses the line into abuse. (See for example Dyfed Powys online Protection of Vulnerable Adults Policies and Procedures). Examples include:

- a one-off instance of a missed visit by a domiciliary care company with no serious consequences, dealt with appropriately by the registered manager would not trigger POVA. A persistent pattern of missed calls, not followed up by the company could;
- a single instance of a serious (Grade 3 or 4) pressure ulcer appropriately treated in a care setting might not result in a POVA referral; a pattern of such injuries could.

308. However, there are problems with trying to create thresholds in this way. The same actions have different consequences and result in different levels of harm for different people:

- "One missed call so that a person with diabetes misses their medication is much more serious than a missed call without time-dependent medication being involved;
- The psychological consequences of one family member often shouting at another may be water off a ducks' back in the context of some families, but deeply psychologically damaging in others;
- The theft of £10 per week whilst needing to be dealt with in any case may not make a real difference to the finances of some people, but push others into real hardship".

(Independent Sector Provider)

309. A linked issue is whether we should retain the *In Safe Hands* definition that a person should be unable to protect him, or herself from:

"significant harm, or exploitation"

310. The Scottish legislation refers to 'harm', not 'significant harm'. It was generally thought in our review that having a clear threshold between harm and 'significant harm' was problematic. If we look to domestic violence legislation in

relation to the offence of causing, or allowing the death of a vulnerable person, the bar to reach 'significant harm' is very high:

> "'serious' harm means harm that amounts to grievous bodily harm for the purposes of the Offences against the Person Act 1861 (c. 100);"
>
> (s5 (6) Domestic Violence, Crimes and Victims Act 2004)

311. Whilst the instinct to achieve clarity is understandable, if we return to the fundamental premise that abuse needs to be considered from the perspective of the victim and is situation dependent, then maybe the test has to be:

    - For each particular adult, or group of adults, in each particular set of circumstances, is the conduct of an individual, or individuals causing, or is it likely to cause them harm?

312. One of the potential benefits of creating specialist safeguarding adults teams is that a principle for the public and staff should be: if in doubt about whether conduct amounts to abuse, ask. Safeguarding Teams should be skilled and experienced enough to gather sufficient information to enable them judge each case on its merits and to determine a proportionate response. Using current guidelines on thresholds for training purposes with staff may be helpful to illustrate some of the dilemmas within safeguarding, but they should not be treated as definitive.

Recognising and responding to abuse

313. The importance of awareness-raising about abuse amongst the public and staff in all agencies, is illustrated by some of the issues raised by the Ombudsman in the Carmarthenshire case. A manager who had had no training in adult protection was asked to investigate an allegation of physical abuse (slapping). Evidence emerged during the course of the investigation that a learning disabled women had been 'pushed and pulled' and had been denied food as a punishment. The investigating officer did not recognise these courses of conduct as abusive.

314. It is of concern that a Police Officer in this case as reported by the Ombudsman asserted that:

> "withholding food and force-feeding might be abuse in an adult protection context, they did not constitute criminal offences, and had those been the only allegations made against Officer B then the Police would have take no action".
>
> (para 198)

315. On the face of it, it is difficult to see how a person could be force-fed without being assaulted in the process. As the victim had serious learning disabilities, there also seems at least a prima facie case of the criminal offence of ill-treatment, or neglect of a person who lacks capacity (s44 Mental Capacity Act 2005) having been committed.

ISSUES AFFECTING PARTICULAR GROUPS

DIRECT PAYMENTS

316. The policy of Direct Payments involves payments being made directly to adults so that they can purchase services themselves to meet their own social care needs. This gives control and flexibility to people to put packages together that means they can have the type of care they need at the times that suit them. It is an approach that very much supports adults' autonomy. 1991 Direct Payments were made to adults in Wales in 2008-09 (Local Government Data Unit Wales 2009). This compares with 86,000 Direct Payments being made in England over the same period. There is no doubt that Direct Payments suit some people very well and are valued by them. During our review, however, there have been very serious concerns raised about the balance between safeguarding and autonomy not being right when it comes to adults at risk from abuse and direct payments.

Limiting choice

317. Direct Payments are intended to increase choice, but voluntary sector organisations are worried by feedback from England that Direct Payments are being forced on people in vulnerable situations in a bid to reduce the cost of administering and commissioning social care.

Debt

318. In order to have Direct Payments the adult concerned has to have at least a basic bank account. The financial services sector, voluntary sector and CPS have

reported that adults in vulnerable situations, unused to dealing with such accounts are getting into a spiral of debt. In some cases, because of general financial pressures the resources intended for care providers get spent on other things – even though this is not allowed theoretically. The banks' systems are automated so when there are not sufficient resources to pay the adult's care provider an unauthorised overdraft results. The first call on the next Direct Payment is automatically to service the overdraft. In the time it takes for it to become clear that an adult cannot handle Direct Payments they can be in significant debt – putting them in a more vulnerable situation than they were to begin with.

Independent sector providers

319. Debts related to people in receipt of Direct Payments, or following the death of a person in receipt of payments is also becoming a problem for care providers. We have examples of such debts running into many thousands in relation to individual care providers. We do not have overall figures for how big this problem is, but experience with Direct Payments in terms of housing is that in the first 18 months of that policy, whereby tenants had to receive Direct Payments for their rent instead of the money being paid direct to landlords, private sector landlords across the UK are said to be faced with bad debts of £220 million (BBC 2009). Landlords and Shelter are lobbying for choice to be given back to tenants for rent to be paid directly to landlords. As Shelter put it:

> "It can be a very responsible choice not to have direct payments when you are under a lot of financial pressure, so you know that at least the rent is being paid".
>
> (Shelter: *You and Yours* October 2009)

320. Care providers with accumulating bad debts are faced with having to take legal action against someone who is already in a vulnerable situation. This is a poor outcome both for the adult concerned and for the company.

Targeting

321. Some adults in receipt of Direct Payments are being targeted for abuse. The review has heard of targeting for financial abuse and also of targeting by drug dealers to pressurise people into using resources intended for their care needs

for illegal drugs - leading to harm related to drug-taking as well as creating a spiral of debt.

Vetting and barring

322. An adult in receipt of Direct Payments may use them to pay a personal assistant. They are advised to check if the person they plan to employ is ISA registered, but they do not have to do so. Although an adult in receipt of Direct Payments can ask their local authority to undertake ISA checks on their behalf, the adult him, or herself, as a private individual, is not currently allowed to seek an enhanced CRB check. Where a service is purchased from a regulated provider then CRB and ISA checks are the responsibility of the regulated provider. Where a personal assistant is employed directly by the adult – perhaps through an advert in the local press, or by employing a friend, or neighbour, the ISA currently counts this as a 'private arrangement' and the personal assistant is not required to be ISA registered; although the ISA would encourage people in frequent contact with a vulnerable adult to provide care to register voluntarily.

323. There is considerable concern from a wide range of our interviewees that the current arrangements are not adequate to safeguard adults at risk. We are well aware of the controversy around the ISA's role in terms of whether it is interfering excessively in people's lives, for example, in relation to parents being asked by clubs to give each others children lifts. But in relation to those that the ISA defines as 'vulnerable adults', we have concluded that the ISA is not sufficiently engaged. As things stand someone could act as a personal assistant to a vulnerable adult who would be barred from working with vulnerable adults if they had to register with the ISA. Indeed care workers who had already been barred could work illegally, undetected, by targeting people in receipt of Direct Payments and persuading them that ISA checks were unnecessary. This potentially puts adults into a situation where they could be abused by a known abuser.

Getting help

324. If an adult were to be abused by a personal assistant who is not employed by a regulated care provider, getting help could be problematic. They are the person's employer, so there is no employer to turn to. Local authorities still owe a duty of care to those in receipt of Direct Payments and some local authorities offer regular review of people using Direct Payments – this is an

important safeguard alongside giving people information about safeguarding arrangements and who to contact with concerns at the point that a Direct Payment arrangement is put in place.

SELF-FUNDERS

325. Another group about whom concern has been expressed are those who have sufficient resources so as not to be eligible for support for their social care needs from the state: known as self-funders. People in receipt of Direct Payments are known to social services because it is through their local authority that Direct Payments are set up. Some self-funders may be assessed by local authorities and have their care packages arranged for them by social services even though they are paying for services from their own resources. Other self-funders, however, may not be known to the local authority at all; for example, in instances where families realise the person with care needs has too much capital to be eligible for support. An adult in this case may arrange their own care package, without ever being assessed other than by the company providing the service. The risks are that they may end up with an inappropriate service, (for example going into institutional care when a domiciliary care package would better meet their needs). In terms of safeguarding risks, one of the few safeguards for an older person with dementia in a failing care setting, whose family stops visiting once the older person no longer recognises them and who is not known to social services is that all self-funders have to be notified to CSSIW once a year.

326. In terms of their financial well-being, there need to be mechanisms to ensure that care providers fees do not eat into the capital allowance that a self-funder is allowed to retain at the point that their resources are depleted to the extent that they become entitled to state support.

327. In domiciliary care settings, an older person who is a self-funder and is not known to social services with a degenerative condition, like dementia, has increasing care needs over time. Relying on the care workers from the company providing the service to recognise when the level of support being offered is not enough, may not be adequate to prevent neglect. If such a person is socially isolated that too increases the vulnerability of the situation they are in.

328. In Chapter 8 in our conclusions and recommendations, we look at some of the safeguards that could be in place to redress the balance between the adult's autonomy and safeguarding in relation to Self-funders and Direct Payments.

PRISONERS

329. The prevalence in the prison population of people with mental health problems, learning disabilities and drug and alcohol dependency caused a number of contributors to reflect on whether better preventative strategies should be in place to recognise that many of these adults are themselves at risk; to divert them from the criminal justice system more effectively; and whether adult safeguarding services should to work in partnership with the prison authorities where people are identified as vulnerable prisoners.

ISSUES CONCERNING SPECIFIC FORMS OF ABUSE

INSTITUTIONAL ABUSE

330. *In Safe Hands* did not identify 'institutional abuse' as a category of abuse in its own right. There is an argument that a person who is abused in an institutional setting will be subject to categories of abuse that are set out in the guidance, such as physical abuse, or neglect and that safeguarding can operate in that context. However, contributors to the fieldwork reinforced our survey findings (see para 251, Chapter 5) that there is strong support for new guidance including institutional abuse as a separate type of abuse in its own right.

331. Academic disciplines including organisational theory and psychology have recognised the potential for abuse in institutions because of characteristics that are intrinsic to institutions, (Goffman 1961, Clegg et al 2006) including:

- Power centred in the leader of the organisation
- Power over people living and working in the institution
- Failure to treat people with dignity and respect (dehumanizing)
- Routinised activities

332. In these conditions in care settings there is the potential for wide-spread abuse of residents, including serious neglect and generalized fraud. This is so not because one, or a number of staff are 'bad apples' but because of systemic failure, with those in authority presiding over abusive regimes with staff who

either do not recognise abuse for what it is, or do not feel that they can (or want to) speak out. In addition to the regulators ensuring that organisations are training their staff in safeguarding adults and are signed up to local [ideally national] safeguarding policies:

- training in safeguarding procedures by safeguarding co-ordinators/teams;
- a duty to report abuse on the part of care staff;
- clarity for staff about to who they can report abuse outside of their organisation, if necessary; and
- effective whistle-blowing procedure as a back-up

might help to empower staff to speak out.

333. Where the question of systemic failure arises, highly skilled investigators are needed to ensure that all the pieces of the jigsaw are being put together. Where there appears to be abuse, perhaps neglect, affecting a number of residents, it would appear to be prudent to ensure that the financial management of the setting is fully explored alongside other inquiries and that the investigators include, or have access to appropriate finance/audit skills. The Health and Safety Executive also have an important role to play in the context of unsafe systems of work that put people at risk, or that have already harmed their health and safety.

334. Current arrangements give some proprietors total control, even to the extent that medically qualified proprietors could attempt to cover up abuse that has caused, or contributed, to the death of residents by certifying cause of death themselves. New legislation in the post-Shipman era is proposed in the *Coroners and Justice Bill*, (currently before Parliament) that would provide for attending physicians' death certificates to be reviewed by Medical Examiners appointed by the Local Health Boards. An added safeguard would be to forbid a medical practitioner who is the proprietor of a care setting to certify residents' deaths.

335. The *Coroners and Justice Bill* also makes provision for developing training schemes for Coroners. It would appear to be a good opportunity to offer Coroners training so that they are alert to the possibility of abuse being a factor in a person's death - particularly in relation to neglect, including dehydration, malnutrition and pressure ulcers.

336. There are safeguards in place through regulation and inspection, commissioning and contract management, adult protection procedures and guidance on escalating concerns with care homes (Welsh Assembly Government 2009b) that aim to prevent, or respond to failing institutions. In our conclusions and recommendations, (Chapter 8) we consider what could be done to strengthen these safeguards.

NEGLECT

337. Neglect is defined in *In Safe Hands* as:

> "**neglect**, including failure to access medical care, or services, negligence in the face of risk-taking failure to give prescribed medication , poor nutrition, or lack of heating".

338. The issues that arose around neglect during the review included:

- the conceptualisation of 'poor practice' compared with 'neglect' in the NHS;
- the management of pressure ulcers; and
- "commissioning for neglect"

Safeguarding in the NHS

339. As discussed in Chapter 5, and confirmed during our field work, the role of the NHS in safeguarding is contentious. Whilst in some areas relationships with other statutory partners was considered to be highly effective, during the fieldwork, NHS Trusts were not uncommonly (including by local authorities and regulators) portrayed as:

- Not taking safeguarding seriously enough – including not appointing people within trusts to manage safeguarding effectively;
- Being happy to refer external bodies, for example if a patient was admitted in poor condition from a care home, but not looking at their own practice critically enough;
- Conceptualising abuse within their own organisations as clinical /sentinel incidents/clinical governance issues/ untoward incidents/ complaints/ rather than neglect, or other form of abuse;
- Not supporting adult protection procedures by taking a full part in strategy discussions, strategy meetings and case conferences; and

- Investigating themselves, including holding case conferences and developing plans for people, without necessarily involving other agencies.

340. This picture was very different in areas where trusts had created their own expert, highly trained safeguarding teams. Where trusts had taken this approach:

    - The engagement of health is reflected in prevalence data. (see Chapter 4). One trust with a safeguarding team made 12% of adult protection referrals locally in 2008-09; another that has not had a history of working in this way made 5% of referrals. The data suggest that this difference is not untypical;
    - The health team is respected as a fully engaged partner;
    - Team members have been trained to investigate at the standard required by the Police and Criminal Evidence Act 1984 (PACE) and so have the clinical and investigative expertise to support vulnerable victims and partner agencies in the police and CPS to enable victims to access justice.

Pressure Ulcers

341. Some of the current ambiguity in relation to identifying and responding to neglect can be illustrated through the issue of pressure ulcer management.

342. The first observation to make is that although neglect evidenced by the development of serious (Grade 3/ Grade 4) pressure ulcers has been a major issue in response to our review, serious pressure ulcers are not listed as an illustration in the definition of neglect in *In Safe Hands*. As clinicians contributing to the review have pointed out, to include them in the definition would have to be qualified, because for a small number of people with certain types of condition, (for example affecting their vascular system) serious pressure ulcers are not entirely preventable. However, for the vast majority of people, serious pressure ulcers **are preventable**, and if ulcers develop they are **treatable**. Given that serious pressure ulcers are life-threatening it is important that this is universally understood by those with a role in safeguarding. The report by one of our contributors of an observation by a Coroner that:

> "older people do get pressure sores don't they – it's inevitable"

lies behind the suggestion that further training for Coroners is required, in the context that neglect of pressure ulcers can cause death. (see para 335 above.)

343. Some NHS trusts have built into their safeguarding procedures that there must be a referral to their safeguarding team in all cases where someone develops a serious pressure ulcer. In other words, all serious ulcers are treated as a prima facie case of neglect.

344. A typical comment about the general NHS response to pressure ulcers, however is:

> "they tend to deal with then as a clinical incident, rather than neglect"
> (Local Authority)

345. As discussed with a number of clinicians including a nurse assessor, nurse academic, and an NHS safeguarding team, the root of this may well lie in Royal College of Nursing and National Institute for Health and Clinical Excellence (NICE) guidance on pressure ulcer management: *The management of pressure ulcers in primary and secondary care. A Clinical Practice Guideline*:

> "The following recommendations were identified as priorities for implementation:
>
> - Record the pressure ulcer grade using the European Pressure Ulcer Advisory Panel Classification System.
> - All pressure ulcers graded 2 and above should be documented as a local clinical incident.
> - Patients with pressure ulcers should receive an initial and ongoing pressure ulcer assessment. [within 6 hours of admission].
> - Patients with pressure ulcers should have access to pressure-relieving support surfaces and strategies – for example, mattresses and cushions –24 hours a day, and this applies to all support surfaces.
> - All individuals assessed as having a grade 1-2 pressure ulcer should, as a minimum provision, be placed on a high-specification foam mattress or cushion with pressure-reducing properties combined with very close observation of skin changes, and a documented positioning and repositioning regime.
> - If there is any perceived or actual deterioration of affected areas or further pressure ulcer development, an alternating pressure (AP) (replacement or overlay) or sophisticated continuous low pressure

(CLP) system – for example low air loss, air fluidised, air flotation, viscous fluid – should be used.

- Depending on the location of ulcer, individuals assessed as having grade 3-4 pressure ulcers – including intact eschar where depth, and therefore grade, cannot be assessed – should, as a minimum provision, be placed on an alternating pressure mattress (replacement or overlay) or sophisticated continuous low pressure system.
- Create the optimum wound healing environment by using modern dressings for example hydrocolloids, hydrogels, hydrofibres, foams, films, alginates, soft silicones – in preference to basic dressing types – for example gauze, paraffin gauze and simple dressing pads …

This is an NHS guideline. Although it will address the interface with other services, such as those provided by social services, the independent sector, secure settings and the voluntary sector, it will not include services exclusive to these sectors".

(RCN/NICE 2005)

346. This guidance therefore instructs the NHS to deal with all pressure ulcers graded 2 or above as clinical incidents which helps to explain the conceptualisation in the NHS of serious pressure ulcers as clinical incidents, rather than neglect.

347. There was also ambiguity about the applicability of these guidelines in non NHS settings. On the face of it though, if these are the steps that need to be in place to prevent, or treat ulcers in NHS settings, they are also required for people at risk of ulcers in other settings. In terms of preventing harm from neglect for people assessed as being at risk of developing serious pressure ulcers, where care settings cannot provide the assessment, equipment, specialised dressings and turning regimes required, then they cannot be considered to be in a position to meet the needs of that person. As a nurse assessor observed, qualified nursing staff have a duty within their professional code to keep up to date with developments in clinical practice and whatever setting they work in should not be prepared to care for people without access to necessary equipment and staffing levels to meet the key recommendations of these guidelines on pressure management.

348. In terms of regulated care settings it transpires that in the standards concerning the notification of incidents to CSSIW, Regulation 26 for domiciliary care:

Notification of serious injury and other incidents and Regulation 38 for care homes: *Notification of death, illness and other events* do not give serious pressure ulcers (Grade 3, or 4) amongst the examples of issues that should be reported.

349. All in all there is a degree of confusion and ambiguity about safeguarding in relation to life-threatening pressure ulcers that is in need of clarification in new guidance.

"Commissioning for neglect"

350. An issue raised by the independent sector was the role of commissioning in safeguarding. Independent providers highlighted two areas in which they felt under pressure in the way that services are commissioned by local authorities. The first was in setting fee levels too low for providers to be able to resource services of sufficient quality. (An extreme example was the reverse auction undertaken by a Scottish council as reported by *Panorama* on 6 April (BBC 2009) whereby domiciliary care agencies were asked to bid lower and lower to win a domiciliary care contract.) The second was the example of local authorities commissioning 15 minute slots for lunch to be provided in people's homes. Where people were frail, or had dementia, 15 minutes did not allow sufficient time for the person to be supported in eating and could amount to them not receiving adequate nutrition.

351. The approach we advocate in terms of information sharing (see para 214, Chapter 5) would see commissioning brought within safeguarding intelligence gathering and should guard against commissioning practices being developed that have an adverse impact in terms of increasing the vulnerability of people needing care.

352. The Welsh Assembly Government is currently out to consultation on *Fulfilled Lives Supportive Communities Commissioning Framework and Guidance* (Welsh Assembly Government 2009c). The framework should reassure the independent sector that Wales has taken on board the link between quality services and negotiating realistic fee structures with the independent sector. The draft guidelines refer to the quality of services at several points, but do not refer to the role of commissioning in safeguarding. This link should be incorporated into the final guidance and also argues for policy makers to consider safeguarding implications as part of policy development processes.

Commissioning in the context of escalating concerns

353. Where there are concerns about a care setting, an embargo may be put in place to prevent further admissions being commissioned by the local authority. Contributors from the police wished to see emphasised the need for such embargos:

- to be applied consistently;
- not to be lifted without interagency agreement;
- not to be used repeatedly – where a setting has been previously subject to an embargo, the working assumption should be to move towards closure rather than re-imposition of an embargo; and
- the needs of self-funders should be taken into account, including advising potential/new residents of concerns relating to the care setting.

OPERATION JASMINE

354. Operation Jasmine is a Gwent Police investigation concerning the care of older people with mental health problems. The investigation is on-going and many aspects of its work are currently sub judice and cannot, therefore be discussed in this review. Nonetheless, there are many important general lessons that have already been identified and shared with other agencies by Gwent Police. Key areas are:

- The first priority is to prevent on-going abuse.
- Good communications amongst all agencies is essential.
- Assessments should be undertaken by trained staff and routinely include risk assessment.
- Contract, quality and commissioning staff need to be involved in robust interagency monitoring of care providers.
- The needs and welfare of self-funders must be taken into account.
- An immediate risk assessment must be carried out when referrals for adult protection are received, including the risk to other adults.
- Information gathering must be adequate and reasons for decisions evidence based and properly recorded.
- All stakeholders should be fully engaged and represented at strategy meetings.

- Where it is not a police matter, competent and independent investigators must be used.
- All records relating to adult protection procedures, including meetings and attendance at meetings must be fully recorded and held securely in well-ordered files.
- Cases must not be closed until all actions have been completed.
- Potential criminal offences must not be dismissed as 'care issues'.
- High quality training should be available to care providers. Training received should be tested to ensure it has been understood. Providers refusing to offer/accept training should trigger escalating concerns monitoring.
- The use of health and social care staff to support failing care homes require critical risk assessment and should be subject to legal advice to ensure they are not in danger of colluding, (either actively, or inadvertently) in the provision of unacceptably poor care.

FINANCIAL ABUSE

355. Dealing effectively with financial abuse seems to be an under-developed area in relation to the *In Safe Hands* guidance despite the publication of supplementary financial guidance relating to care homes and domiciliary care (Welsh Assembly Government 2003b, 2009d).

356. The Department of Work and Pensions (DWP), Post Offices, banks and other financial institutions were considered difficult to engage, even though they were considered by adult protection co-ordinators to be important in terms of preventing and identifying financial abuse. (There were 3 referrals from DWP in 2008-09 – Local Authority Data Unit 2009) The Mental Capacity Act 2005 meant that protection for adults at risk who lack capacity is more robust than for those who have capacity, but cannot protect their own rights effectively.

357. In *In Safe Hands* the examples of financial abuse given in the definition of financial abuse are:

- theft, fraud, pressure around wills, property, or inheritance, misuse , or misappropriation of benefits.

358. However, forms of financial, or material abuse of differing character and complexity way beyond these examples were flagged during the course of the review including:

- financial abuse of a person within their own home by relatives/friends/care workers;
- distraction burglary;
- rogue traders;
- top-up fees within care settings not being used to support the care of the resident who has been charged for additional services;
- failing to provide the level of care commissioned because of diverting fee income for personal enrichment;
- domiciliary care companies charging for calls they have failed to make, or have cut short;
- targeting adults for theft of benefits/ to divert direct payments;
- 'boiler-house' and other financial scams based on mail, cold-calling by telephone and the internet; and
- so called 'suckers lists' targeting people who have previously responded to scams. The *Think Jessica Campaign* launched a poster campaign in October 2009 to alert older people to the dangers of responding to scams.

359. The Economic and Social Research Council has commissioned research due to report in September 2010 on *Detecting and preventing financial abuse of older adults* (Penhale et al) which should be a useful resource.

360. The Financial Services Authority has been working to raise awareness about financial fraud and has engaged in capacity building with adults at risk of financial abuse through its National Strategy for Financial Capacity – reaching vulnerable people programme.

361. The British Bankers Association expressed interest in joint-working at a national level to explore how the financial services sector might play a bigger part; for example in responding to unusual spending patterns on the part of those with power of attorney.

362. The Welsh Assembly Government's Adult Protection Advisory Group has undertaken some work on financial abuse. It is an issue that would benefit from a national approach.

363. Resources to investigate different kinds of financial abuse need to be available to safeguarding investigations.

ISSUES CONCERNING INFORMATION SHARING

364. As one of the Adult Protection Co-ordinators observed, (reflecting the views of a number of participants in the review:

> "information sharing is one of the biggest battles"

365. The *Welsh Accord on Sharing Personal Information (WASPI)* (Welsh Assembly Government 2008) and supporting documentation under the WASPI banner on model Personal Information Sharing Protocols for Unified Assessment and guidance on the development of Personal Information Sharing Protocols set out the legislative and statutory powers than enable organisations from the statutory, private and voluntary sectors involved in the health and social well-being of the people of Wales to share personally identifiable information. It clarifies that:

- On a need-to-know basis
- The minimum necessary information

can be shared, ideally with a person's consent - but may be shared without consent in cases where there is a substantial overriding public interest including:

- In life and death situations;
- Where there is a risk of abuse or serious harm to themselves, or others; and
- On a case, by case basis to prevent serious crime.

366. The WASPI guidance states in large bold letters:

> "Staff should not hesitate to share personal information in order to prevent abuse or serious harm, in an emergency or in life or death situations. If there are concerns relating to child or adult protection issues, the relevant local procedures must be followed … "

367. The guidance also sets out the action to be taken if information is used without consent:

> "Reasons that lead to a decision to proceed with a disclosure without consent must be fully documented and be filed in the service user's record. Wherever practical and possible participating organisations must inform the service user of the decision and the reasons for it and indicate the legal basis on which the disclosure is permitted or required."

368. The main issues resulting in information-sharing still being seen as a battle ground in the context of apparently clear guidance appeared to be:

- Staff need training to be confident that they have the power to share information when there are adult protection concerns;
- Legislating for a statutory duty to share information is important so that staff have to share information, rather than being put into having to make a 'should, I or shouldn't I' decision;
- There needs to be grater clarity about the protocols required by WASPI being in place between all relevant organisations in a consistent way;
- Better arrangements for data security need to be available, for example ensuring that the NHS can send encrypted email to adult protection services and the police;
- Financial institutions and the Post Office need to be brought into the fold in terms of information sharing as relevant private sector organisations with a role in prevention and damage limitation in connection with financial abuse;
- Information needs to be brought together in one place and considered systematically as part of safeguarding arrangements.

ISSUES CONCERNING SERIOUS CASE REVIEW

369. The Department of Health commissioned *Serious Case Reviews in Adult Safeguarding* (Manthorpe and Martineau 2009) which looked at the lessons learned from 94 reviews in England and 7 in Wales between 2000 and 2006. In October 2009, Ofsted published *Learning lessons from serious case reviews: year2* concerning serious case reviews relating to children. The main findings of these reports align closely with the views of interviewees in our review:

- Serious case Reviews are widely valued as learning tools.
- Strong support for a legislative framework for Serious Case Review, backed by national guidelines.
- A desire for a national approach to collation and dissemination of Serious Case Reviews (CSSIW could take on a similar role to Ofsted in evaluating reviews and disseminating lessons learned and good practice.)
- Serious Case Reviews should be conducted within an established timeframe of three months [in the context that the review may not be triggered until any criminal investigations are concluded].
- There should be an independent chair of each Serious Case Review and an independent person commissioned to write the overview.
- The reasons for the review being required and its methodology should be included in the report. A chronology of events should be included.
- Adult Protection Committees must:
    - be rigorous in scrutinising individual management reviews and overview reports, returning them to the commissioning agencies for revision if they are not sufficiently robust;
    - ensure that social, culturally and ethnic issues are properly explored; and
    - ensure robust quality assurance, recommendations and action plans.
- The abused person and where appropriate, their families should be involved in the Serious Case Review. Where families are not involved there should be justification for this in the report.

370. Consideration should be given when HIW conduct homicide reviews in cases when there has been a murder, or manslaughter carried out by someone with mental health problems as to whether there should also be a serious case review centring on the issues concerning the person with mental health problems. The homicide and serious case reviews would need to be conducted in a integrated way to ensure consistency.

ORGANISATIONS AND SAFEGUARDING

371. Various organisations with a role in safeguarding with whom we held discussions and about whom others commented in the course of the fieldwork included:

- The Independent Safeguarding Authority (ISA)
- CSSIW, HIW and HMIC
- The Public Services Ombudsman
- The Older People's Commissioner

ISA

372. As it is such a new organisation, experience of working with the ISA was limited. Issues around vetting and barring tended to be discussed in the context of the Protection of Vulnerable Adults (POVA) list that pre-dated the ISA system. Some of the concerns raised around vetting and barring were:

- The length of time it took for CRB checks to be completed;
- Potential over-reliance on CRB checks (it may mean an abuser just has not been caught yet);
- The length of time it took for a decision to be reached about whether or not someone was POVA listed;
- Lack of feedback about progress with a POVA decision;
- Lack of feedback about whether a person referred had been listed; and
- When a referred person was not listed no feedback about why the evidence supplied had not been sufficient for a listing to be made.

373. It was of great concern, and considered to have undermined confidence in the POVA system that less than 11% of referrals made resulted in the person referred being barred. (Penhale et al 2007).

374. There were particular concerns on the part of the independent sector. If adult protection issues are raised, they may well be instructed by the adult protection team, or the regulator to suspend one or more members of staff. Especially where a referral to the POVA list was made, staff may be suspended for months. There was support by the independent sector for people who should be listed to be listed and indeed independent sector providers refer their staff themselves,

but the delay in decisions being reached is costly even to the point of threatening the viability of some businesses.

375. There was also concern about the 'Dark side' of POVA including:

- Precipitate instructions to suspend staff, when it could easily be established there was no case to answer (for example a member of staff being accused of abuse at a time when they were not on duty).
- False accusations by staff against other members of staff who were being scape-goated, or ostracised.
- False accusations by adults believed to be at risk.
- Independent sector managers being tarnished as 'abusers' in cases of one-off incidents relating to an individual member of staff.
- An incident in which a member of staff wrongly accused and subsequently completely exonerated of abuse had attempted suicide.

376. Independence in investigating allegations of abuse is a principle that many participants in the review would like to see. This would apply to all sectors, so that local authorities and health services would not lead investigations into their own services. Similarly, independent sector providers should not lead investigations into their own services. Nonetheless, unless the registered manager, and/or proprietor is implicated in alleged abuse, they should contribute to and be part of any investigation and be included in strategy meetings and case conferences.

Discussion with the ISA suggests their approach should resolve some of the perceived short-comings of the POVA system:

- The ISA has developed clear guidance about what should be incorporated in a referral for barring;
- The ISA sees itself having a developmental role in improving the quality of referrals to ensure that people who should be barred, are barred;
- Unlike the POVA system, there will be the opportunity for dialogue during the course of the referral between the ISA and the referrer;
- There will be feedback to employers when a member of staff is barred (unless the person has already been dismissed).

377. Whilst there will not be hearings as part of the barring process, the ISA may in some circumstances arrange for the adult subject to alleged abuse to be

interviewed. This will need to be carefully co-ordinated with local safeguarding services and the police.

378. The ISA has built in target timescales into the elements of vetting and barring over which it has direct control. Its reliance on investigation by others means that it will still not be able to guarantee the timescale in which decisions will be made, but dialogue with referrers should help to give them some idea of progress.

379. There is clarity on the part of the ISA that only people who represent an on-going risk will be barred. One-off abusers judged to be unlikely to abuse again will not be barred. This suggests that prospective employers should not overly rely on vetting and barring procedures. CRB checks and references will be essential in ensuring that a person is someone they are confident in employing.

380. Issues to do with the ISA's role in vetting procedures raised during our fieldwork are discussed in the section on direct payments (see paras 322-3 above). The ISA, whistle-blowing and confidentiality is discussed in para 304.

REGULATORS: CSSIW, HIW and HMIC

381. CSSIW, HIW and HMIC have all been involved in reviewing aspects of adult protection in 2009. A number of contributors to the field work and a finding from the Stakeholder Workshop (see Chapter 7) is that there would be merit in creating a programme of joint inspection in relation to interagency working to safeguard adults. An integrated approach to the inspection of all statutory partners by the regulators would be beneficial in ensuring the effectiveness not only of each individual agency in terms of its own role and responsibilities for safeguarding, but also the effectiveness of interagency working between statutory bodies in each locality.

CSSIW

382. As the regulatory body with responsibility for inspection and regulation of:

- Domiciliary care
- Care Homes (residential and nursing)
- Nursing Agencies
- Adult Placements

and in its role of inspecting local authority social services (including how local authorities co-ordinate adult protection) CSSIW has an important role in preventing and responding to abuse.

383. During the course of the review, the Welsh Assembly Government has consulted on *In safe Hands - The Role of* CSSIW (Welsh Assembly Government 2009e). This document has gone some way to address the general lack of clarity amongst partner agencies about CSSIW's role. CSSIW's principal role is as regulator and inspector. It is not intended to be the lead agency in relation to adult protection. However, in recent years CSSIW's predecessor the Social Services Inspectorate for Wales (SSIW) chaired the Welsh Assembly Government's Adult Protection Advisory Committee. Also, because of their investigative expertise (all Inspectors are trained to PACE standards) at the local level it became common practice for CSIW/CSSIW inspectors to be involved in investigating general allegations of abuse. When CSSIW quite legitimately re-centred itself as an organisation to concentrate on its core functions of regulation and inspection, handing over the chair of the Advisory Group to a Director of Social Services, it was perceived to have pulled back from a national leadership role that had been valued by other partners; because with the advent of CSSIW inspectors refocused on their principal role in adult protection in relation to abuse that involves a potential, or actual breach of regulations, inspectors were also thought by other agencies to have disengaged from investigating abuse allegations at the local level in the way that they had in the past.

384. The response to the consultation document has been broadly positive in that there is much greater clarity about CSSIW's distinct responsibilities for regulation and inspection of regulated organisations on the one hand and inspection of local authority social services on the other. The separation into different teams of inspectors to carry out these functions so that it is clear which role an inspector is fulfilling has been welcomed.

385. The fact that in the past SSIW/CSIW/CSSIW took on these wider roles at the local and national level tends to indicate that these organisations were by default filling in some gaps in the overall arrangements in adult protection policy. Whilst through *In Safe Hands* local authorities have a co-ordinating role in relation to adult protection, no agency is given a leadership role as such and no agency has a duty to investigate. The reliance on the expertise of local inspectors to investigate abuse seems to have, in effect, bolstered the limited

resources available to adult protection co-ordinators. This has implications for how these gaps should be filled in future in terms of:

- National leadership to safeguard adults
- Creating a duty to investigate (for local authorities)
- Developing investigative capacity available to the safeguarding system.

CSSIW's future role in safeguarding adults

386. Whilst CSSIW will not have the lead role for safeguarding, it does have and will continue to have a role in policy development for safeguarding; for example, through its representation on bodies like the Assembly Government's Adult Protection Project Board and through CSSIW's annual analysis and publication of prevalence data. This is an important contribution that has put Wales in the vanguard of understanding trends in safeguarding. In recommending the establishment of new arrangements at the national level (see Chapter 8) CSSIW will have an important part to play.

387. The desire to achieve clarity about CSSIW's role has, however, possibly resulted in over-simplification in relation to:

- Quality of care
- Proportionality in regulation, inspection and enforcement
- Abuse amounting to a breach in regulations
- Duty of care

Quality

388. The overall responsibility for the quality of care in regulated setting is that of the registered provider. In the fieldwork it has been put to us that CSSIW's role is simply to ensure that minimum standards are met, whereas local authorities that commission services from regulated providers have the opportunity to insist on services of a better quality than that required by minimum standards through the contracts they put in place with providers. However, CSSIW within the provisions of the Care Standards Act 2000, does have a general duty to encourage improvement in the quality of regulated services.

Proportionality

389. The proportionality principle is based on CSSIW bringing together information from assessing and inspecting regulated providers along with other sources of information, for example from interviewing adults who have care from regulated providers, local authority contractors and commissioners, and creating a risk-based programme of inspection. This leads to high risk organisations being inspected across a wider range of regulated activity and more frequently than providers assessed as being lower risk. In terms of prevention of and protection from abuse, this approach relies on effective intelligence gathering and argues for CSSIW fully engaging with multi-agency arrangements around performance management and escalating concerns with care settings to ensure that even where there may not initially be an apparent breach of regulations, they are attuned to providers about whom other agencies are concerned. For CSSIW to have the capacity to work in this way is linked to our recommendation to establish either 4 specialist adult safeguarding teams based on Police/CPS boundaries, or 7 based on the new Local Health Board boundaries. (See Recommendation 6, Chapter 8).

390. Concern was expressed on the part of some local authorities and the police that the methodology and skills of CSSIW inspectors need to be further enhanced along the lines of police accredited training: *Professionalizing the Investigation Process*. This would help to ensure that indications that a regulated setting is becoming problematic are picked up early. The priority should then be to stop continuing abuse. It may be in the best interests of residents in a care home to try to work with providers rather than closing a setting, but that has to be in the context that there is confidence that residents are not at further risk of harm.

391. There was some uncertainty about whether all regulated settings would continue to be inspected at least annually. Our understanding is that all providers will be inspected at least annually, but that the scope and frequency of inspection will vary according to risk. Some settings, for example, care homes offering nursing for people with dementia, will automatically be classed as high risk. A further protection in terms of safeguarding is that we understand, and would encourage, that there is a shift in emphasis from announced to unannounced inspections for all categories of risk of providers.

392. Concern was expressed by a number of contributors from various organisations, including the voluntary sector, police and CSSIW itself about the enforcement of

requirements made as a result of inspections. It was put to us that some proprietors responded to Health and Safety Inspectorate requirements because they were perceived to:

"have teeth"

in that failure to comply resulted in prohibition notices, or prosecution - whereas, because CSSIW was perceived as aiming to work with providers to achieve improvements, CSSIW was thought less likely to prosecute, or to close a business down. This was thought to have led to a pattern of requirements being made by CSSIW inspectors with which some proprietors were failing to comply – sometimes over the course of several inspections.

393. The commencement in Wales of new fixed penalty and other sanctions, (for example extending powers for CSSIW and HIW for urgent suspension of registration) provided for by the Health and Social Care Act 2008 is due to be considered by Ministers in 2010. The availability of these sanctions would be useful in the enforcement of requirements, whereby proprietors and organisations failing to comply with requirements face being fined. Fines could, perhaps, be incorporated into a points system along the lines of traffic offences whereby repeated failure to comply with requirements leads to the accumulation of penalty points and the automatic cancellation of registration.

Abuse amounting to a breach in regulations

394. Regulations include making proper provision for health and welfare including care plans, medication and access to services and to have robust financial management arrangements. It is very unlikely that where abuse has occurred there would not also be a breach of regulations. However, some instances of abuse, despite their impact on health and welfare, might not necessarily amount to a breach of regulations in cases where a one-off case of abuse is dealt with appropriately by the management of the provider organisation. In such cases, CSSIW would ensure that the incident has been referred into local safeguarding procedures. Where, as is usually the case, abuse does involve a breach of regulations CSSIW does have a role in the investigation of abuse as part of a co-ordinated response to an allegation, or allegations of abuse that may amount to a breach in regulations. Currently, the lack of statutory powers for safeguarding adults means that CSSIW are an important resource alongside adult protection procedures in terms of the statutory powers already available to them; for

example to enter premises, seize documents and to undertake surveillanc. Whilst such powers can only be used in relation to CSSIW's role as registration authority and not for the purposes of other agencies, such intelligence has the potential to make an important contribution to CSSIW's understanding of the issues relating to an organisation that may be causing concern and to inform the information CSSIW is able to share with other agencies.

Duty of care

395. In safe Hands- The Role of CSSIW refers to local authorities having specific statutory and common law duties towards vulnerable individuals. The document is silent as to whether CSSIW has itself a duty of care towards individuals. As has been described in para 159 and 160 above, the existence of any common law duty of care owed by local authorities and registration authorities towards individuals has been the subject of recent litigation (the Hounslow and Jain cases).

The House of Lords in the case of Jain v Trent HA (2009) concluded that a care standards registration authority did not owe a duty of care to the proprietors of a care home when exercising its statutory powers to apply for an urgent cancellation of registration. During the course of the judgment the House of Lords did consider the possibility of a duty of care being owed by care standards registration authorities towards the residents of a nursing or care home:

> "It might be fair and reasonable to conclude that the [registration] authority did owe a common law duty of care to the residents of a nursing home, or a care home if conditions at the home warranting the exercise of the [registration] authority's statutory powers had come to the authority's attention but nothing had been done".
>
> Scott LJ [2009] All ER 957

However, the House of Lords were not called upon to consider whether there is in fact a common law duty of care in such circumstances. The existence and extent of such a duty will depend on the outcome of future court cases.

Apart from the existence or not of any common law duty of care, both local authorities and care standards registration authorities do have statutory duties and powers in relation to the protection of vulnerable adults. In the Z case, the High Court described the extent of local authorities' statutory responsibilities in

cases such as Mrs Z's (see para 161). In the Jain case, it was acknowledged by the House of Lords that the purpose of the registration authority in exercising the power to apply for an urgent cancellation of registration was the protection of the residents of the home in question. Any complaint that a local authority or registration authority is not exercising its statutory duties or powers properly can give rise to a challenge in the Courts by way of judicial review or to a finding of maladministration by the Ombudsman.

396. As our focus groups made clear, the main priority for people being abused is for the abuse to be stopped. CSSIW does have a role once abuse amounting to a breach in regulations is apparent to take appropriate steps within its powers to prevent further harm.

Extending regulation

397. Regulation is in itself an important preventative and protective safeguard. CSSIW and the Public Services Ombudsman, Wales see the need to extend regulation to cover day centres. (A Commencement Order is required in relation to existing legislation to achieve this). Also, there is concern that some supported housing facilities are in fact operating as residential care homes and should be regulated accordingly.

HIW

398. HIW have an important role in safeguarding through their regulation of health care services both in independent healthcare settings under the Care Standards Act 2000[4] and through inspecting NHS services. As an element of its *Review of Progress Against Healthcare Standards in Wales*, (2009) HIW has considered progress against Standard 17:

> "Healthcare organisations comply with national child protection and vulnerable adult guidance within their own activities and in their dealings with other organisations"

399. Overall, health organisations were regarded as requiring further development in relation to adult protection. A key issue was to ensure a consistent approach to ensuring that up to date CRB checks are in place, including in primary care and that training is available in a consistent way, including in primary care.

[4] Nearly 100% of private mental health and learning disability beds are commissioned for NHS funded care.

400. HIW agreed with the perceptions of other agencies about the tendency of the NHS to conceptualise issues as 'incidents' rather than recognising them as adult protection, or safeguarding concerns.

OLDER PEOPLE'S COMMISSIONER FOR WALES

401. The Older People's Commissioner for Wales has a unique statutory role, independent from Government. The Commissioner may:
    - promote awareness of the interests of older people in Wales and the need to safeguard those interests;
    - promote the elimination of discrimination against older people in Wales;
    - encourage best practice in the treatment of older people;
    - keep under review the adequacy and effectiveness of law affecting older people;
    - review the discharge of functions of most of Wales' public bodies in relation to older people;
    - review the advocacy, complaints and whistle-blowing arrangements of many of Wales' public bodies in relation to older people;
    - examine the case of an individual older person where it raises a question of principle which has more general application to the interests of older people in Wales.

    By September 2009, the Older People's Commissioner had received 18 complaints specifically about adult protection issues. In July 2009, *The Commissioner's view on Elder Abuse in Wales* was published. In this position paper the Commissioner's view includes:

    1. "There is a pressing need to review current legislation as it relates to the protection of older people. The law needs to be clear, accessible and in line with the need to promote equality and human rights.

    2. The law is part of a wider picture and not a solution in itself. It is, however, an important tool and we need to ensure that it is an effective one.

    3. Any way forward should:

        - engage with older people, carers and others who have direct contact with issues affecting older people;

- bring practical benefit to older people;
- promote the value and equal status of older people;
- reflect the United Nations Principles for Older People;
- take an evidence-based approach to reform;
- engage with voluntary and statutory bodies and the private sector in Wales.

4. Any new way forward should recognise the central importance of advocacy services for older people. Specific provision should be made for the facilitation of complaints and whistle-blowing. [i]

5. Any reform should lay a firm foundation for developing models of best practice, promoting awareness of the interests of older people in Wales and challenging age discrimination".

(Older People's Commissioner for Wales 2009)

402. The Commission is working with Age Concern Cymru and Help the Aged in Wales and with others in relation to elder abuse.

Emerging issues include:

- There needs to be better public engagement to change public attitudes towards abuse, and the link between age discrimination and abuse needs to be recognised.
- Experience suggests common lack of understanding of POVA amongst GPs – some assume no need for training. Others will only attend training if costs of locums are covered.
- Legislation is essential to safeguard adults in vulnerable situations: there are parallels with the framework for child protection and much can be drawn from legislation on domestic abuse.

- There is a need for a duty to co-operate and share information between all agencies with a safeguarding role.

- There is a need to develop dedicated safeguarding adults teams, along the lines of developments in North Wales.

- It is important to look in detail at the barriers to referral – a key benefit of legislation would be to have consistency in frameworks for handling referrals.

- There is a need for the CPS to adopt a zero-tolerance approach to abuse of vulnerable adults. There should be clear identification of age-related hate crime that amounts to an aggravating factor. This arises where an offender deliberately targets an older person because of his/her hostility towards older people. (See *Crimes Against Older People – CPS Prosecution Policy, CPS 2008*).

- It is vital to get the issue of thresholds clear if courts are going to be able to make orders (otherwise precious time could be spent debating whether a threshold is satisfied or not).

- The need to see better use of 'Achieving the Best Evidence' with older people - better use of circumstantial evidence gathering to overcome problems with witness reliability. We also need to understand the limitations the CPS often works under.

- A more active stance is needed to remove instigators of abuse rather than assuming that the victim must always be moved.

PUBLIC SERVICES OMBUDSMAN FOR WALES

403. The Ombudsman's reports on investigations into complaints against Welsh local authorities in which current procedures for the protection of vulnerable adults have featured have a number of common themes:

- Culture of service provision in which leadership is constructed around the needs of staff, not of the people for whom the service is provided;
- Lack of training in adult protection procedures;

- Investigations being conducted by staff who have not been adequately trained either in adult protection, or in investigation;
- Failure to follow existing adult protection policies and procedures;
- Very poor record keeping and falsification of records;
- Failure to recognise and act on abuse including:
    - **Financial abuse**: where a person with power of attorney was allowing debts to be run up with a local authority despite her relative having sufficient funds not to be in debt. (The local authority treated this only as a problem debt, not as an adult protection issue);
    - **Physical abuse**: Slapping was recognised as abuse, but pushing and shoving was not;
    - **Neglect/Psychological abuse:** Withholding of food as a punishment was not recognised as neglect and psychological abuse.

- The high level guidance in *In Safe Hands* is too open to differing interpretation. There is a lack of resilience in the current arrangements. Legislation backed by detailed guidance is necessary. At the moment there is too much muddling along and a lack of formality.

- The desirability of regulation extending to day centres is illustrated by investigations into a number of complaints, including in Carmarthenshire and the Vale of Glamorgan.

- In terms of information sharing, there needs to be clarity amongst agencies not only that they have a duty to share information to safeguard adults, but that they have the power to do so.

404. Clarification that the Ombudsman and CSSIW can share information prior to the conclusion of an investigation, not only to protect individuals, but also in relation to apparent systemic failings within organisations under investigation would be welcome.

405. There are well established links between the Ombudsman and CSSIW, CCW and HIW. A protocol between the Ombudsman and the Older People's Commissioner for Wales is being developed.

ACTION ON ELDER ABUSE: THE STORY OF DEREK PARKER

406. In September 2009, Action on Elder Abuse published their highly critical views about the involvement of the Vale of Glamorgan Adult Protection service, CSSIW and the Older People's Commissioner for Wales in responding to concerns raised about the care of Derek Parker:

> "The protection of adults who may potentially be at risk of abuse is a major issue for all the nations in the UK. But Wales has gone further than most; with a regulator which has statutory duties under the Care Standards Act 2000, adult protection systems guided by In Safe Hands, *and the first and only UK Older People's Commissioner.*
>
> But processes and systems are only of value if they achieve the purpose for which they are established. And if they fail to do so, they create the potential for an illusion of safety and protection rather than making safety a reality".
>
> (*A year of failure* … Action on Elder Abuse 2009b)

407. The circumstances as they describe them highlight:

- the need for clarity about roles and responsibilities between local authority adult protection services, CSSIW and the Older People's Commissioner;
- the issues we have referred to throughout our review of *In Safe Hands* whereby abuse is not recognised for what it is, but conceptualised as 'a complaint', or an 'incident';
- the dangers of creating questionable thresholds for intervention instead of considering the issues from the perspective of the person being harmed in all the circumstances of that particular person;
- the priority needing to be action to prevent abuse continuing for not only the person about whom concerns have been raised, but also for others who may also be affected.

LEGISLATION: SAFEGUARDING ADULTS

408. In line with the ICM opinion poll (see para 200, Chapter 4) and the results of our survey, there was almost unanimous support in our fieldwork for legislation based on:

- symbolism

- interagency duties to:
  - investigate
  - consider advocacy support
  - co-operate
  - share information
- a statutory basis to serious case review
- sanctions for interagency failures
- new powers:
  - of entry
  - of removal (with consent)
  - to ban perpetrators
  - to prevent obstruction
- a new offence of ill-treatment, or neglect of an adult with capacity

409. The details of new legislation and the reasons for its support are set out in Chapter 4, Chapter 5, and Chapter 7.

410. A number of contributors made the point that in their view legislation was necessary, but not by itself sufficient to create a good safeguarding system. There also needed to be:

- cultural change
- national leadership
- national policies and procedures supporting legislation
- supported implementation

411. There were only two dissenting voices that did not agree that legislation was necessary. One from a general practitioner - their view that legislation was not needed and that GPs did not need to be trained in safeguarding adults was not the consensus view of a range of agencies and individuals about the role of primary care. The second was concern on the part of a Director of Social Services that safeguarding depended on generic social work staff – not specialist teams and not on new legislation. Zealotry, and the instinct to control needed to be avoided on the part of statutory agencies. There needed to be the recognition that any intervention in a family situation, however, well-intentioned, changes the dynamics within that family.

412. Mental Health voluntary sector organisations did not support the idea of new powers in the context of the *No Secrets* consultation. There is, however,

support in Wales for legislation from the mental health voluntary sector because of the fundamental principle in proposed legislation for Wales that any intervention would be based on consent. This is seen as a crucial difference from both the *No Secrets* consultation and the Scottish legislation.

ACCESS TO JUSTICE

> "The lack of a legislative framework puts the police and other agencies in an awkward position, in terms of having to make available legislation fit – child protection is much clearer"
>
> (Police)

413. A common criticism of the current arrangements for safeguarding adults was that access to justice is too dependent on a degree of luck in happening to have frontline police, social work, health and CPS staff who are imaginative and creative in how they respond to a particular set of circumstances and work out which bits of legislation they might be able to use.

414. Adult Protection is a developing area for the police with more resources being applied to this work in the recent past. Making the case for additional resources has been hampered by the lack of a statutory framework translating into a lack of priority. Adult protection specialists within the police are generally based in Public Protection Units at alongside those working in domestic abuse, (linked with MARAC) and public protection (linked with MAPPA).

415. Police participants would welcome the development of an NPIA doctrine on safeguarding adults, along the lines of a doctrine that is already available for safeguarding children.

Domestic abuse

416. A frequently made observation was that current arrangements to tackle domestic abuse are much better developed than those for adult protection and that there is much to learn from the domestic abuse field that could inform developments in safeguarding adults. There is a degree of overlap that calls for an integrated approach to managing safeguarding adults, domestic abuse and public protection. In relation to older adults, the National Assembly for Wales Communities and Culture Committee, held an inquiry (2008) into domestic abuse of older people. The inquiry concluded that further research was

necessary and recommended that the Welsh Assembly Government's domestic abuse policy and strategy should be amended to better reflect the needs and reality of older peoples' lives. A new violence against women and domestic abuse strategic action plan for Wales is currently being developed. The action plan will reflect the needs of older people experiencing domestic abuse.

Transferability of the domestic abuse model

417. The establishment of Safety Units, for example in Cardiff and Pontypridd have led to much improved conviction rates in cases of domestic abuse (around 70% of those prosecuted are now convicted). It has become clear that special measures, such as the use of screens and video links are beneficial to victims, but are not enough in themselves to support them through a prosecution. The Safety Units include Independent Domestic Violence Advisors, (IDVAs) specialist volunteers, social workers and seconded police staff. They work in close partnership with Witness Support Units, and Victim Support. The CPS have prosecutors specifically trained in domestic abuse and in some places there are Special Domestic Violence Courts in which Court Officials and Magistrates have also had specialist training. This approach gives a 'wrap around' service that supports victims of domestic violence from when an incident is first reported through the whole system. After a successful prosecution, (or if the alleged perpetrator is acquitted) ongoing support is available. Support is still necessary whilst a perpetrator is in prison – and crucially at the time that they are due to be released. The possibility of piloting this kind of approach for victims of abuse was thought to have a lot of potential.

418. As with domestic abuse this kind of specialisation could support a 'positive prosecution policy' on the part of the CPS. This would be welcomed by victims and partner agencies amongst whom the perceptions is that the CPS are reluctant to bring prosecutions at present.

419. Complex cases involving institutional abuse might not be suitable for the Special Court model, but the principles in the way that victims should be supported in such cases would be the same.

420. The domestic abuse model requires victim care to be delivered in response to the level of risk, not solely because the victim is in the criminal justice system. Cardiff Women's Safety Unit developed a now evaluated model of reducing repeat victimisation in high risk domestic abuse cases. The principles of the

model are:

- Enhanced case management of targeted high risk victims.
- Enhanced case management of perpetrators.
- Strengthened criminal justice system, placing the victim central to the process.

A Risk Assessment Checklist (RIC) was developed by South Wales Police and the NSPCC, and used by all relevant professionals in contact with domestic abuse cases. This developed a common understanding of the nature and severity of risk in domestic abuse cases. A common threshold was then agreed and all high risk cases were offered an intensive tailored package of risk reduction by the IDVA and referred into a multi-agency risk assessment conference (MARAC) process. At MARAC up to 20 relevant agencies meet on a fortnightly/monthly basis and share up-to-the- minute risk information on each case.

421. The MARAC focuses on the victim but addresses the level of risk to all members of the family and relevant others. The MARAC then develops a multi-agency action plan to reduce risk. The IDVA then delivers 80% of these safety packages designed by the MARAC and remains alongside the victim until the victim is no longer high risk.

- By 2009 720 IDVA's were trained across the UK and 181 MARAC's submitted data. Despite being at present a non-statutory process, these MARAC's have in 2009 supported 29,000 adult cases with 40,000 associated children, stopping abuse in over 60% of these cases.'

- Some of these MARAC's have representation from Safeguarding Adults Teams, and those that do, undoubtedly provide a superior service for vulnerable adults.

- All of the MARAC research is available on the Coordinated Action Against Domestic Abuse (CAADA) website (www.caada.org.uk)

- In January 2010 the 4 Welsh Police forces and other agencies attending MARAC have adopted the DASH Risk Indicator Checklist, an updated RIC, this can be accessed on the CAADA website.

We would advocate that all professionals who come into contact with victims of domestic abuse should make use of the RIC to assist in identifying the level of risk and thus providing an appropriate response.

Investigation of allegations

422. The CPS stressed the importance of allegations of abuse being undertaken by skilled investigators. The consequences of a safeguarding investigation, whether, or not it results in criminal charges are very serious for:

- victims and their families
- alleged perpetrators
- livelihoods
- businesses

and everyone concerned is owed that investigations are undertaken by people with the right training and competencies, including understanding evidential requirements.

423. If it seems that prosecution is a possible outcome, the CPS would like to be involved to give their advice about the evidence needed, even before a vulnerable witness, (or the alleged perpetrator) is interviewed. The very first interview is absolutely crucial if there is to be the likelihood of successful prosecution. People in safeguarding teams with clinical skills and who are trained to PACE standards are very valuable in supporting the police in interviewing; for example, when a victim has mental health problems staff with these skills are able to identify whether on a particular day they are going to be best able to give a statement, or whether it might be better to wait.

424. In principle, victims should be included at all stages of an investigation – including, if they wish, in strategy meetings and case conferences. As a learning disability organisation put it, this is on the basis of:

"nothing about us, without us".

425. If a strategy discussion concludes that it would not be appropriate in all the circumstances to include victims, then the reasons for this should be fully recorded.

Advocacy and intermediaries

426. The availability of advocacy support for victims was thought to be very important in supporting people who have been abused, especially if prosecution is one of the outcomes sought. The availability of high quality advocacy support is thought to be patchy and fragile. Independent Mental Capacity Advocates are valued, but are only available to those who lack capacity. This argues for capacity building in relation to people who have capacity but need advocates and those who lack capacity and whose abuser may be a family member.

427. The CPS has been piloting the use of intermediaries, for example in cases involving people with learning disabilities who have communication difficulties. Intermediaries are not yet widely used, but are important in terms of supporting victims to be 'credible' witnesses. This is especially important in the context that research into jury behaviour suggests that juries are very influenced by how a witness presents themselves and how they look.

428. 'Reliability' interviews are now possible to check that a witness sufficiently understands in advance the evidence about which they will be cross-examined. Such interviews have to be disclosed to the defence team, however, and may result in the victim having to:

> "give yet more of themselves away to the perpetrator".

Hate crime

429. The CPS is now very attuned to aggravated crime that might affect adults at risk, including disability hate crime. Issues such as racial, or religious hatred, or disability hate crime will have an impact on the length of a sentence, for example if someone is convicted of assault, but hatred of disability is also a factor. It is important therefore that such issues are explored in investigating abuse.

430. The CPS has established a Hate Crime Scrutiny Panel whereby cases are reviewed by members of the public, including people with disabilities.

431. Community impact statements are being developed, with the possibility that perpetrators would be left in no doubt that their behaviour was unacceptable to

their own communities. This would be a contribution to the need to generate cultural change in not tolerating abuse.

Perpetrators

432. There are many complexities around the actions and motivation of perpetrators of abuse. It was a consistently held view amongst contributors to the review that the term 'perpetrator' should not be used in relation to over-stretched carers who can no longer cope. Nor, except in wholly exceptional circumstances should such carers be dealt with through the criminal justice system. Prevention, in terms of support before they reach breaking point and support services for them and the person they are caring for if they have reached breaking point was required.

433. The other group of perpetrators about whom there was concern are those who are themselves vulnerable adults. Their interests too need to be safeguarded.

Interagency working

434. The police and CPS in Wales work in four regional areas. Interagency working would be facilitated for them by a move towards legislation, supported by national polices and a reduction in the number of local Adult Protection Committees.

SAFEGUARDING INFRASTRUCTURE

435. A number of issues emerged in relation to the robustness of the various structures associated with adult protection in Wales. The general perspective was that the Adult Protection Advisory Board when Chaired by SSIW had had an important and valued leadership role (albeit that as discussed in relation to CSSIW's role, arguably this was the wrong organisation to chair the group). The more recent split with policy advice and development now resting with the Adult Protection Project Board and practice advice and development now resting with the Adult Protection Advisory Group was thought to be unhelpful – and to have led to the perception that national leadership in this field is rather weak.

436. The calls were universal for the development of:

- national policies and procedures; and
- outcome-based monitoring based on nationally agreed data definitions.

437. In fact work is already underway to achieve both of these goals, but at present these initiatives are being driven from the bottom-up. An informal element of the system has proved to be fundamental in that the adult protection co-ordinators have self-organised to meet regularly as a group and have become extremely important in leading and driving change. It was strongly believed that the development of national policies and procedures could not wait any longer, and the development of national policies and procedures based on the Dyfed Powys policies and procedures is being taken forward by a group put in place by the four Regional Adult Protection Forums. The lack of a national lead to carry out this work under the wing of the Welsh Assembly Government has, however, led to this work having ambiguous status that will have to be addressed at the point that consultation is required.

RESOURCES

438. In understanding interviewees' own priorities in making progress with safeguarding adults in Wales, the review team had to encourage contributors not to focus on resources. Even so, everyone was acutely aware of the pressure there is going to be on public and private sector resources over the next few years and the point was made to us forcefully throughout that:

    - a lack of resources had adversely impacted on the implementation of *In Safe Hands*; and
    - new legislation, guidance and awareness raising publicity would require new resources, including additional finance.

    Nonetheless, whilst recognising that resourcing is an important issue, the debate about what safeguarding should look like should not be constrained from the outset by perceptions about what might be affordable. In this context, resourcing a new approach becomes a question of priorities for the Welsh Assembly Government.

439. As part of the correspondence sent out with the survey, we asked some questions about current resources applied to adult protection. However, this is not recorded routinely. We received a very limited amount of financial information that did not appear to have been compiled in a readily comparable

way between organisations. The best evidence we have on the costs associated with a statutory basis to safeguarding is from Scottish contributors (see discussion in paras 73-78 Chapter 4). Adjusting for population size, investment on the same scale as Scotland would equate to £9.6 million in year one with resources tapered over 3 years to support:

- the implementation of new legislation and procedures
- training, (including if the Scottish model were to be followed, offering free training to the voluntary and independent sectors).

440. An estimated £300,000 would equate to the Scottish spend on an awareness raising publicity campaign.

441. However, as discussed in Chapter 4 – this level of spend would not be needed in the Welsh context, because elements of the safeguarding system are already in place in Wales including:

- adult protection co-ordinators
- administrative support
- adult protection teams, in some parts of Wales
- Adult Protection Committees
- existing training programmes

442. Whilst investment would be required as part of a programme of supported implementation, it would be significantly less than has been required, comparatively in Scotland.

Chapter 7 | Stakeholder workshop

443. A stakeholder workshop was held on 10 September 2009 at Aberystwyth University. The aims of the day were to:

- Share evidence from the review
- Test views on complex areas
- Test views on tentative conclusions
- To discuss:
  - Principles
  - Definitions
  - Legislation
    - ◊ Symbolism
    - ◊ Inter-agency framework
    - ◊ Sanctions
    - ◊ Powers
  - Training
  - Models of practice
  - Co-ordination of related policies

Those invited to take part were:

- Adult Protection Co-ordinators
- Fieldwork Interviewees

444. 33 people attended, including people from amongst:

- Adult Protection Co-ordinators
- NHS Trusts (including the Welsh Ambulance Service NHS Trust)
- Local Health Boards
- Police
- Voluntary sector
- CSSIW
- Law Commission

WORKSHOP FEEDBACK

LEGISLATION

445. Fundamentally, legislation based on legislative principles, backed by robust procedures was required. Symbolically legislation was important to foster:
    - Cultural change – people should have the right to live free from abuse; and
    - New ways of working that prioritise safeguarding adults for all agencies with a role to play.

446. Guidance to support legislation should be clear, crisp and concise. Safeguarding policy should be proportionate and sensitive – envisaging a range of possible outcomes. Prosecution of perpetrators may sometimes be the right outcome, sometimes not.

DEFINITIONS

447. It was important that the scope of safeguarding procedures should be targeted towards people who were:

    - Not in a position to protect their own well-being, property, or other interests; AND
    - Are at risk of harm from abuse; AND
    - Because they are affected by disability, mental disorder, illness, or physical, or mental infirmity are more vulnerable to being harmed than adults who are not so affected; AND
    - That another person, or persons conduct is causing, (or likely to cause the adult to be harmed.

448. This is similar to definition of 'adults at risk' set out in the Adult Support and Protection (Scotland) Act 2007. The differences are that in the working definition from the workshop, 'harm' is specifically linked with abuse and not other kinds of harm. Secondly, the Scottish legislation also applies to those who self-harm. In our review, unless self-harm was itself a response to abuse, the consensus was that issues of self-harm posed a different problem from abuse of one person by another and should not be addressed through safeguarding measures.

449. It was thought to be important that the definition of an 'adult at risk from

abuse' is de-coupled from the definition in *In Safe Hands* that links a 'vulnerable adult' to being in need of community care services.

450. Powers of entry and banning orders need to be used in the least intrusive way possible, but are needed. Powers need to be consolidated in one place as with legislation on child protection.

INTERAGENCY WORKING

451. A statutory framework would ensure that:

> "the right people are round the table and that safeguarding has the right priority".

452. APCs being on a statutory basis with clearer lines of accountability was welcomed. Membership must be mandatory and at a senior enough level.

> "being on a statutory footing trumps guidance, every time."

453. The current heavy reliance on persuasion and networking was not adequate.

454. The duty to co-operate and share information must include health, especially General Practitioners.

455. HMIC, CSSIW and HIW could help drive prioritisation by inspecting against new legislation.

SANCTIONS

456. Sanctions such as fines should be directed towards organisations, rather than individuals. It would be counter-productive if sanctions led to defensive practice.

TRAINING

457. A training needs analysis should be undertaken to support new ways of working. The level of training offered needs to be standardised according to the role of the person being trained with competencies linked to differing levels of training. Specialist qualifications could usefully be developed, based on defined

competencies, including training for trainers. If safeguarding is to be co-ordinated well, training, supervision and support of administrative staff needed to be part of the equation.

> "Everyone who picks up a phone to a member of the public should be trained to deal with a safeguarding query."

458. Cross-agency training is important. The Home Office has upgraded police training, but this needs to be linked in with local authorities, health, housing and probation.

459. Social work training would benefit from having a clear statutory framework for safeguarding adults against which their learning could be tested and quality assured.

MODELS OF PRACTICE

460. It was acknowledged in *Partnership and Regulation in Adult Protection* (Penhale et al 2007) that models of practice for safeguarding is under-researched. The workshop would welcome research being commissioned to explore models of practice.

461. On the day, initially there was discussion of two basic models, one based on generic social workers undertaking adult protection work alongside their case-work; the second, the development of specialist teams to investigate and co-ordinate safeguarding.

462. Experience suggested that trying to supervise care managers who were being asked to investigate abuse to follow procedures correctly was problematic when they were also trying to juggle a caseload - although the practicality of having (centralised) specialist teams in rural parts of Wales was questioned. Where specialist teams were in place, the development of consistent, well-established relationships across agencies was valued. Experience where an authority had disbanded its specialist team and gone back to relying on an approach embedded in care management had resulted in a system viewed as less effective by the adult protection co-ordinator concerned and local agencies (notably, the police). There was a general view that skilled investigators are needed.

463. It was thought that there were advantages in bringing these two approaches together, whereby once a prima facie case of abuse had been identified, specialist teams would investigate and co-ordinate safeguarding procedures, but if the abused person had a generic social worker, then their own social worker would be involved in all strategy discussion, strategy meetings and case conferences. This approach would ensure that specialist teams did not result in de-skilling frontline staff.

464. It was thought there was merit in specialist teams:

- offering each other peer support;
- facilitating independence in investigations (teams could call on each other to support investigations to avoid any organisation investigating itself); and
- building a better rapport with other agencies.

CO-ORDINATING POLICY

465. The Welsh Assembly Government was believed to have a leadership role in ensuring that adult safeguarding was considered in relation to policy development in a systematic and integrated way.

There was a recognition that intelligence from:

- disclosure
- complaints
- whistle-blowing
- grievance
- disciplinary
- unified and risk assessment
- contract monitoring
- commissioning
- regulation and inspection
- partner agencies in safeguarding
- ISA

needed to be brought together in a systematic, frequent and consistent way.

466. The location of meetings might play a part in engagement, particularly in relation to mental health services. Holding meetings at mental health facilities

would facilitate the engagement of victims and mental health staff.

CONCLUSIONS OF THE REVIEW

467. Those attending the workshop were in broad agreement with the conclusions of the review and looked forward to consultation based on the review of *In Safe Hands* along with the results of CSSIW's national inspection and the work of the Welsh Assembly Government Project Board on Adult Protection.

SECTION 3 | CONCLUSIONS AND RECOMMENDATIONS

Chapter 8 |Conclusions and recommendations

OVERALL CONCLUSIONS

468. Taking account of the evidence from all of the various strands of the review, *In Safe Ha*nds can justifiably be seen as ground-breaking policy that has made a real and important contribution to adult protection in Wales. Nevertheless, in a fast-developing legislative and policy environment between 2000 and 2009, our overall conclusions are that *In Safe Hands* is now:

- partially effective;
- in important aspects, no longer appropriate; and
- not sufficiently robust.

Effectiveness

469. Some groups of people are referred more readily and there is more confidence about the support they receive than others. People with mental health problems, from BME communities, who misuse drugs or alcohol, or who are homeless appear to be disadvantaged. There are particular concerns about people in receipt of direct payments and those who fund their own care.

470. Some agencies work together and share information more effectively than others. Primary care, health services, the criminal justice system and financial institutions are not all working together with local authorities as well as they might.

Appropriateness

471. The title of the guidance *In Safe Hands* these days sounds out-dated - it implies that people are passively leaving their fate to others; and that people are in care and dependent on care workers. It does not reflect policy aspirations to co-produce services with empowered, fully engaged citizens.

472. People do not like being labelled as 'vulnerable'. People are not intrinsically vulnerable, some situations make people vulnerable. Vulnerability fluctuates over time as situations change. A new statutory definition is needed of people

who are at risk of harm from abuse and who are not in a position to protect their own interests.

473. There should be more of an emphasis on prevention as well as protection and on post-abuse support. The phrase 'Safeguarding adults' has a broader scope than 'adult protection' that better reflects this wider agenda and is the preferred term for this policy area.

Robustness

474. Interagency working and the regulatory system needs to be strengthened, particularly in relation to institutional abuse.

475. Given these overall conclusions, we now consider the recommendations we would make in the context of the findings of our review to improve the system of safeguarding adults in Wales.

RECOMMENDATIONS

RECOMMENDATION 1: PRINCIPLES OF SAFEGUARDING

Safeguarding adults in Wales should be based on the following principles:

- the views and wishes of victims should guide how they are supported;
- the starting point must be to believe people who raise concerns about abuse;
- safeguarding should be based on consent;
- we should maintain the current legal position in Wales that adults with capacity have the right to refuse intervention even if this leaves them at risk of significant harm;
- the priority should be to stop abuse continuing whilst safeguarding procedures are followed;
- there is a crucial balance to be struck between autonomy and protection;
- people at risk from abuse should be involved in decision-making processes, including strategy meetings and case conferences, unless there are exceptional and compelling reasons not to do so;
- people should be supported with strategies to keep themselves safe; and
- safeguarding should be in the context of fully engaged citizenship, not restricted to social care, health services and the criminal justice system.

RECOMMENDATION 2: LEGISLATION

New legislation is required. The symbolism of legislation is important in fostering cultural change. Safeguarding adults at risk from abuse who cannot protect their own interests must have the same legislative status and priority as protecting children.

Legislation should include:

- defining people to whom policy for safeguarding adults applies as those over 18 years of age who are:
  - Not in a position to protect their own well-being, property, or other interests; AND
  - Are at risk of harm from abuse; AND
  - Because they are affected by disability, mental disorder, illness, or physical, or mental infirmity are more vulnerable to being harmed than adults who are not so affected; AND
  - That another person, or persons conduct is causing, (or likely to cause) the adult to be harmed.

- a statutory framework for interagency working, including a duty to investigate, a duty to co-operate and a duty to share information
- a duty to consider advocacy support
- a statutory framework for serious case review
- a new offence of ill-treatment, or neglect of a person with capacity
- new powers including power to:
  - enter premises to assess whether someone is at risk of abuse, or is being abused, to review /remove records and to arrange a medical examination
  - remove an adult (with their consent) to a place of safety, even if others in the household disagree
  - ban perpetrators from premises
- a new offence of obstruction
- sanctions in relation to offences by 'bodies corporate' (including statutory agencies) and individuals within them in cases of consent to, or collusion in abuse, or negligence.

In principle, banning a perpetrator should be considered preferable to removing a victim.

Inevitably, it will take time to get legislation in place. There is no reason, however to delay the other recommendations made as part of this review until legislation is in place. Implementing the other recommendations will mean that the preparatory work is in place to enable rapid, effective implementation of the legislation as soon as it reaches the statute books.

RECOMMENDATION 3: SANCTIONS

We asked as part of our survey, reported in Chapter 5, and in qualitative interviews whether specific sanctions should be available if corporate bodies failed to follow new guidance /legislation and this led to serious harm. The majority of respondents were in favour of robust accountability arrangements being in place including disciplinary action, and organisational and individual fines being available. A substantial minority (47%) of survey respondents favoured imprisonment being an option in the most serious cases (para 263). In respect of sanctions, we recommend that there should be further consultation about the range and scope of possible sanctions to ensure an appropriate balance is found between accountability on the one hand, and, on the other hand the potential for sanctions to impact adversely on people wanting to work in the adult safeguarding field.

RECOMMENDATION 4: NATIONAL ARRANGEMENTS. GUIDANCE, POLICIES, PROCEDURES AND MONITORING

The National Adult Protection Project Board and National Adult Protection Advisory Boards should be disbanded and a single new national organisation should be created. This body should have an independent chair, expert in the adult safeguarding field and bring together adults with experience of safeguarding issues and experts in policy and practice in safeguarding (including the voluntary sector, local authorities, health, police and CPS) and related fields, including development agencies (SSIA, NPIA, NLIAH) regulation and health and safety. The new National Safeguarding Adults Group would have the following role:

- to advise the Welsh Assembly Government on policy to safeguard adults;
- to lead policy and practice development to safeguard adults in Wales, including ensuring related policies, such as commissioning guidelines, and direct payments have safeguarding built in;
- to inform and oversee the development and implementation of the legislative

programme set out in recommendations 2 and 3;
- in partnership with CSSIW and HIW to be a repository for and to ensure the dissemination of good practice, (including from Serious Case Review and Homicide Review) throughout Wales;
- to build on the work of Adult Protection Co-ordinators, CSSIW and the Local Government Data Unit Wales, to develop outcome based monitoring arrangements based on nationally agreed data definitions;
- To ensure there is an integrated approach based on clear roles and responsibilities for safeguarding on the part of the National Safeguarding Adults Group, Safeguarding Adults Boards (see Recommendation 6) CSSIW, HIW, HMIC, the Older People's Commissioner for Wales and the Public Services Ombudsman;
- To oversee the development of a national competency based training programme and advise on the development of qualifications in safeguarding.

It is imperative that the proposed National Safeguarding Adults Group builds on the work of the current Regional Forums to develop and consult on interim national guidance, policies and procedures, until the new legislation is in place, followed by revised national guidance, policies and procedures once legislation is enacted.

RECOMMENDATION 5: CATEGORIES OF ABUSE

New national guidance should include the following categories of abuse:

- Physical (including chemical/medication abuse)
- Sexual
- Psychological
- Financial/Material
- Neglect
- Institutional

It should be clear that abuse by strangers comes within safeguarding policy.

Hate crimes (based on race, religion, disability, sexual orientation) should all be recognised as aggravating other offences, potentially leading to longer sentences in cases where perpetrators are successfully prosecuted.

Cases involving domestic abuse, or forced marriage require joint working between

safeguarding teams and partners with responsibility for domestic abuse/forced marriages to ensure that an abused person's needs are addressed holistically and seamlessly.

RECOMMENDATION 6: SAFEGUARDING ADULTS BOARDS

Local authorities should be the lead agency in relation to safeguarding adults. New Safeguarding Adults Boards (SAB) should be formed, based on local authority boundaries, grouped in accordance with the principles set out in the Beecham Report: *Beyond Boundaries: Citizen-Centred Local Services for Wales* (Welsh Assembly Government 2006). (See also para 62, Chapter 4).This would give the Boards and the specialist Safeguarding Adult Teams (see Recommendation 7) that we propose should support them the critical mass they need to develop expert, robust safeguarding arrangements. Each Board should have a chair who is independent from local adult social services.

The proposed Safeguarding Adults Boards would be senior interagency bodies, supported by expert Safeguarding Adults Teams (SAT) who:

- ensure effective interagency working locally, based on national legislation, guidelines, policies and procedures;
- ensure that each of the Directors of Social Services from constituent local authorities can demonstrate that they are fulfilling their s.7 guidance responsibilities for safeguarding adults through the SAB and SAT;
- ensure there is an integrated approach and read across between adult safeguarding and related policies and activities;
- oversee a training needs analysis for safeguarding adults and the development of a consistent approach to training, based on a nationally devised training programme; and
- develop a consistent approach to data collection, based on nationally agreed data definitions.

The new Safeguarding Adults Boards could be based, for example, on local health board boundaries, so there would be 7; or based on Police / CPS boundaries in which case there would be 4.

There are pros and cons to each of these configurations that can be tested in consultation. For example, aligning with local health board boundaries would promote greater integration of health into safeguarding and would retain a degree

of localness. Aligning with Police/CPS boundaries would reduce complexity in supporting victims to access justice.

RECOMMENDATION 7: SAFEGUARDING ADULTS TEAMS

Each of the proposed Safeguarding Adults Boards should have a specialist Safeguarding Adults Team who would lead the investigation and co-ordination of safeguarding adults for their area. The teams would be based on a model that integrates generic practice with the specialist team. Where an adult at risk of abuse has a social worker, their generic social worker would take part in all strategy discussions, strategy meetings and case conferences and would have an important role in post-abuse support. Safeguarding teams should include, or have access to specialist investigators with expertise in finance/audit and be able to call on Local Health Boards for expert investigators with health expertise.

Once a strategy discussion identifies a prima facie case of abuse, all investigations would be led either by the police, or by an investigator who has been trained to PACE standards.

All lead investigators will be independent from the setting that is being investigated. Investigators will involve local services, including independent sector mangers/proprietors, in investigations and in decision-making processes (strategy discussions, meetings and case conferences) unless there are compelling reasons not to do so. (Principally that they are implicated in the abuse).

RECOMMENDATION 8: ACCESS TO JUSTICE

- Safeguarding Adult Teams and the police will ensure early involvement of the Crown Prosecution Service in cases where a crime may have been committed;
- Access to justice will be supported by the police and (where appropriate by Safeguarding Adult Team investigators trained to PACE standards);
- In all cases involving adults at risk, victims will be offered advocacy support[5] and special measures for court appearances - including the use of intermediaries if needed;
- Perpetrators will be offered advocacy support and special measures for court

[5] This does not refer to advocacy in the sense of legal representation but to advocates specialising in safeguarding adults.

appearances, including the use of intermediaries if needed, if they are themselves adults at risk;
- 'Wrap around' (see para 417, Chapter 6) support based on the Safety Unit model for domestic abuse should be developed to support abused adults.
- A pilot scheme should be put in place to give abused adults access to special courts, on the model developed for Special Domestic Violence Courts.
- The CPS should adopt a culture supporting a 'positive prosecution policy' in cases of alleged abuse.

RECOMMENDATION 9: REGULATION

Guidance on the role of CSSIW should make explicit their role in improving the quality of regulated services (see para 388).

In the event that future case law establishes the existence of a common law duty of care by care standards registration authorities towards individual service users, CSSIW should give guidance on the circumstances in which such a duty may arise (see para 395, Chapter 6). In the mean time, CSSIW should ensure that once it is aware of abuse in a regulated setting, CSSIW takes the appropriate steps available within its statutory powers to safeguard against the risk of further abuse.

In order to strengthen role of CSSIW in the prevention of abuse:

- day centres should be regulated by CSSIW;
- supported housing schemes should be assessed and regulated as residential care settings if that is how they are in fact operating;
- unannounced visits to regulated agencies and care settings should be the norm;
- notifications under Regulation 26 for domiciliary care: *Notification of serious injury and other incidents* and Regulation 38 for care homes: *Notification of death, illness and other events* should include serious pressure ulcers (Grade 3 and 4);
- electronic recording of visits by domiciliary care workers should be a requirement;
- medically qualified proprietors/mangers should not be permitted to certify deaths arising in their own establishments; and
- the implementation of sanctions provided for under the Health and Social Care Act 2008 should proceed. Consideration should be given to

the system of penalty points and fines being further developed to allow for the accumulation of penalty points to lead to automatic suspension of registration in the event of repeated failure to comply CSSIW/HIW requirements.

RECOMMENDATION 10: DIRECT PAYMENTS

Adults at risk of abuse should be carefully assessed in relation to whether direct payments will meet their needs. The support of local authorities, or disability coalitions through local authority Direct Payment support schemes in handling the employment aspects of direct payments including:

- Recruitment
- Checking references
- CRB /ISA checks
- Paying fees/salaries
- Making Tax and National Insurance payments

are useful in ensuring an adult at risk has the flexibility associated with direct payments in being able to choose how and when a service will be provided without being exposed to some of the risks.

We recommend that policy on Direct Payments should be changed so that it is not possible to make Direct Payments to a person who has not been CRB/ISA checked. (To do otherwise leaves adults at risk of abuse by a known abuser who is being paid with public money see para 323, Chapter 6).

Once Direct Payments are in place the arrangement should be reviewed by the local authority regularly (after the first 3 months and at least 6 monthly thereafter).

Arrangements should be made for regulated providers being paid through a Direct Payment to notify the relevant local authority if an adult is getting into arrears, to ensure that the arrangement is not putting the adult concerned under too much pressure and that they are not subject to financial abuse on the part of a third party.

RECOMMENDATION 11: SELF-FUNDERS

Regulated providers should notify proposed self-funders to the person concerned's local authority so that they can be offered assessment and regular review of their needs. Self-funders who are socially isolated, or who have lost links with their families should be offered advocacy support.

RECOMMENDATION 12: LOCAL HEALTH BOARDS AND NHS TRUSTS

Local Health Boards and NHS Trusts should ensure they have robust safeguarding arrangements, including:

- establishing specialist teams with the appropriate level of investigative skills and clinical expertise to contribute effectively to:
  - being a resource to staff within the LHB, or NHS Trust who have safeguarding concerns;
  - referring prima facie cases of abuse into safeguarding arrangements;
  - training others in safeguarding adults; and
  - local Safeguarding Adult Teams, including contributing to reciprocal investigation arrangements to ensure independence in investigation;
- ensuring that incidents of abuse are conceptualised as abuse;
- investigating all incidences of serious pressure ulcers (Grade 3and 4) to assess whether they have resulted from neglect;
- ensuring that all staff in contact with adults at risk are CRB checked;
- ensuring that all staff are trained in safeguarding adults to a level commensurate with their role;

LHBs should:

- support general practice in putting CRB checks and appropriate training in place;
- facilitate engagement of primary care in screening for abuse, safeguarding procedures, and information sharing;
- introduce screening for adult abuse in Accident and Emergency Departments; and
- ensuring that settings providing continuing healthcare have the necessary staff and equipment to support adults at risk, (including those at risk from pressure ulcers); and
- nurse assessors should be trained as investigators to PACE standards and play an integral part in the Boards safeguarding arrangements.

RECOMMENDATION 13: RAISING AWARENESS

There should be a national publicity campaign aimed at raising awareness amongst the general public, including adults who may themselves be at risk of abuse, about:

- what abuse is
- being clear that they should not have to tolerate abuse directed at themselves; nor should they tolerate abuse of other people
- who they can contact if they have concerns about abuse
- a national phone number that they can ring if they have concerns

The campaign should be timed to happen after the implementation of new policies and procedures and in the run up to new legislation being implemented to ensure there is capacity in the system to deal effectively with concerns and to highlight the new arrangements.

RECOMMENDATION 14: DUTY TO REPORT ABUSE

Staff working with vulnerable adults should have a duty to report abuse. Such a duty to report could be:

- a responsibility to maintain a member of staff's registration;
- a condition of employment;
- a requirement by regulators that such a duty is reflected in the policies and procedures of regulated settings;
- enshrined in new legislation (as in some other countries, including Canada – see para 68, Chapter 4).

There should be further consultation on each of these possible approaches.

Where reporting within organisations is problematic, concerns could be raised directly with safeguarding teams.

Whilst whistle-blowing policies should still be in place as a last resort, it was the general view that a change in culture was necessary based on a duty to report, rather than staff being seen as acting against their peers by taking it on themselves to act. This would take the "should I say something, or shouldn't I?" dilemma away from staff.

RECOMMENDATION 15: RESOURCES

The implementation of a system to safeguard adults in line with the recommendations in this review will not be cost neutral – although we do not think that the level of resources required will be comparatively as high as in Scotland. (See paras 435-8 , Chapter 6). Resourcing the proposed system is a question of priorities for the Welsh Assembly Government and its partners in safeguarding.

In order to identify the costs associated with these recommendations we recommend that local authorities, LHBs and the police in Wales should be asked to identify the resources associated with their safeguarding adults services including, as a minimum:

- staff
- non staff
- training

with effect from the financial year 2010/11 in order to identify the baseline spend.

Initiatives to support the implementation of new legislation, policies and procedures should be costed, taking into account resources that are already built in.

RECOMMENDATION 16: CONSULTATION AND DEVELOPMENT PROGRAMME

The review of *In Safe Hands* contains a wealth of information and ideas from contributors on a wide range of subjects. We could make many hundreds of detailed recommendations based on our findings for example on:

- institutional abuse
- financial abuse – especially in relation to adults with capacity;
- developing advocacy capacity;
- developing post-abuse support capacity in the voluntary and statutory sectors;
- information sharing
- commissioning
- training (including all of the groups set out in para 239, academic social work training, Coroners and others identified through training needs assessment.)
- data definition (for example, using 'substantiated' rather than 'proved' to improve accuracy of reporting).

However, our remit was principally to look at the policy level aspects of safeguarding and much about how the details of the report could be tackled will turn on the model for safeguarding that the Welsh Assembly Government decides to adopt. This will not be clear until all strands of the policy review, including:

- this review of *In Safe Hands;*
- CSSIW and HIW inspections of adult protection; and
- The work of the National Adult Protection Project Board

can be considered as a whole and a consultation exercise is carried out. We recommend that once the model for safeguarding adults is settled following full consultation, the proposed National Safeguarding Adults Group, (or equivalent) will work through the details of this review to create a development programme that ensures the rich detail of the review informs the future development of safeguarding policy.

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APPENDIX 1

FIELDWORK: SCHEDULE OF ORGANISATIONS/GROUPS

Action on Elder Abuse

Adult Protection Co-ordinators

Age Alliance Wales (Age Concern Cymru and Help the Aged in Wales)

Age Concern and Help the Aged Scotland

Association of Directors of Social Services Cymru

Blaenau Gwent Council

Blaenau Gwent Community Safety Partnership

Blaenau Gwent Local Safeguarding Children's Board

Blaenau Gwent Local health Board

Bridgend Local Health Board

British Bankers Association

Cardiff Council

Cardiff and Vale NHS Trust

Care and Repair

Care and Social Services Inspectorate Wales

Care Forum Wales

City of Edinburgh Council

Coalition of Scottish Local Authorities

Crossroads

Crown Prosecution Service

Department of Health (England)

Financial Services Authority

Gwent Police

Health Inspectorate Wales

Home Office

Independent Safeguarding Authority

Isle of Anglesey Council

Innovate Trust (Housing)

Law Commission

Learning Disability Alliance

Mental Health Alliance (MIND Cymru)

North Wales Police

Office of the Older People's Commissioner for Wales

PAVA (UK)

PAVA (Wales)

Pembrokeshire Council

Public Services Ombudsman for Wales

Regional Adult Protection Forums

Royal College of General Practitioners

Scottish Executive

Shaw Homes

South Wales Police

Voluntary Action Cardiff

Wales Council for Voluntary Action

Welsh Local Government Association

Welsh Institute for Health and Social Care

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