LAW REFORM COMMISSION ISSUES PAPER A REGULATORY FRAMEWORK FOR ADULT SAFEGAURDING

May 2020

A submission from the Nursing Homes Quality Initiative

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Issue 1 Values And Principles Underpinning Adult Safeguarding

Q. 1.1 Do you consider that the proposed guiding principles, as set out above in paragraph 1.14 of the Issues Paper, would be a suitable basis to underpin adult safeguarding legislation in Ireland?

Ans. 1.1

Yes

Q. 1.2 Do you consider that additional guiding principles should underpin the legislation? If yes, please outline the relevant additional guiding principles.

Ans. 1.2

Drawing on our experience with the implementation of nursing home quality standards, we strongly contend that adult safeguarding legislation and systems must be based on the principle of service user involvement, both directly and through independent user voice advocacy. This principle should be applied for the drafting of the general scheme and Bill. Otherwise, there is a real risk that the oversight system becomes mechanistic and self-serving.

*While we agree that **proportionality** (ref. to level of risk presented) and **integration** and **cooperation** (ref. to multi-agency approaches) are values to be aspired to, the safeguarding systems which emerge should not be hampered by risk-averse bureaucracy and buck-passing. Timely decision-making and decisive actions are essential, in our view, in these contexts. There are too many examples in the personal services areas of organisational inertia hampering effective interventions due to one or more of the conditions that we mention here.*

Issue 2 Defining Key Terms For Adult Safeguarding

Q. 2.1 Do you consider that the statutory regulatory framework for adult safeguarding should define the categories of adults who come within its scope?

Ans. 2.1
Yes. However, definitions should not be so exclusive as to rule out, in the future, persons whose profile is not anticipated at the drafting stage, but whose plight cries out for relief under safeguarding legislation.

Q. 2.2 If the answer to Q. 2.1 is yes, what definition of the categories of adults who come within its scope would you suggest?

Ans. 2.2 *The excellent LRC Issues Paper provides comprehensive food for thought on this complex but crucial aspect. We lean towards a somewhat elastic 'social sciences' definition as opposed to a purer 'legal' definition.*

- *We agree that the term 'vulnerable' is inappropriate for the reasons given.*
- *The condition 'exploitation' is essential (c.f. [2.6]).*
- *The definition should acknowledge that abuse can occur in the context of an individual's personal, family or social circumstances – and not exclusively because of a 'lack of mental or physical capacity to protect themselves…' [2.6].*
- *We see merit in the use of the term 'unable to protect him or herself from abuse, harm ([2.7]) or exploitation'.*
- *Re [2.8], we are drawn to (a) and (b) of the Scotland (2007) Act.*
- *It is important not to stigmatize people or classes by virtue of social status or age.*

After some reflection, we conclude that, short of re-drafting the relevant definition in its entirety (which we are not qualified to do), we cannot give a confident answer to this question. However, we would appreciate if the sentiments expressed in the bullet points above are given due weight.

Q. 2.3 Do you consider that the Commission has, in Issue 2 of the Issues Paper, defined the following terms with sufficient clarity:
(a) "safeguarding";
(b) "abuse" and "harm" (including whether you consider that the definition of "abuse" should include "harm" or whether "abuse" and "harm" should be separately defined);
(c) "neglect";
(d) "capacity".

Ans. 2.3

(a) *Re [2.15], we favour the term 'safety from harm and exploitation'*
(b) /(c)

We are leaning towards the British Columbia 1996 definition of abuse ([2.31]).

In the literature on institutional care, the terms abuse and neglect are frequently twinned. As concepts, the lines between these are often blurred and they appear to exist as a continuum. For example, conditions may be allowed to exist, in a residential setting, through negligence, which are conducive to the occurrence of harm or abuse. Is there a different level of culpability in such an instance than in the case of a more direct 'episode' or pattern of abuse? Notwithstanding your heroic efforts at [2.24] to [2.47], one wonders whether any useful purpose is served by defining these concepts separately. It might be worth exploring a different approach, based, perhaps on the effect or impact of such actions or omissions on the victim. Where feasible, there may be merit in relying on standard dictionary meanings of abuse, harm, neglect. Such reliance, informed by the appropriate context, could be suitably articulated in procedural documents such as codes of practice.

(c) *(dealt with at **Ans. 2.3(b)/(c)**)*
(d) *Re. 'capacity', we are in agreement with the approach outlined in [2.48] to [2.53].*

Issue 3 Physical, Sexual, Discriminatory And Psychological Abuse, Neglect And Deprivation Of Liberty

Q. 3.1 Do you consider that adult safeguarding legislation should impose a statutory duty on an adult safeguarding service provider to prepare a care plan for each adult in receipt of safeguarding services?

Ans. 3.1 *Yes, absolutely. This duty is already legislated for in respect of the nursing home sector, to which this submission speaks (The Health Act 2007 and the National Quality Standards for Residential Care Settings for Older People in Ireland). Notwithstanding that fact, deficiencies in, or total absence of, care plans have frequently been reported by the oversight body (HIQA) over the ten /eleven years of its existence.*

Q. 3.2 Do you consider that adult safeguarding legislation should impose a duty on an adult safeguarding service provider to safeguard adults at risk?

Ans. 3.2 *Yes, absolutely.*

Q. 3.3 If the answer to 3.1 is yes, do you consider that such a care plan should address the prevention of physical, sexual or psychological abuse, or neglect?

Ans. 3.3 *In relation to the nursing home sector, the National Standards referred to at Ans. 3.1 provide for the safeguarding and protection of nursing home residents – (Theme 3 of the Standards is reproduced in shaded print below). Yet, sadly, there are too many instances of reported failure in this area. Furthermore, there are many nursing homes currently on the register that due to environmental shortcomings, management failures or outdated institutional cultures, provide care settings where conditions conducive to the commission of abuse and neglect are present.*

It is clear to us from our experiences of many years, that existing regulations governing the care plan must be strengthened and oversight, including penal sanctions for failure to comply with the terms of their contract of registration made more effective as inducements to adhere to better practices.

Theme 3: Safe Services	
Standard 3.1	Each resident is safeguarded from abuse and neglect and their safety and welfare is promoted.
Standard 3.2	The residential service has effective arrangements in place to manage risk and protect residents from the risk of harm.
Standard 3.3	Infection prevention and control practices achieve the best outcomes for residents.
Standard 3.4	Each resident is protected through the residential services policies and procedures for medicines management.
Standard 3.5	Arrangements to protect residents from harm promote bodily integrity, personal liberty and a restraint-free environment in accordance with national policy*.
Standard 3.6	Each resident's personal property and finances are managed and protected.

Q. 3.4 If the answer to either 3.1 or 3.2 is yes, do you consider that breach of such a duty or, as the case may be, duties should give rise to civil liability on the part of an adult safeguarding service provider?

Ans. 3.4 *Yes – see also* **Ans. 3.3** *above.*

Q. 3.5 If the answer to either 3.1 or 3.2 is yes, do you consider that breach of such a duty or, as the case may be, duties should give rise to criminal liability on the part of an adult safeguarding service provider?

Ans. 3.5

Yes.

Q. 3.6 If the answer to 3.2 is yes, do you consider that breach of such a duty by a person responsible for providing adult safeguarding services, where this occurs in the course of his or her duties or, as the case may be, within the scope of employment of an adult safeguarding service provider, should give rise to a complaint to a professional body with regulatory functions in relation to a person who is a member of that professional body?

Ans. 3.6

To the extent that the objective is to remove unfit persons from practice, then the gravity of the failure on the part of a professionally registered employee or contractor will dictate which path the complaint should follow. Procedural protocols may be implied in the individual's contract of service or conditions of employment. If not, they should be so provided in legislation.

Q. 3.7 Do you consider that there are any additional legal measures that could be introduced to prevent physical, sexual, psychological abuse or neglect?

Ans. 3.7

Again, in respect of the nursing home sector, the HIQA annual overview of regulatory outcomes have, year after year, recognised the correlation between the levels of regulatory compliance and the quality of management at a centre. Yet, there is no evidence of any proactive measures having been taken to act upon this evidence.

We are strongly of the view that a recognised system for assessing managerial competency is called for. This should be guided by and compatible with the National Standards 2016. We get the impression that the 2007 Health Act and the associated regulatory standards are seen as a barrier to progress in this area. It may be necessary to legislate for the assessment of competency standards, which might be specified in the form of a standalone selection/assessment code for service providers and senior managers in the personal services sectors.

Issue 4 Financial Abuse

Q. 4.1 Do you consider that sectoral regulators and bodies such as the Central Bank of Ireland and the Department of Employment Affairs and Social Protection currently have sufficient regulatory powers to address financial abuse in the context of adult safeguarding?

Ans. 4.1

No.

Q. 4.2 If the answer to 4.1 is no, do you consider that either or both of the following would be suitable to address financial abuse:
(a) a statutory financial abuse code of practice or protocol;
(b) a statutory form of protected disclosure, along the lines of the *Protected Disclosures Act 2014,* for financial institutions that engage in responses to suspected financial abuse in good faith.

Ans. 4.2

We agree with the general thrust of [4.38] and [4.39].

We would emphasise that the legislation should underpin a clear code that is easy to comprehend by the at-risk person and family members and their advocates. In the case of persons in residential care, the care home provider should sign up to the code as part of the service contract. Such code would then become a governance issue, compliance with which would be inspected by the regulator for nursing home services.

Q. 4.3 Do you consider that further additional regulatory powers are required to address financial abuse? If yes, please give examples.

Ans. 4.3 *None.*

Issue 5 What Body Or Bodies Should Have Responsibility For The Regulation Of Adult Safeguarding?

Q. 5.1 The Commission has discussed the following 5 possible institutional or organisational models for the regulation of adult safeguarding:

- Establishing a regulatory body within the Health Service Executive;
- Establishing a regulatory body as an executive office of the Department of Health;
- Establishing a regulatory body as an independent agency;
- Amalgamating a regulatory body with an existing agency
- Conferring additional regulatory powers on an existing body or bodies.

In your view:
(a) which of the above is the most appropriate institutional or organisational model for the regulation of adult safeguarding?

Ans. 5.1(a) *The choice of organisational model for the regulation of adult safeguarding is of the most fundamental importance to the success of the entire project. For convenience, we refer to the five alternative models above as Model 1 to Model 5.*

Model 1: This is not appropriate: The Commission of Investigation into Leas Cross (Department of Health, 2009) drew attention to the unsuitability and obvious pitfalls of the service provider as regulator. Furthermore, long-stay centres administered directly or funded by the HSE are frequent offenders in respect of non-compliance with the existing regulations and standards administered by HIQA.

Model 2: This is not a suitable or appropriate model. A model under the direct control of the Minister or Government of the day is not desirable for a number of reasons –

- *While the new organisation may be independent in the performance of its duties and functions, it is at the risk of being 'nobbled' or restricted for political expediency or by means of budgetary restrictions. Examples of such do crop up in the history of public administration in Ireland;*
- *The independence conferred on executive offices under the direct control of ministers can be illusory: the controlling Department may have little tolerance for actions or views that are at variance with traditional departmental thinking ("…you have not been funded to criticise the Government…");*
- *A decision on the part of Government to take the 'executive office' option may be motivated by a wish to keep control at a strategic level, either through budgetary or staffing measures, or simply by operational steerage. The executive office model can be*

used to facilitate the exclusion of community or NGO input and hinder wider public accountability for their stewardship;

We have also noted a structural resistance to service user input into regulatory matters concerning social care: this deficit is not exclusive to an executive office model.

In relation to [5.15], we do not comprehend the comparative advantage cited here. In relation to the example cited in that paragraph, we believe that the 'key advantages' attributed to the executive office model in that case would likely be given much greater expression in an independent agency. [Incidentally, we believe that the jury is still out on whether existing organisational structures can provide a suitably proactive, creative and representational response to the seemingly intractable scourge of violent crime within Irish homes.]

Model 3: We believe this to be the option with the greater chance of delivering on the complex and multi-faceted mission of adult safeguarding. The establishment of a regulatory body with independent agency status and appropriate governance structures provides the safeguarding project with the single best chance of success. We believe it will be necessary for the new agency to oversee the performance of other actors in the sector as well as driving the necessary culture change.

Model 4: We see conflicts of interests occurring in the pursuit of their respective roles by existing agencies. In the nursing home domain, for example, it is our experience that the breadth of the HIQA remit is already a challenge. In our view this has resulted in, inter alia, a lack of focus on individual sectoral needs and an unfortunate disconnect with nursing home service users. In any event, we foresee grave challenges ahead for the health and social care regulator as a profound reimagining of residential care gets under way.

Model 5: (As for Model 4)

(b) do you consider that any of the models discussed would be completely inappropriate? Please give reasons for your answers to (a) and (b).

Ans. 5.1(b)
Yes, we consider Models 1, 2, 4 and 5 to be unsuitable, mainly for the reasons *given at Ans. 5.1(a) above.*

The relationship between the new agency and other relevant agencies requires to be thought out carefully but, in our view, its governance must reflect an independent oversight of the other relevant agencies in respect of adult safeguarding.

Internal governance arrangements designed to best serve the mission and aims of the new agency may preclude representation by vested interests, including state organizations, private providers, trade and professional bodies.
The new agency should be demonstrably answerable to the citizens and service users through an all-party Oireachtas Committee representative of both Houses.

Q. 5.2 Do you consider that any, or all, of the 6 core regulatory powers that the Commission has identified in paragraph 5.38 of the Issues Paper should be applied in the case of adult safeguarding and, if so, whether they would be sufficient in the context of adult safeguarding legislation?

Ans. 5.2
We are in general agreement with the terms of [5.38] and [5.39]

Q. 5. 3 Do you consider that there is a need for a statutory regional adult safeguarding structure, which would have a broad remit in respect of all safeguarding services for adults? If so, how would such a regional structure be best integrated into existing structures?

Ans. 5.3 *We do not have a view on these specific questions. We expect that structures appropriate to the fulfillment of the mission fully and fairly across all regions will be adopted. We do feel strongly, however, that service user participation is essential in the ongoing operation of safeguarding structures – such participation might be best served by local or regional networks.*

Based on our experience, we believe that it may be necessary to make appropriate statutory provision in order to assure service user involvement in the proposed new scheme of adult safeguarding.

Re Issue 5, par. 2(e)

[5.40] We advise caution in relation to the sway that should be given to the practical advantages of handing over the new powers and functions to existing bodies, some of which have been, arguably, overtaxed in the performance of analogous functions. We do not deny the financial and administrative gains in such arrangements. However, we would argue that these potential gains are outweighed by the significant culture shifts that would be required in existing agencies. Hence, we hold that none of the existing agencies, likely to be candidates for such conferral, are well placed to lead the transformation.

[5.41] We concur with the general sentiments expressed here.

[5.42] We submit that there is a world of difference between oversight in financial services and oversight in personal care services.

[5.43] Where persons at risk are in present or imminent danger, there is an obvious need for immediate decisive interventions. The oversight monitoring body, as a model, has appeal where the need for intervention is not so absolutely time-critical. It would not meet the safeguarding objectives in a nursing home context. Existing processes for processing complaints ('concerns') through HIQA, service providers, the Ombudsman and the courts are slow, unwieldy and generally unsatisfactory in the eyes of service users.

In this regard, a trawl through HIQA inspection reports will reveal its reliance on subjective opinion in its assessment of conditions pertinent to complaints made. Such a trawl will also reveal that a worrying number of nursing homes are able to continue in operation without implementing remedial actions specified by HIQA for the purpose of addressing non-compliances – thereby leaving numbers of residents exposed to the risk of neglect or abuse.

Re Issue 5, par. 3

[5.47] We note a preponderance of professional and institutional stakeholders in the proposals laid out here – to the exclusion of service users. This must be questioned and challenged in the strongest terms. There has been an unfortunate lack of meaningful engagement with service users in regulatory oversight of the nursing home sector in the eleven years since the current regime was established. We consider this to be a serious omission and there is a growing body of international evidence to support our position on this matter.

We have noted the exemplars cited in [5.47] and we refer you to the views expressed by us at Ans. 5.1(b) in relation to vested interests. We have also noted the OECD views cited.

Issue 6 Powers Of Entry And Inspection

Q. 6.1 Do you consider that adult safeguarding legislation should include a statutory power of entry and inspection of premises, including a private dwelling, where there is a reasonable belief on the part of a safeguarding professional, a health care professional or a member of An Garda Síochána that an adult within the scope of the legislation may be at risk of abuse or neglect in the premises or dwelling, and where either a third party is preventing them from gaining access or an adult within the scope of the legislation appears to lack capacity to refuse access? Please give reasons for your answer.

Ans. 6.1
Yes. This power is fundamental to the effective safeguarding of people at risk who by definition may lack the capability to defend themselves or summon help. We include the nursing home as 'premises' in this context. We suggest that issues around reporting and jurisdiction be made clear where there is reason to believe that human rights violations are practiced in the residence. Examples might include the use of physical restraints, the abuse of psychotropic drugs or 'punishments' such as social isolation.

Q. 6.2 If the answer to Q.6.1 is yes, do you consider that evidence of reasonable belief that a person may be at risk of abuse or neglect would constitute a sufficient safeguard to ensure that such a power would be used effectively and proportionately, or would any other safeguards be required?

Ans. 6.2 *This is a complex area of law and practice*. *It seems to us that the challenge here is to find a responsible and respectful social services solution: a case of less law and more commonsense! While accepting that there is a need for safeguards against abuse of process, we are concerned that excessive checks and balances will unduly hamper necessary interventions and, eventually, lead to inertia.*

Q. 6.3 If the answer to Q.6.1 is yes, do you consider that such a power of entry and inspection:
(a) should be conferred directly on a safeguarding professional, a health care professional or a member of An Garda Síochána, or
(b) that such entry and inspection should require an application to court for a search warrant, whether in all instances or only where entry and inspection is to a private dwelling.
Please give reasons for your answers to (a) and (b).

Ans. 6.3 (a) and (b)
We do not feel qualified to answer the specifics of these questions. However, we respectfully suggest that the drafters give full consideration to the mission and purpose behind the legislation and are guided by those principles.

Q. 6.4 If a power of entry and inspection to a private dwelling were to be conferred on a member of An Garda Síochána, do you believe that a member should be permitted to use reasonable force, if necessary, to gain access to a dwelling?

Ans. 6.4

This is a technical issue beyond our competence. Again, we ask that drafters be guided by the mission and purpose driving the legislation.

Issue 7 Safeguarding Investigative Powers

Ans. 7 (overview)

As with the entirety of this Issues Paper, the discourse in section 7 is extremely clear and informative. Here again, our comments are informed by our knowledge and experience of practice on the ground, and of the operation of the regulatory system, in the nursing home sector over the past ten years.

The unequal relationship between nursing home provider and resident, a matter that is widely reported in the literature, is relevant across the entire safeguarding discussion. As a rule, a resident's family will not question staff decisions in nursing homes and residents, even where they are cognitive, will not feel empowered to question nursing home provider management or staff. This can become insidious over time and cause a resident to be isolated and at risk with no redress. Experience shows that the regulator is not necessarily in a good position to intervene in a timely and effective manner. These realities must advise a number of facets of the proposed adult safeguarding arrangements as they apply to the nursing home population.

We rely on those who are more skilled in the machinations of law and legislation to take note of the particular vulnerabilities of nursing home service users in the drafting of the proposed adult safeguarding bill.

Q. 7.1 Do you consider that adult safeguarding legislation should include a statutory duty on relevant regulatory bodies to make inquiries with a view to assessing whether to apply for a court order for the removal of a person or for a safety order, barring order or protection order, similar to the orders in the *Domestic Violence Act 2018,* as discussed in Issue 7 of the Issues Paper? Please give reasons for your answer.

Ans. 7.1

It seems to us that a barring order, or other protective measure is appropriate in the nursing home setting only when the 'respondent' is a visitor to the residential centre, be they a person related to the 'applicant' or other visitor (including a visitor to another resident) or an agent of any of the above, including an agent of the service provider.

Where the 'respondent' is a proprietor, employee or volunteer at the centre, we would expect that such person, having betrayed a trust and/or acted offensively or unprofessionally, would be removed completely from the centre. Where the alleged perpetrator is another resident, the first priority will still be to safeguard the alleged victim while the matter is investigated, in the first instance, by external persons, viz. An Garda Siochana, a doctor and social worker and (in the interests of natural justice) an advocate for the alleged offender.

Re powers of removal and assessment (of a nursing home resident) under the Mental Health Act [7.11], we urge caution for the well-known reason that anti-social or disruptive behaviours can be provoked as a consequence of <u>unmet needs</u> or in situations where behavior by others is (deliberately, perhaps) provocative or disrespectful – in effect, the resident in question may be a

victim. The participation of an independent advocate who knows the individual is essential to decision-making in such cases (together with a social worker if deemed necessary). It is well to bear in mind that the person had been assessed as suitable for the nursing home setting in the first place.

Q. 7.2 Do you consider that the *Domestic Violence Act 2018* should be amended to empower bodies other than the Child and Family Agency, such as for example the Health Service Executive or any other adult safeguarding regulatory body, to apply to court for an order under the 2018 Act?

Ans. 7.2
Yes, subject to the other comments made in reply to **Q. *7***.

Q. 7.3 Do you consider that adult safeguarding legislation should include separate provisions for barring orders, protection orders and safety orders that would apply in situations outside of the circumstances set out in the *Domestic Violence Act 2018* or section 10 of the *Non-Fatal Offences Against the Person Act 1997*?

Ans. 7.3 *Yes*

See also **Ans. 7 (overview)** *above.*

Issue 8 Reporting

Questions for Issue 8

Ans. 8 – General Comment on Issue 8

Our views on the matters covered in the Issues Paper under Issue 8 are set out in the following paragraphs; specific responses to **Qs 8.1, 8.2** *and* **8.3** *are given beneath:*

(i) *We note that the concept of mandatory reporting is seen as problematic in many quarters within the Irish administrative system. Although we came to this project with an open mind on that particular matter, we are unconvinced by the arguments put forward both against mandatory reporting, and in favour of waiting for further evidence of its efficacy before adopting it for the Irish context. We see dubious merit in further delaying decisions on this matter. The older population in Ireland is a fast-changing demographic and the performance of new systems set up in the short term under new legislation will have to be monitored and evaluated on an ongoing basis.*

(ii) *We know only too well the burden of rules, codes and standards carried by nursing homes and residential centres. We are aware that some nursing homes continue to struggle under the weight of these. For these reasons, we advocate that the new safeguarding system be easily understood and capable of being complied with at all levels of care systems.*

(iii) *We speak of the unequal relationship between nursing home provider and resident, in response to* **Issue 7** *above. With that particular condition in mind, we regard it as essential that all parties associated with a nursing home, either formally or casually, are obligated to report knowledge or suspicion of harm, abuse or neglect – see Scottish model at [8.7]. These would include service providers, staff and volunteers in the residential centre, agents, contractors, suppliers, medical personnel, therapists, podiatrists, and hairdressers. It would also include, under a universal mandatory reporting model, HIQA inspectors, resident advocates and visitors.*

(iv) *The Nova Scotia model at [8.15] has caught our interest. We would welcome further information on the efficacy of this model which appears to date back to the 1980s.*

(v) *We are surprised by an element of the Australia model at [8.11] which provides for discretion in the reporting of alleged assaults perpetrated by residents who have been assessed as lacking mental capacity. The rights and dignity of all victims are paramount, and all victims must be respected and protected equally.*

(vi) *Effective provisions for the protection of the identity of a person reporting an incident are essential in the Irish culture which carries a historical hostility towards whistleblowers – see [8.14].*

(vii) *We favour a universal obligation over a restricted provision quoted at [8.17] (S.21(1 of the Adult Safeguarding Bill 2017)). We can envisage, for example, a situation where the clause 'in the course of his or her employment or profession' is used by a witness (a) as a pretext to avoid their obligation to report or (b) by an accused as a defence on technical*

grounds. In any event, this clause may fall should a universal mandatory reporting model be adopted.

(viii) *We are in general agreement with the arguments at [8.19] to [8.22] in favour of mandatory reporting.*

(ix) *We are, on the whole, unconvinced by the various arguments against mandatory reporting – [8.25] to [8.33]. Regarding [8.25] and [8.26], it is our experience that existing systems and legislation are not adequate in the context of progressive adult safeguarding systems. Whether it is the actual rules or their enforcement that need strengthening is moot. It would help us, however, to have an input from the regulator (HIQA) on this matter. We are familiar with cases of regulatory non-compliance from HIQA publications and reports in the wider media.*

(x) *We are somewhat disappointed by the positions put forward to the Joint Oireachtas Committee on Health. Service providers are weighed down with rules, codes, standards and guidelines as it is. The current regulatory regime is in its eleventh year and we fail to see how further 'guidelines' are an answer. There is also reference in [8.26] to 'managing complaints'. The current practice of categorising complaints as 'concerns' to be dealt with as regulatory matters at arm's length from the resident (the alleged victim) and relatives does not work to the satisfaction of the service user. An objective of the safeguarding legislation will be to simplify the making of complaints and the reporting of incidents – an outcome that, in itself, will serve to raise awareness and strengthen safeguarding practice.*

(xi) *We would be concerned about the separation of complaints into major and minor categories at local level as this is open to manipulation by vested interests. It is also an additional procedural step that might lead to delays in pursuing investigation/resolution of same.*

(xii) *Re [8.27], the option of suing organisations or professionals is not a realistic option for the nursing home population or families, for obvious reasons, not least that the average stay in residential care is c.3 years.*
*Re [8.28], the existence of policies and procedures is no guarantee of safe ethical services. The National Standards for Residential Centres for Older People in Ireland 2016 provide a comprehensive suite of procedures for nursing homes. The standards in respect of staffing (Standard 7: Responsive Workforce) require: '*planning, recruiting, managing and organising staff with the necessary numbers, skills and competencies to respond to the needs and preferences of people in residential services'.

It will be seen in the HIQA Overview Report 2018 that management competency and staffing issues feature prominently among the challenges that nursing homes are still grappling with, ten years on from the introduction of the current regulatory regime (2009).

(xiii) *On the whole, we find the arguments against mandatory reporting at [8.23] to [8.33] less than convincing. We approached this project with an open mind on that specific issue. However, we have now come to the view that legally mandated obligations on all*

parties have the greater potential to alter behavior and change culture in the nursing home sector which still carries many of the institutional traits of a bygone age.
We have noted counter-arguments at [8.30] (Department of Health, 2017). The challenge is to make universal mandatory reporting uncomplicated so that it can work in a practical, streamlined fashion. In taking that position, we are keenly aware of the fact that personal care services are heavily laden with administrative procedures and obligations which, according to nursing home managements and staff, detract from the quality of the personal care provided for residents.

(xiv) Re [8.34], we favour option (ii), universal mandatory reporting – which should also provide protections for reporters for their own protection and also as a means of encouraging the reporting of suspected abuse/neglect or conditions/behaviours conducive to same. We do not favour options (i), (iii) and (iv).

(xv) Re [8.35], [8.37], we are opposed to further delay in legislating for or <u>commencement</u> of adult safeguarding legislation, or to putting it once more on the long finger.

(xvi) Re [8.36], we believe the same outline process should apply in all contexts, namely, to the new safeguarding authority which would direct investigations from that point.

(xvii) Re [8.38], we fully agree with the sentiments expressed.

Q. 8.1 There are four possible reporting models for suspicions of abuse or neglect concerning adults within the scope of adult safeguarding legislation:
(i) permissive reporting;
(ii) universal mandatory reporting;
(iii) mandatory reporting by specific persons;
(iv) a hybrid or "reportable incidents" model.
In your opinion, which of these is the most appropriate model for reporting incidents of the abuse of adults within the scope of adult safeguarding legislation, or reporting reasonable suspicions regarding abuse of those adults? Please give reasons for your answer.

Ans. 8.1

Model (ii), universal mandatory reporting: we have come to the view, on the balance of the arguments and opinions presented, that this is the more appropriate model for Irish conditions.

Q. 8.2 If the current permissive reporting model were to be retained, should it be placed on a statutory basis? If yes, should statutory protections be enacted for those who report concerns in good faith?

Ans. 8.2 *See* **Ans. 8.1** *and sub-paragraph (xv) above.*

Q. 8.3 If a hybrid or "reportable incidents" model were to be enacted, to what incidents of abuse or neglect should mandatory reporting apply? Should mandatory reporting apply to financial abuse, for example?

Ans. 8.3

Yes. Financial abuse is a serious breach of trust and is likely to be perpetrated progressively and repeatedly. We place financial abuse towards the higher end of harm and abuse committed against at risk adults. In a hybrid model we see non-reportable incidents as those very minor inadvertent conditions or events which may be corrected on the spot by the service provider on being drawn to their attention by HIQA or a relative or an advocate. Mandatory reporting would apply to willful neglect or abuse by act or omission.

Issue 9 Independent Advocacy

Q. 9.1 Do you consider that there should be statutory provision for independent advocacy in the context of adult safeguarding?

Ans. 9.1

Yes.
Regrettably, a statutory provision would appear to be the only best way.
Attempts to establish an independent advocacy service for nursing home residents, post-Leas Cross, would appear to have stuttered. For one thing, some nursing homes have not embraced the idea. Also, attempts to recruit, train and retain volunteer advocates seem to have had limited success. We also note the strong anecdotal evidence that some nursing home managers will prefer to deal with 'advocates' of their own choosing.

Reflecting on your Issues Paper, the data presented and the timelines, we must ask whether advocacy provisions and other related questions have not been over-thought. We trust that there will emerge from your research and public consultations a fresh approach to providing for a right to access to an independent advocate based, first and foremost, on the needs and rights of at-risk adults.

We make reference elsewhere (Ans. 7) in these responses to the unequal relationship between nursing home provider and resident, a matter that is widely reported in the literature. Another manifestation of this, also reported in the literature, is the evidence of collusion between the care organisation and the resident's family to the detriment of the wishes and interests of the resident.

Q. 9.2 If the answer to Q.9.1 is yes, do you consider that:
(a) it would be sufficient to commence the relevant provisions of the *Citizens Information Act 2007* providing for a Personal Advocacy Service; or
(b) additional statutory provisions should be enacted providing that advocacy services could be provided in addition to those under the 2007 Act?
Please give reasons for your answer to (a) and (b).

Ans. 9.2

We are uneasy about the relevant provisions of the Citizens Information Act 2007. We would need further briefing as to how these provisions would operate in the context of personal safeguarding for nursing home populations, who by their very condition and circumstances are at the outer extreme of vulnerability and whose primary need is to have someone who can intervene/speak on their behalf locally in a situation of acute threat or risk, or in the aftermath of same – or in environments where continuous or ongoing low-to-medium-level risk of neglect or abuse are present.

Section 5 of the Citizen Information Act 2007 appears to us to be overly-complicated and risking the establishment of a bureaucratic system that is not readily accessible to those who need it most. In the first instance, the notion of establishing qualification criteria unrelated to need and risk (Section 5 subsection 7A(3)) would appear to run counter to the values and principles put forward at ***Issue 1.****It is essential that safeguarding legislation provide legal standing for locally-based volunteer independent advocates and funding structures for their training and mentoring.*

While we find the discourse in your ***Issue 9*** *chapter extremely helpful, there are significant gaps from our perspective. For example, in pages 151 to 155 a number of sources are cited in respect of the need for a statutory framework, but the service user community is conspicuous by its absence. There is a need for discussion with service users on the specific needs of our sector and its population of 35,000+ older men and women.*

Q. 9.3 If the answer to Q. 9.2(b) is yes, do you consider that there is a need for a national advocacy body in the context of adult safeguarding? If yes, do you believe that this should operate as an independent agency or that it should be located within an existing agency?

Ans. 9.3

See **Ans. 9.2.** *The specific needs of the nursing home population should be teased out as a first step.*

Issue 10 Access To Sensitive Data And Information Sharing

Q. 10.1 Do you consider that existing arrangements for access to sensitive data and information sharing between relevant regulatory bodies are sufficient to underpin adult safeguarding legislation?

Q. 10.2 If the answer to Q. 10.1 is no, should arrangements for access to sensitive data and information sharing between relevant regulatory bodies include interagency protocols coupled with statutory powers? If so, please indicate your view on the form of such powers.
Ans. 10.1 and 10.2

The Issues Paper recognizes the need to strike a balance between the right to privacy of the individual and the wider public interest.

We support the Commission on the Future of Policing view, which favours a legislative obligation on agencies to share all relevant information within their possession in order to help reduce harm to people at risk ([10.26]).

Issue 11 Multi-Agency Collaboration

Q. 11.1 Do you consider that:
(a) non-statutory interagency protocols are sufficient to ensure multi-agency cooperation in adult safeguarding, or
(b) a statutory duty to cooperate should be enacted.

Ans. 11.1 *We favour option* **(b)** '*a statutory duty to cooperate should be enacted'.*

Q. 11.2 If the answer to Q. 11.1(b) is yes, to which bodies with adult safeguarding regulatory responsibilities should the duty apply?

Ans. 11.2

We are acutely aware that where serious neglect/abuse occurs over a period of time, the full impact on the victim may not be immediately apparent. It would appear that the HIQA model is unable to offer immediate or direct protection to the victim. Similarly, the effectiveness or appropriateness of the Ombudsman, which is essentially a historic review function, as a mechanism for timely identification/resolution of complaints affecting the life and acute health of at risk persons is questionable.
In the light of ongoing concerns about individual cases (e.g. Richard Dillon (deceased), Mount Carmel and HSE – reported on RTE Prime Time 27/02/ 2020), new interventions and investigative structures must give confidence to relatives and guardians that timely protective actions can be taken, and accountabilities established promptly. The best prospect of achieving this is under the direct remit of a new independent safeguarding agency.
A strong, independent overarching entity, answerable to the citizen, may be necessary in order to provide the required oversight. Such an entity would have to be completely separate from any outside influences or vested interests such as HSE, HIQA, NHI or professional groupings. Such a body should be obligated to report to the public via a Joint Oireachtas Committee (of the Dail and Seanad) on the efficacy of regulatory oversight arrangements in the various settings, and the outcomes achieved.

Q. 11.3 Do you consider that there should be statutory provision for transitional care arrangements between childcare services and adult safeguarding services?

Ans.11.3

We do not have the requisite expertise/experience to offer a view on this matter.