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Joint Committee on Disability Matters

Ensuring rights based adult safeguarding in Ireland

2024

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Committee Membership

Cathaoirleach

Michael Moynihan TD, Fianna Fáil

Leas-Cathaoirleach

Pauline Tully TD, Sinn Féin

Members

Seán Canney TD, Independent

Dessie Ellis TD, Sinn Féin

Frankie Feighan TD, Fine Gael

Gary Gannon TD, Social Democrats

Emer Higgins TD, Fine Gael

Brian Leddin, Green Party

Jennifer Murnane O'Connor TD, Fianna Fáil

Senator Tom Clonan, Independent

Senator Eileen Flynn, Independent

Senator Erin McGreehan, Fianna Fáil

Senator Fiona O'Loughlin, Fianna Fáil

Senator Mary Seery Kearney, Fine Gael

Cathaoirleach's Foreword

Safeguarding is everybody's responsibility.

However, there is a profound failure of empathy, understanding and compassion with regard the lack of urgency in ensuring development of comprehensive policy, regulation, and legislation to protect people with disabilities.

This report focusses on two public meetings undertaken by the Committee; 31 March 2022 HIQA, Sage Advocacy, the Irish Association of Social Workers and Professor Brendan Kelly, professor of psychiatry at Trinity College Dublin attended. Safeguarding Ireland attended a public meeting on 21 February 2024. Several key findings and recommendations arose from the meetings.

Key stakeholders who have responsibility for safeguarding, as well academics, presented alarming evidence to the Committee regarding the prevalence of abuse and safeguarding issues, and lack of appropriate management. It is alarming to hear of the extent of under reporting, and that we are only seeing the 'tip of the iceberg' with regard the cases reported.

Abuse can include sexual and physical assaults, and financial abuse, however, abuse also includes when someone is being left for a long time, the bell is not being responded to and his or her needs are not being met, or instead of getting a 20-minute walk in the garden because he or she needs to use the commode, the person will miss out on a walk that day.

As well as urgent enactment of appropriate adult safeguarding legislation, the Committee call for the immediate establishment of a working group to consider the system required when the legislation is enacted. We must be ready to meet the legislation when it is enacted.

I would like to thank all the stakeholders who attended meetings and those who made submissions to the Committee for their valuable engagement. Thank you to

Committee Members for all their hard work. I also wish to acknowledge the assistance of the Committee support team in preparing this report.

Michael Moynihan T.D.

Cathaoirleach to the Committee on Disability Matters

Recommendations

Governance and data collection

1. The Department of Health must eliminate the practice of placing older and/or disabled people in large group settings and ensure that all providers of residential and day settings have measures in place to prioritise the protection of individuals and investigation of all allegations.
2. The Department of Health must ensure the voice of people with disabilities in safeguarding policy and practice through research and meaningful participation structures.
3. The Department of Health must develop a comprehensive and inclusive national rights-based safeguarding policy and regulatory infrastructure to ensure appropriate resourcing, monitoring, and implementation of standards across all services. Appropriate definitions to support monitoring within a rights-based model of safeguarding are also required, including;
    a) developing a zero-tolerance approach to adult abuse across all settings and supporting a cultural change
    b) ensuring that every public or private body put a safeguarding policy in place, as well as ensuring all relevant sectors have appropriate data collection policies.
    c) that any process to safeguard a person's liberty should apply to all people equally and where a person's liberty is being restricted, they should have access to an independent advocate to ensure their will and preference.
4. The Department of Health must establish a National Adult Safeguarding Authority, led by the Department of Justice with the involvement of the Departments of Health, Social Protection, Housing, Finance and Children,

Equality, Disability, Integration and Youth. In addition, participation by key statutory agencies such as the National Safeguarding Office, Decision Support Service, HSE Health and Social Care Services, Mental Health Commission, Citizens Information Board, Courts Service, Data Protection Commissioner, Central Bank, Financial Services Regulator and An Garda Síochána is essential.

5. The Department of Health must ensure national collection of data across all sectors, which incorporates a framework and statutory bases for inter-agency co-operation, collaboration, and data sharing. Detailed safeguarding activity by HIQA, An Garda Síochána, Safeguarding and Protection Teams and service providers to inform service responses must be published as well as full, transparent, and accessible safeguarding adult reviews.

6. The Department of Health must develop systematic co-working between mental health services, primary care, and social care in line with good data protection practice and introduce Individual Health Identifier numbers to connect services.

7. In the interim, the Department of Health must set up of a working group to scope out legislative provisions and consider the composition of the national safeguarding authority on foot of the Law Reform Commission's report to ensure the State is ready to meet the legislation when it is enacted. All relevant stakeholders including IASW and Safeguarding Ireland, as well as direct consultation with persons lived experience must be included.

Awareness raising and human dignity.

8. The Department of Health must ensure comprehensive training for all staff across all government departments and agencies providing services to adults who may be at risk of harm or abuse. The private sector and the providers of

essential services such as financial services and utilities must also be included.

9. The Department of Health must ensure increased safeguarding measures and run a national information campaign advising how people can access Safeguarding and Protection Services, including residents and their families.

10. In the instance of safeguarding abuse, the Department of Health must ensure that families are fully and formally informed of risks in their own environment at the same time as the service provider.

Eliminating financial abuse

11. Under their role to set up a new regulatory regime for online safety, Coimisiún na Meán, must ensure digital services are designed in order that people with disabilities can use them safely.

Effective safeguarding service

12. The Department of Health must ensure resourcing to support limitations on the role of HSE safeguarding personnel.

13. The Department of Justice and An Garda Síochána must introduce specific safeguarding police officers.

14. The Department of Health must introduce specialised teams, staffed with appropriate professionals, such as social workers, speech and language therapists, psychologists, occupational therapists, counsellors, and social care staff, to provide person-centred support in the aftermath of abuse to ensure that people with disabilities, who may have communication difficulties, can tell their story of abuse, at their own pace and in their own way and with the right supports.

15. In the interim the Department of Health must;

    a) ensure a single point of contact for any adult who is at risk or has experience of abuse including access to Legal Aid or representation.
    b) immediately establish a national 24-hour dedicated support line for adult safeguarding with the capacity to initiate an effective and appropriate response.
    c) undertake a public campaign to highlight the existing service and that safeguarding is everyone's responsibility.

Legislative provision

16. The Department of Health must ensure urgent enactment of safeguarding legislation based on appropriate principles, including the UNCRPD to ensure that instances of exploitation, violence, and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

17. The Department of Health must immediately:

    a) Consider establishing social work as the relevant expert profession with responsibility and accountability for safeguarding decisions and processes, with appropriate governance structures and operational autonomy with final decision-making resting with an accountable, registered Chief Social Worker appointed in the HSE.
    b) Increase HIQA regulatory powers, to include inspection of social work safeguarding activity.
    c) Address organisational cultural barriers which prevent staff speaking up.

d) Consider that all relevant HSE job descriptions must refer to the requirement to demonstrate competency in adult safeguarding, including reporting procedures.
e) Ensure that all agencies with a safeguarding remit must resource social workers/Designated Officers to carry out their work.
f) In conjunction with the Department of Justice, include groups at higher risk of abuse, including adults with disabilities, in the new national gender-based violence strategy.
g) Resource Safeguarding and Protection social workers and A Garda Síochána to carry out investigations with adults with disabilities when abuse is reported.
h) Ensure access to specialist expertise (therapeutic services) to assist both the person with a disability and the investigation teams, in the aftermath of a report of abuse.
i) Consider placing public health visiting guidance on a statutory footing with consequences for service providers who introduce excessive visiting restrictions.

18. Government to expedite statutory home care legislation.

19. Social care legislation promoting the well-being of individuals, requires organisations both public and private to have systems in place to promote well-being, to prevent and reduce abuse and advise individuals as to where they can get assistance.

20. Immediate enactment of Deprivation of Liberty legislation and consultation with people with disabilities and families.

21. Ensure resourcing so that people with mild intellectual disability and mental health problems have a dedicated service, similar to if they had moderate intellectual disability.
22. Ensure the publishing of the report of the Law Reform Commission on a legislative framework for adult safeguarding during 2024.

Summary of findings

Significant prevalence and underreporting of abuse in Ireland.

1. The prevalence of safeguarding issues and failures in the management of these safeguarding concerns is impacting Irelands progress in adhering to the principles set out in Articles 16 and 19 of the UNCRPD. Abuse and neglect of vulnerable adults is significantly underreported in Ireland.

2. In 2022, Safeguarding Ireland published the most comprehensive overview and analysis of adult Safeguarding issues in Ireland to date in a discussion paper called *Identifying RISKS Sharing RESPONSIBILITIES The Case for a Comprehensive Approach to Safeguarding Vulnerable Adults*, describing the nature of adult abuse in Ireland, the patchwork of legislation that exists to protect people and the deficits in terms of what is known about adult safeguarding. The current policy and legislative response and the absence of an overarching governing body creates a gap in accountability, collaboration, and coherence across all sectors.

3. Despite growing awareness, a culture that is dismissive of certain forms of abuse, which trivialises other forms of abuse and that plays down the human rights of many adults in vulnerable circumstances persists in Ireland. Significant cultural change is required.

4. There are many gaps which have led to significant breaches of human rights for people with disabilities and elderly people in residential settings, both State and in private settings. These include adult safeguarding legislation, social care legislation, and the absence of a uniform regulatory framework covering legislation, policies, accountability, and enforcement across all settings. Others include legislation on deprivation of liberty to include a place of care; regulation of home care services; legislative underpinning for the practice of independent advocacy in Ireland; multidisciplinary and cross-sectoral policy on self-neglect; guidance and regulation on data sharing; a

comprehensive cross-sectoral framework for data collection on abuse of adults; and departmental and agency policy and related accountability procedures and training for staff outside of health and social care sectors, which applies to all Departments and agencies providing services to adults who may be at risk of harm or abuse.

5. The requirement for policy also extends to the private sector and, to the providers of essential services such as financial services and utilities. Also necessary is the need for the recognition and criminalisation of coercive control in non-intimate partner relationships; access to legal aid and-or representation; and a single point of contact for any adult who is at risk or who has experience of abuse.

6. It is in scenarios and cultures where rights are overlooked, well-being is ignored and a person lacks choice and autonomy in his or her own life, that abuse is most likely to occur.

7. Abuse in Ireland includes the more significant instances of abuse, including sexual and physical assaults, and financial abuse where social welfare payments abused by a third party. However, abuse also includes when someone is being left for a long time, the bell is not being responded to and his or her needs are not being met. Abuse is when, instead of getting a 20-minute walk in the garden because he or she needs to use the commode, the person will miss a walk that day. Abuse is when people's money is being used to pay for things that have nothing to do with themselves, or units where milk and sugar are still added to pots of tea because that is the way one person likes it and it does not matter that someone else does not, so that is the way he or she is getting it.

8. Peer abuse is often minimised, ignoring the fact that it is akin to experiences of domestic violence for a resident in a care setting.

9. Nursing assistants can be fearful to report up the line, which sustains the lack of reporting. Many people who are the victims of abuse or lack of safeguarding are also afraid because they may be dependent on other people. It is everyone's responsibility to recognise and raise awareness about any form of abuse.

Significant concern with regard financial abuse

10. Financial abuse is very prevalent in Ireland as reported by the HSE. Coercive control, controlling behaviour for financial, sexual, or physical abuse, permeates all other types of abuse.

11. Safeguarding Ireland undertook a survey which asked the question, "Does another person have a right to make decisions on behalf of a person who is old and frail without their consent?" Some 57% of the Irish population think you can do so without the consent of the person, even if they have capacity. Decisions are made on behalf of people, particularly people in vulnerable circumstances or people with disability. There is a greater lack of respect for their rights. For example, families think they can just manage the money or decide. They think they can pick up the pension or disability benefit and it is family money, not that individuals' money.

12. People with disabilities can be put under significant pressure from family to sell a house they have inherited and distribute the money among the family and may end up homeless. Before the Assisted Decision-Making Capacity Act, there was no oversight of attorneys, and there were cases of financial abuse including attorneys not paying for care or collecting the pension of the person concerned but also selling a person's property. Under the Assisted Decision-Making Capacity Act if a court order is made to appoint somebody to deal with somebody's property, it must be used for the benefit of that person and the Decision Support Service has a specific function of oversight in relation to any of the decision's supporters who are appointed under the Act.

13. The Department of Social Protection pays out in the order of €25 billion annually in pensions, disability payments and so on, however the percentage of financial abuse is estimated between 12% and 20%. The Department has a vulnerable customers section that will respond to complaints made, but it does not share that information with other organisations that may also need the information. There is no reason under the current legislation, either GDPR or the 2018 Act, why the information is not shared, but it is not done because there are no protocols regarding the necessity to do it.

14. The Committee's public meeting – 10 March 2022 'Enabling financial independence for disabled women' highlighted the difficulties gaining financial independence for women with disabilities considering the effect of double discrimination and because financial independence can be challenged due to cognitive, physical, or sensory disability, an acquired brain injury, mental health difficulties, an inability to communicate effectively, lack of family and community supports, or an inability to access financial services that meet their needs.

15. As noted by Sage Advocacy, where there are challenges to financial independence, there is a need for robust systems in place for the monitoring and management of an individual finances when they are, due to their disability, a resident in a hospital, nursing home or residential setting. If robust systems are not in place financial exploitation can take place. This financial exploitation can go beyond personal finances and often include the illegal or improper use of property, the misuse of an adult's home, theft of possessions, inappropriate use of resources such as utilities, food, and transfer of resources such as property and assets and coercion and intimidation to gain access to assets including gift giving and creating a will.[1]

[1] suppor-1.pdf (sageadvocacy.ie)

Lack of monitoring of safeguarding concerns

16. Adult safeguarding reviews are rarely published in full in Ireland and are 'owned' by the HSE/Service Provider who are then the gatekeeper of information about failures in their own services. Residents and families are uninformed about the true extent of failings within their 'home'.

17. A culture of underreporting can prevail in a public domain where language is minimised, for example, 'rough handling' is used instead of physical abuse, 'inappropriate use of resident finances', instead of financial abuse, 'poor quality care', is used instead of neglect.

18. Research by the Department of Health shows that people do not know how or where to report abuse.

19. Ireland does not collate adequate data about the abuse of adults with disabilities, this impacts negatively on service planning**.**

20. While 51,000 concerns about the abuse and neglect of adults have been reported to the HSE Safeguarding and Protection Social Work teams since 2015, it is unknown how many relate to people with disabilities. 143 sexual assaults against residents of care settings were reported to HIQA from 2015 to 2022; 87 of these assaults were in nursing homes where many people with disabilities reside and 56 cases in disability centres. However, this data is limited to the health and social care services and does not extend to other HSE facilities.

21. In 2019, Safeguarding Ireland carried out a poll of a representative sample of adults asking them about their experience, or an experience they had witnessed, of adult abuse. Some 10% of adults said that they had either experienced or witnessed adult abuse. This adds up to approximately 400,000 cases. The HSE Safeguarding Office Annual Report 2023 has more than 13,000 reported cases of suspected adult abuse. This demonstrates a

significant gap between what is reported to the HSE services and what may be the reality.

22. The figures from the HSE indicate that almost 80% of the main perpetrators of financial abuse are relatives and family members. A risk of financial abuse is most definitely created where people find it difficult to engage with services, financial services in particular, and do not have the assistance of a third party.

23. An Garda Síochána cannot provide figures about the rates of abuse and neglect of residents in nursing homes or disability centres reported to them.

24. In the absence of primary safeguarding legislation, guidance and information is required to ensure personal sensitive information and data can be shared securely for the purposes of safeguarding a person. The interpretation of GDPR and lack of statutory bases for interagency work and information sharing, severely restricts safeguarding practice. Therefore, a hospital social worker who is asked to review an adult with a disability admitted with signs of serious neglect from a nursing home or disability centre, cannot then identify that individual to HIQA for follow up, but can only express general concerns about care standards in that centre/residence.

25. People with disabilities are often regarded as ‘unreliable witnesses.’ The new Garda National Protective Services Unit does not highlight that people with disabilities are within their remit and expertise. This may mean that those who are most at risk of abuse are less able to protect themselves, less able to report the abuse and have less access to justice and reparation processes.

Failures in governance

26. Unlike Tusla, there is no ‘one stop shop’ to report adult abuse. Residents and Families are ‘bounced’ between services, contacting Safeguarding and Protection Social Work teams (who do not have a remit in private services), HIQA (who do not investigate individual complaints), the Ombudsman (who

does not investigate clinical complaints), the Office of the Confidential Recipient (who can only accept concerns in relation to HSE services) and An Garda Síochána. The needs of the person with disability are easily lost.

27. The Garda Síochána process highlight that where an individual lacks capacity and the Gardai do not interview, even though the individual may have very clear evidence of financial abuse. There is a need to raise awareness to ensure that An Garda Síochána follow up on their obligation in line with the Assisted Decision-Making Capacity, even though it may not lead to a prosecution.

28. HIQA regulates designated centres and nursing homes but has no remit in terms of dealing with individual safeguarding issues.

29. In comparison to child protection, social work has less influence in adult safeguarding practice and policy development. Operational social work governance and expertise, drawing on human rights lens and approach to practice, is absent at senior HSE management level which in turn has significant implications for how the HSE understands and responds to adult safeguarding throughout the country. This has a direct impact on people with disabilities living in residential care settings.

30. The HSE published adult safeguarding policy, Safeguarding Vulnerable Persons at Risk of Abuse - Policy and Procedures (2014) and CHO Safeguarding Operations are part of a wide range of measures to protect the welfare and safety of adults who may be vulnerable and at risk of abuse. However, the policy excluded adults using services such as mental health services and private nursing homes.

31. In 2019 a new HSE draft adult safeguarding policy was published, which identifies new safeguarding roles and responsibilities without any commitment to increased staffing and resources. Multiple stakeholders have

expressed concerns about both the viability of this and the overall policy direction the HSE is taking in adult safeguarding.

32. The National Independent Review Panel established by the HSE, reviews cases related to serious failings by the HSE and/or its funded organisations. In the case of the 'Brandon' report, the National Independent Review Panel advised that HSE management disregarded the advice and expertise of the Safeguarding and Protection social work team in terms of how serious safeguarding concerns should be dealt with. This was despite the establishment of a HSE National Safeguarding Office, the introduction of a national safeguarding policy and advice from an expert social work team.

33. When safeguarding policy was established, the process did not require direct social work involvement in the assessment of concerns about abuse anymore, and instead, social workers on the safeguarding teams had oversight of what the service was doing to protect people. This meant that HSE-funded section 38 and 39 services are meant to safeguard the residents of their services and let the safeguarding team know what they do. These services report the concern and are also responsible for safeguarding.

34. The Department of Health is developing a national adult safeguarding policy for the entire health sector, together with accompanying legislation however no interim measures have been taken to address risks in safeguarding practices and systems.

35. Failure to report and follow up in the 'Brandon' case where the abuse of adults with disabilities repeatedly occurred over decades, and was known to HSE staff and management, demonstrates the clear need for new and effective legislation to mandate staff to report abuse of adults in residential services and in certain other circumstances. When there are serious concerns of abuse, the lack of appropriate legal mechanisms to support social work access to the adult at risk of abuse, in cases when access may be denied by

service providers (i.e., private residential services) or individuals (i.e., private dwellings).

36. There was appropriate outrage, and a redress scheme was set up in response to children harmed in the CAMHS failure in Kerry, but no such scheme has been proposed for residents who were repeatedly sexually assaulted in the 'Brandon' case. Shortly after the 'Brandon' report, another serious safeguarding failure in emerged, causing HIQA to question the HSE's ability to provide safe services for people with disabilities.

37. There is no national social work strategy in Ireland and no plan for how Government policies will be implemented and delivered where they depend on social workers. There is also no social work strategy or a social work workforce plan at a national level.

38. Social work faces very challenges in influencing the governance and management of adult safeguarding and practice through the human rights lens and approach, as the medicalised model is encountered at strategic and practice level as that described by people with disabilities, which does not adequately address their needs.

Inconsistencies and resourcing issues across CHOs

39. Current Safeguarding policies are limited, resulting in inconsistent approaches across sectors and organisations, and gaps in responses from State Agencies and other parties to adequately safeguard the person at risk of abuse.

40. Each CHO has a Safeguarding and Protection Social Work team, led by a Principal Social Worker who reports to a Head of Quality, Safety and Service Improvement, who in turn reports to the most senior manager in each CHO, the Chief Officer. Due to several challenges, including critical under-resourcing, safeguarding referrals are responded to in different ways by each safeguarding and protection social work team. There has been consistent

under-resourcing of social workers and designated officers at local service level, even when there is a high-profile case or crisis in an individual HSE CHO area/local service.

41. There are also concerning variations in the type and quality of adult safeguarding reviews commissioned by organisations when failures arise.

42. There is a need for developed systems and efficiencies within the HSE regarding adult safeguarding. Some safeguarding teams go into private nursing homes and others do not, the same for acute hospitals. There are also gaps in dealing with self-neglect and other issues.

43. The HSE plans to introduce new safeguarding roles (alongside existing social work safeguarding posts) solely for the nursing profession. However, this is a concerning extension of the existing medicalised approach and ignores the central message of the 'Brandon' report, which is to move away from viewing safeguarding through a clinical, medicalised lens and instead operate from a rights-based model with a broad range of professional expertise and perspectives. Given the size of the nursing workforce already present in both strategic management and frontline practice posts, the HSE should include additional and holistic perspectives in the safeguarding of their systems, to avoid dominance of any one clinical or professional paradigm.

Awareness raising, lack of human dignity and will and preference.

44. The lack of statutory right to home care, along with the staffing crisis in privatised home care sector, means people with disabilities are being prematurely admitted to nursing homes, against their will and preferences, which is a deprivation of liberty. People with disabilities who use safeguarding services are often viewed solely as recipients of services, rather than rights holders, with their own wishes and preferences. The HSE has not commissioned any research to understand the preferences of people who use safeguarding services. This means the voices of adults at risk are absent,

giving imbalanced weight to the views of professionals and paid advocates. More research has been funded into the experience of care staff, rather than residents of care settings over the time of Covid.

45. Of most importance, residents are often denied information about their own care setting and their voices are often absent or marginal in discussions about monitoring of the system in which they are the most important stakeholder. The quality of sex and sexuality education in congregated settings is unknown. Understanding about and approaches to the management in residential services of those who have committed sexual offences is variable across settings.

46. Where a person lacks decision-making capacity, this is used as an excuse not to pursue issues that arise in relation to his or her rights. If a person has dementia or has an intellectual disability then rather than, as the Act provides, there being a clear presumption of capacity, straight away people revert to an assumption that the person lacks capacity. A significant cultural shift is required.

Urgent need for independent advocacy

47. Independent advocacy is an important resource for individuals at risk of abuse, yet statutory advocacy support, on an independent basis, despite being available in other jurisdictions, is not within Ireland's safeguarding responses. Independent advocacy is important process in supporting people to make and communicate decisions and to participate in decisions about their lives, such as access to finances, accessing services, planning ahead, support when there is desire to move residence, issues relating to abuse or neglect and barriers to decision-making.

48. While thousands of adults receive care at home, with family members acting as a principal carer, more still receive care in a variety of residential care settings. It must be acknowledged that though many care-givers discharge

their responsibilities conscientiously and to the best of their abilities, this does not guarantee that the rights, will and preference of the individual are front and centre.

49. There is a need to ensure that individuals living in settings where there may be a risk of safeguarding concerns have access to advocacy support. Advocacy is especially important regarding making and communicating decisions when there is desire to move out of a congregated setting.

50. Where a person's liberty is being restricted, they should have access to an independent advocate to ensure their will and preference is heard. If a person who has been in a system of care where other people have been making decisions, and that is the only thing the person is familiar with, is offered a choice to move out, it may not be comprehensively understood. It may be necessary to pilot options until the best solution is identified by the individual. The individual needs to know he or she has equal rights, that he or she is not beholden to somebody else and that there are organisations that are independent and can help.

51. The Committee heard how there is a need to ensure roll out of appropriate training using a whole of organisation approach on adult safeguarding across care settings including all levels of staff because it may be the porter, the cleaner or even the visitors coming in who see something and can raise a concern.

People in congregated settings are disproportionately impacted.

52. Residents who live in congregated or campus-based settings often experience significant safeguarding issues, inequalities in the quality and safety of their services, control over their own lives and the ability to exercise their rights and choices independently. These types of residential settings in tandem with providing people with no choice, are sustaining safeguarding issues.

53. Residents can abuse other residents, but there is also sustained organisational abuse where the provider has failed to adequately protect residents and meet their needs. While this situation can occur in any setting, there is a higher risk of organisational abuse in congregated settings than in community-based houses.

54. These residents may not wish to live together or are living in large groups, sometimes in overcrowded environments and this can lead individuals to express their distress and unhappiness behaviourally. It has also, on occasion, led to residents hurting and harming themselves or their fellow residents, sometimes on an ongoing basis, including residents living in fear of their peers. This is not acceptable and has been a major challenge for the disability sector.

55. At the Committee's public meeting – 9 February 2023 'Awareness raising – congregated settings', Paul Alford spoke about his experience in a congregated setting and what it was like to live in these types of settings and how his freedom, dignities and rights were impacted along with a lack of support to become more independent. Sometimes Paul lived in dormitories with other people with disabilities, with no choice over what to eat and what time to get up and had to get permission any time he wanted to leave. Paul was supported to move from these settings to live independently in the community which greatly improved his quality of life.

56. Paul told the Committee that 'we need more people out of these institutions and leading a good life with their own support and choice with who they want to live with'. Paul also told the Committee that 'the Government need to listen to people in these settings and what they want. It's our choices and our voices at the end of the day'.

57. While there has been a continued effort within the disability sector to reduce the number of large, congregated settings, many residents continue to be accommodated in these living arrangements.

58. Individuals with significant behavioural presentations when they were living in congregated settings, had a positive experience when moved to community-based services and the intensity and frequency of those behavioural presentations significantly reduced.

Deprivation of liberty legislation that balances protection with autonomy.

59. A deprivation of liberty is defined as an oppressive restriction by a third party' and people are de facto detained if they are in residential care and the building is secured, requiring residents to ask permission to leave the premises.

60. Individuals who are residing in a care setting may not have made the choice to do so but are there due to a lack of a statutory right to homecare, a lack of flexible models of care to meet individual's needs, and lack of adequate homecare service provision. At present, unfortunately, there is a one-way system within nursing homes which limits the possibility of going out back into the community.

61. There is a disproportionate deprivation of liberty for people with mental illness. Irelands involuntary admission rate is positive but low admissions come at a price, resulting in people with mental illness in prison, homeless or at home and too ill to accept treatment but not ill enough for treatment without consent.

62. There is specific legislation for people who commit crime; they have a right to a fair trial and to legal representation. There is detailed mental health legislation for people who are involuntary detained. However, there is no detailed legislation covering people who are put into places of care or into

congregated settings where they do not want to be. There is a need to ensure their individual rights, their will, and their preference are respected. The deprivation of liberty is a constitutional matter under the Assisted Decision-Making (Capacity) Act 2015. However, there is no process prescribed by law as is required by the Constitution, the European Convention on Human Rights, and the UN Convention of the Rights of Persons with Disabilities.

63. A change is required to Coercive Control legislation to relate it to people in non-intimate relationships.

64. The Committee noted the importance of the enactment of Deprivation of Liberty legislation which should also consider expanding coercive control outside restrictive scope of the Domestic Violence Act 2018 in dealing with coercive control Criminal Justice (Miscellaneous Provisions) Act 2023; revising and progressing the Mental Health Act, 2001 and safeguarding provision in police and community legislation and a need for the collection of data.

Monitoring Legislative and regulatory provision

65. An adequate legislative foundation is crucial if Ireland is to have a fit-for-purpose safeguarding capability, to address the gaps and deficits, and ensure compliance with Article 16 of UNCRPD.

66. Legal protection from abuse, neglect and exploitation decreases for every person, including a person with disability, when they turn 18 in Ireland.

67. There is urgent need to develop the regulatory and legislative infrastructure to safeguard people with disabilities in Ireland and protect against harm while supporting higher quality of life outcomes for individuals who may be vulnerable across all settings, create the conditions of possibility for prevention, early intervention, and ongoing comprehensive management of cases of safeguarding adults. Safeguarding legislation should ensure;

    a) reflection of deprivation of liberty arrangements

b) reflection of Health Act 2007 and associated regulations
c) placing the wishes and preferences, including right to live independently of adults at the heart of safeguarding in line with the underpinning principles of the Assisted Decision-Making (Capacity) Act, 2015
d) regulating Mandatory, Transparent, Safeguarding Adult Reviews across all health and social care services carried out by suitably qualified personnel.
e) a broader definition of a designated centre that takes a more holistic view of the supports people with disabilities require, providing greater protection and enhancing their quality of life.
f) a right of entry if there is suspicion of abuse happening within a home or any environment and a right of assessment of that person and to issue no-contact orders.
g) the addressing of the limited form of protection afforded by regulation of Nursing Homes
h) appropriate legal mechanisms to support social workers to do their work, and supporting social work access to adults at risk, used as a last resort, when all reasonable efforts to establish access have been denied by a third party.
i) mandatory reporting of abuse and neglect of adults, including provision for dealing with self-neglect
j) a provision for statutory advocacy support on an independent basis
k) that the activity of Safeguarding and Protection Social Work teams are included in the monitoring by HIQA

68. Placing adult safeguarding on a statutory footing acknowledges the State's commitment to adults at risk, and the duty of civil society to adopt a zero-tolerance approach to adult abuse. In the absence of safeguarding

legislation, HIQA uses the current regulatory framework to minimise risk for people living in designated centres. However, ensuring that people with disabilities are free from exploitation, violence and abuse can only be achieved when all parties understand and exercise their responsibilities.

Social model of safeguarding

69. It will take a collective effort across all relevant bodies and wider society to ensure appropriate safeguarding of people with disabilities.

70. Ireland is failing to safeguard mental health, freedom, autonomy, and social well-being as reflected in Articles 16 and 19 for people with severe mental illness such as schizophrenia and bipolar disorder. Solutions including treating mental illness, safeguarding liberty, and safeguarding social and medical well-being in the community, systematic co-working between mental health services, primary care, and social care and individual health identifier numbers to connect services.

71. The Committee heard how there is a need to make sure that people know they have rights; where to go; who to access; that it is safe for them; and that making a report will not impact them. For example, if an individual reports that their caregiver is the person who is abusing, then the response should not be to put the individual into a nursing home or a congregated setting. The Committee acknowledge that there needs to be a cultural shift so that individuals are not afraid to report safeguarding issues for fear of being institutionalised or being deprived of their liberty.

72. There are difficulties with the community services established to replace institutions however there is enormous opportunity within primary care as an existing structure, and in intellectual disability services. However, these services are mostly resourced to see people with moderate or severe intellectual disability who develop mental health problems, not people with mild intellectual disability who develop mental health problems.

73. There is a lack of awareness of the need to ensure person centred care as well as a lack of consistency with regard provision of person-centred care across care settings.

74. The State needs to, in tandem, enact appropriate safeguarding, as well as social care legislation to encompass all sectors.

Urgent need for independent statutory body

75. The Committee heard detailed information on the proposal for a new statutory regulative authority. It should have at its core the overall goal of zero tolerance in our society of adult abuse, which will be emphasised through the four key pillars which Safeguarding Ireland highlight in their discussion paper, namely, prevention, protection, prosecution, and policy co-ordination. The Authority should have with responsibility for;

    a) receiving and investigating individual complaints across residential care settings, community services, and overseeing the investigation of complaints including where a person is not in receipt of any care services, as well as oversight of critical incidents including deaths and matters of abuse and neglect relating to adults at risk.
    b) carrying out statutory inspections of all relevant settings where vulnerable people are being cared for.
    c) relevant statutory bodies including the HSE, the Decision Support Service, HIQA, the Mental Health Commission would have a statutory obligation to report to the Authority on safeguarding issues.
    d) ensuring that Safeguarding and Protection Teams are independent of the HSE.
    e) responsibility for ongoing awareness among professional and the public, particularly regarding supporting decision-making,

empowering people with reduced capacity, using independent advocacy, identifying risk and when and how to report concerns.

f) reporting to a relevant Oireachtas Committee

Appendix 1 - Public stakeholder engagement

Date of public meeting and transcript	Meeting topic	Witnesses
10 March 2022	Enabling Financial Independence for Women with Disabilities	• Representatives from Disabled Women Ireland, Amy Hassett, Co-Director, Nem Kearns, Board Secretary & Aoife Price, Partnerships & Outreach Lead • Representatives from Independent Living Movement Ireland, Paula Soraghan & Nicola Meacle
31 March 2022	Independent and Adequate Standard of Living and Social Protection (Safeguarding)	• Sage Advocacy, Professor Amanda Phelan, Professor in Ageing & Community Nursing • The Irish Association of Social Workers, Vivian Geiran, Chair, Celine O'Connor, Member and Principal Social Worker HSE, Adult Safeguarding and Protection Office & Sinead McGarry, Social Worker • Brendan Kelly. Professor of Psychiatry, TCD • Health Information and Quality Authority (HIQA), Carol Grogan, Chief Inspector of Social Services & Finbarr Colfer, Deputy Chief Inspector of Social Services with responsibility for disability services

09 February 2023	Awareness Raising - Lived experience of congregated settings	• Representatives from Inclusion Ireland, Derval McDonagh, Chief Executive Officer & Paul Alford, Advocacy Project Worker • Representatives from Disability Federation of Ireland, Emer Begley, Director of Advocacy and Inclusion & Ríona Morris, Policy and Research Officer • Representatives from National Advocacy Service, Joanne Condon, Acting National Manager & Suzy Byrne, Greater Dublin Regional Manager Representatives from Acquired Brain Injury Ireland, Barbara O'Connell, Co-Founder and Chief Executive, Karen Foley, Head of Service Operations
21 February 2024	Safeguarding	• Representatives from Safeguarding Ireland, Patricia Rickard-Clarke, Chairperson, Annmarie O'Connor, Programme Manager & Ronan Cavanagh, Communications