Response to the consultation on the review of No Secrets: January 2009

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ACTION ON ELDER ABUSE
NO SECRETS CONSULTATION RESPONSE

Who we are:

Action on Elder Abuse (AEA) was established in 1993 with the aim of preventing the abuse of older people. It is a membership organisation with over 700 individual and group members throughout the United Kingdom and Ireland. These include older people, local and national voluntary organisations, academics, health authorities and trusts, and social services departments (often, but not exclusively, represented by Adult Protection Coordinators). It works proactively with statutory organisations and is variously described as a ‘critical friend’ and as a ‘social entrepreneur’.

The charity is seeking an environment in which the abuse of older people is no longer tolerated. It is seeking to encourage public and practitioner recognition of elder abuse and to facilitate policies, procedures and cultures that both abhor and challenge such abuse. Simultaneously, the charity recognises that it operates within an adult protection environment, and consequently seeks to ensure that its work benefits all vulnerable adults.

We believe it is vital that it is recognised that elder abuse exists and that it may have a profound effect on the quality of life for older people; that both the rights and autonomy of the older person and their possible need to be protected from abuse are recognised; that all older people have the confidence, knowledge and support to take the action they choose to counter abuse; that health and social care practitioners at all levels are trained to recognise the different types of abuse and to respond to the needs of both the abused and the abuser; that both health and social service purchasers and providers have staff and services that are responsive to the needs of the abused and the abuser; that the responses of all statutory, voluntary and independent agencies are collaborative and appropriate; and that a broad range of research is undertaken to expand knowledge of the issues.

Practical activities of AEA include providing up to date information for its members; running conferences on elder abuse and related issues (including an annual two day event that brings together academics, practitioners and voluntary sector representatives to consider current developments and challenges in adult protection); providing direct training, and facilitating training, as appropriate, giving presentations to a wide range of organisations; producing leaflets, resource materials and reports for practitioners and the public; and acting as a resource for practitioners, television, radio and the press.
In recent years the charity has sought to highlight the links between elder abuse, which predominantly occurs within family situations, and domestic violence.

**What do we do?**

Although the primary focus of Action on Elder Abuse is the protection of vulnerable older people we have established ourselves in the last eight years as one of the key voices on the protection of vulnerable adults in general and our work is consequently often generic in nature. We have a stated view that we do not wish to see hierarchies of vulnerability created, and in recent years have chosen to highlight the abuse and disadvantage of people with learning disabilities (LD) wherever possible, as a clear recognition of the scandals of abuse uncovered within LD support services.

We view partnership working crucial, where it is mutually respectful of the strengths and contributions of each partner and this includes our joint working with Age Concern England, Alzheimer's Society, Women's Aid in Ballymena, the Relatives and Resident's Association, the Practitioner’s Alliance against the Abuse of Vulnerable Adults, and the Centre for Sheltered Housing Studies.

Between 2004 and 2006 we undertook a major project on behalf of the Department of Health in Westminster, considering the need for, and structure of, an Adult Protection Data Monitoring and Collection system. The results, which were accepted by the Government, included recommendations on such a system, recommendations for a Performance Indicator on Adult Protection, and recommendations on the need for Adult Protection legislation.

We positively interact with key bodies, including (but not limited to) the Association of Directors of Adult Social Services, the General Social Care Council, the Commission for Social Care Inspection, the Care and Social Services Inspectorate for Wales, the Association of Chief Police Officers, the Police Service of Northern Ireland, the Adult Protection Forum in Northern Ireland, and a range of care provider bodies throughout the UK. We have established an ability to cross divides, being able to speak to and work with statutory, voluntary, regulatory and care provider organisations.

In recent years we have contributed to the development of the Protection of Vulnerable Adults list, the new Safeguarding Vulnerable Groups Act, the Domestic Violence, Crimes and Victims Act, the Adult Protection protocol produced by CSCI and its partners, and the shaping of adult protection thinking and work across the nations.

Our strategy is to criticise where necessary but, more importantly, to help where needed.
Introduction:
Context and stated purpose of the Review

The Intent of the Review:

As an organisation that has been directly involved in this Review since it was announced by Ivan Lewis, Minister for Care services, in June 2007 we remain concerned that the original intentions of the Review (as stated at that time) have not remained as primary objectives throughout the process and have instead been diluted by other Government objectives and strategies. We believe that this has not assisted the consideration of key issues associated with safeguarding and adult protection, and that this has made the Review flawed.

The *No Secrets* consultation document states that, when Ivan Lewis announced the Review in 2007 he indicated that

‘New guidance is necessary to reflect the evidence in today’s report¹ and respond to the new demographic realities which are affecting our society.”

It additionally states that he indicated the Government would

“also consider the case for legislation as part of the Review process.”

This latter statement does not fully reflect what was actually committed. The briefing document issued by the Department of Health (DH) to coincide with the Prevalence Report launch actually indicated that the Minister was announcing

“a refresh of the No Secrets guidance on safeguarding vulnerable adults with particular reference to the legislation underpinning adult protection policy”². (Our emphasis)

Consideration of legislation was consequently not an addendum to the Review, as it has now become, but was instead a specific (rather than general) intent. This was the realization of a commitment given by a previous Minister for Social Care, Liam Byrne, at the AEA national conference in 2006 when he accepted ‘in principle’ the recommendation from AEA that *No Secrets* should be established on a statutory footing.

For information, the briefing document issued by the DH to coincide with the Prevalence Report launch also indicated that,

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¹ *UK Study of Abuse and Neglect of Older People: Prevalence Survey Report*, M O’Keefe et al. (Department of Health and Comic Relief, 2007)
² Briefing Paper, Launch of the elder abuse Prevalence Study, DH, 2007
“there have been some major changes in legislation, such as the Safeguarding Vulnerable Groups Act 2006 and the Mental Capacity Act 2006, which need to be reflected in the guidance”.

The realities of the Review:

Prevalence Report:

In view of the statements at the launch by the Minister, it would not have been unreasonable to expect key aspects of the Prevalence Report, to which the Minister referred and to which the consultation document only briefly refers (the UK Study of Abuse and Neglect of Older People: Prevalence Survey Report, M O’Keefe et al. (Department of Health and Comic Relief, 2007), to be reflected in the content and questions within the consultation. However, this has not occurred. This is one key failing of the Review, given that a stated intent of the Review was that the evidence from the Prevalence Report was to have been reflected in any new guidance.

Legislation:

Equally importantly, consideration of legislation was to have been a particular focus of the Review. This has not occurred and it has instead been considered from an additional rather than a mainstreamed perspective. This is a second key failing of the Review.

To put this into context, 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. This is often acknowledged by the Government.

- For example, while the Domestic Violence, Crimes and Victims Act 2004 introduced some new laws it was also seen as giving

  ‘the police and other agencies the tools to get to the heart of domestic violence crimes’ (Home Office website 2009)\(^3\).

It was recognised that 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 Home Office website clarifies this in its statement that,

\(^3\) http://www.homeoffice.gov.uk/crime-victims/reducing-crime/domestic-violence/
'the Act is a key part of our aim of putting victims at the heart of the criminal justice system'.

It was clearly therefore a strategic response to the realities of victims and the abuse they experienced.

- Again, in commenting upon the Forced Marriage legislation the Minister, Bridget Prentice at the Ministry of Justice, stated,

  'This legislation sends out a clear message that forced marriage, a breach of an individual's basic right to choose who and when they marry, is not acceptable in our society. It will enable us to make better use of civil court remedies to provide protection to those placed in this intolerable position.'  (MoJ website 2009)4.

Once again it 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.

We can find no evidence that these factors have been considered by the consultation document itself or in the consultation events undertaken by CSIP on behalf of the DH. This is another key failing of the Review.

**Serious Case Reviews:**

In considering the effectiveness of *No Secrets* as a mechanism to provide a level of intervention that could protect adults at risk of abuse, it would seem sensible to consider what has failed to work successfully within adult protection, whether such failures were a consequence of the nature of guidance or instead insufficient/inappropriate application of that guidance, and whether such failings could only be overcome by the introduction of legislation. An obvious mechanism that could be used as part of this evaluation process would be the consideration of Serious Case Reviews relating to adults. However, despite proposing this on a number of occasions, we can find no evidence that such consideration has occurred and it did not form part of the February to October 2008 pre-consultation process.

**Impact of alternate legislation:**

The points made by the DH in the briefing paper of June 2007, relating to the Safeguarding Vulnerable Groups Act 2006 and the Mental Capacity Act 2006 (MCA), need to be additionally considered. And in this context we would include

4 http://www.justice.gov.uk/news/newsrelease260707c.htm
the principles of the Human Rights Act 1998 (HRA), and the new NHS Constitution.

The principles and rights enshrined within legislation (and specifically the MCS and HRA) should form the foundations of safeguarding and adult protection activity, and assist in understanding who should be the recipients of intervention work, and the basis of that work. Once again, we can find no evidence that these factors have been considered by the consultation document itself or in the consultation events undertaken by CSIP on behalf of the DH.

**Personalisation:**

The promotion of a personalisation agenda within the Review has been unhelpful, in that it has failed to address issues of choice, control, autonomy and risk from a safeguarding perspective. Speakers at various events have promoted a ‘cash for care’ model of personalisation without considering or addressing the challenges or solutions to this form of empowerment from an abuse perspective. It appears to have (a) focussed exclusively on the desire of (some) individuals to exercise this form of choice and control (i.e. ‘cash for care’), while ignoring their equal desire to exercise that choice and control free from abuse, and (b) failed to address the efficacy of personalisation within more traditionally structured care provision as a mechanism for challenging and reducing the potential for abuse. Effectively the Review of No Secrets has been hijacked by the Government’s perception of the personalisation agenda.

**Other factors:**

Finally, a number of key areas have not been addressed by the Review, but are crucial to adult protection, and these include the role of GP’s in any process, institutional areas of high risk such as secure mental health units, and the limited reach of adult protection services into groups considered particularly at risk of abuse. While much of the Review must of necessity include an assessment of current processes and actions, we believe that it should simultaneously consider those areas or activities that have been currently unaffected by No Secrets.

During the development of the consultation document and at various points throughout the consultation process itself AEA has sought to maintain its role of ‘critical friend’, in bringing these matters and others to the attention of the DH. In early January 2009 we facilitated a meeting with civil servants responsible for the consultation and representatives of safeguarding adult coordinators, and matters discussed during this meeting included concern that the process was giving emphasis to the personalisation agenda at the expense of considering safeguarding in its totality, that consultation events were not addressing key issues and were being excessively controlled, and that there was concern as to
whether views expressed were being adequately recorded. We await the outcome from that meeting, which will not occur until after 31 January 2009.

**Introduction:**  
**Fundamental principles of No Secrets:**

It is important to acknowledge that there are many aspects of the *No Secrets* guidance which remain relevant to the current situation. The stated primary aim of *No Secrets* is

> ‘to create a framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety. The agencies’ primary aim should be to prevent abuse where possible but, if the preventive strategy fails, agencies should ensure that robust procedures are in place for dealing with incidents of abuse.’

While not necessarily framed in the terminology that we would use today, this statement clearly indicated that *No Secrets* was intended to encompass both a safeguarding ‘preventative’ approach, in addition to an adult protection ‘intervention’ one, although we would acknowledge that the intervention role has taken precedence in reality.

It is also important to acknowledge that Section 4 of *No Secrets* established significant guiding principles under which agencies participating together in ‘adult protection’ systems should operate, and it is worth acknowledging the continuing relevance of these principles in the current Review. The identified principles were to:

(i) actively work together within an inter-agency framework based on the guidance in Section 3;  
(ii) actively promote the empowerment and well-being of vulnerable adults through the services they provide;  
(iii) act in a way which supports the rights of the individual to lead an independent life based on self determination and personal choice;  
(iv) recognise people who are unable to take their own decisions and/or to protect themselves, their assets and bodily integrity;  
(v) recognise that the right to self determination can involve risk and ensure that such risk is recognised and understood by all concerned, and minimised whenever possible (there should be an

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5 No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse, DH, 2000
open discussion between the individual and the agencies about the risks involved to him or her);

(vi) ensure the safety of vulnerable adults by integrating strategies, policies and services relevant to abuse within the framework of the NHS and Community Care Act 1990, the Mental Health Act 1983, the Public Interest Disclosure Act 1998 and the Registered Homes Act 1984 (the provisions of which will be extended by the Care Standards Bill).

(vii) ensure that when the right to an independent lifestyle and choice is at risk the individual concerned receives appropriate help, including advice, protection and support from relevant agencies; and

(viii) ensure that the law and statutory requirements are known and used appropriately so that vulnerable adults receive the protection of the law and access to the judicial process.

These principles remain relevant to the changing social policy environment within which safeguarding and adult protection continue to operate, including the personalisation concepts of ‘choice and control’, although they would benefit from the influence of the articles and principles of both the Human Rights Act 1998 and the Mental Capacity Act 2005. *No Secrets* however starts from solid foundations.
Chapter One: Safeguarding is everyone’s business

We believe that, in any policy document relating to abuse, it is important to make a distinction between the effect of an abusive act on the victim, and the motivation of the perpetrator. It is only by making such a distinction that we can ensure that statements or subsequent actions arising from the disclosure of abuse do not marginalise the experiences of the victim, but simultaneously allow us to consider differing intervention strategies. For this reason, while we acknowledge that there may be a need to consider some abusive acts as ‘poor practice’ by a worker, in order to ascertain an appropriate employment response, it does not automatically follow that this precludes the acts themselves from being criminal offences.

Five of the six types of abuse defined by *No Secrets* (physical, psychological, sexual, financial, and discriminatory) are potential or actual breaches of law and the only questions that arise in these contexts relate to mitigating factors, regardless of whether the acts themselves were a consequence of ‘poor practice’. The situation with regard to neglect has changed since *No Secrets* was written, both as a consequence of the Domestic Violence, Crimes and Victims Act 2004 and the Mental Capacity Act 2005, and these add to the provisions within the Mental Health Act 1983. For these reasons the statements made in the Chapter One of the Consultation document in this regard are insufficient and need to be qualified.

Additionally, while we note that this Chapter has drawn attention to the elder abuse prevalence figures of 2.6% and 4%, we had previously indicated to the DH the differing definitions used to establish those figures, and pointed out that the 4% figure equated more closely to the definition used within *No Secrets*.

The fundamental difference between the two definitions is that the 4% one is based upon ‘expectations of trust’ that an older person may have held in relation to their abuser - and therefore includes the neighbour or acquaintance who may abuse - while the 2.6% figure is based upon a societal assumption that certain roles are automatically in a ‘position of trust’ i.e. friends, relatives and paid staff.  

Paragraph 2.10 of *No Secrets* clearly indicates the extensive range of people and roles that may be identified as abusers, and this is not confined to the narrow definition of ‘position of trust’, which was used to establish the 2.6% figure. This Chapter in the Consultation document would therefore have benefited from making such a distinction, particularly as the question of defining who experiences abuse is so crucial to the safeguarding discussion.

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6 Considering the Prevalence Study: an analysis and critique: AEA:2007
Do we need more tailoring of adult protection procedures to individual circumstances, situations or types of abuse?

Given that the dynamics and circumstances of abusive situations are necessarily based upon individual experiences the answer to this question must be yes, and this already occurs as part of strategy meetings. Consequently, it is presumed that the question relates to whether we need more formalised tailoring of systems e.g. sets of protocols or procedures.

Although types of abuse can be aggregated from a research or analysis perspective, it cannot be assumed that they have similarities that automatically lend themselves to generic responses i.e. two individuals may experience financial abuse (theft) but the nature of that theft, who did it, how it was done, the relationship of the thief to the victim etc., all indicate a need for a more individualised approach to the situation.

Such ‘tailoring’ can be achieved through protocols and procedures that are derived from the knowledge and experience of relevant agencies (e.g. police and CPS in relation to theft) and from shared good practice. (See the AEA/PAVA good practice database at www.elderabuse.org.uk).

Do we need to look at safeguarding from an equalities perspective?

Of course, and it is unclear as to why there is a need to ask this question.

No Secrets included discriminatory abuse as a distinct category in recognition of the motivation of a perpetrator and, in recent years, this understanding has evolved in terms of hate crime, forced marriages etc. If we accept the explanations provided by other Government departments in justifying the need for specialist legislation then it must follow that safeguarding and adult protection must be similarly tailored.

Certainly the DH sponsored research conducted by AEA and published in March 2006\(^7\) indicated that, in relation to race,

\[
\text{The majority of referrals showed the victims of abuse to be White British (68.1%) with the next single highest category as Black Caribbean (2%). It is worth noting that in 22.5% of referrals the ethnic origin of the victim remained unknown. The evidence from these statistics would suggest that there is a very low referral rate from Black and Minority Ethnic Communities, and this implies that}
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\(^7\) Adult Protection Data Collection and Reporting requirements: AEA 2006
Local multi-agency protection of Vulnerable Adult Committees need to prioritise work with local communities. Priority activities would be to increase awareness of local procedures, ensure that community groups are aware of their responsibilities to report allegations of abuse and ensure that responses and interventions are appropriate to the needs of these communities.

Additionally, if a person-centred approach and the principles of both the MCA and HRA sit at the heart of safeguarding, then this approach would routinely apply in that the individual circumstances and needs of someone experiencing abuse would be central to any strategy i.e. it would automatically negate a ‘one size fits all’ approach.
Chapter Two: The new policy context: personalisation, community empowerment and access to criminal justice for all

Policy context:

This Chapter begins with the assertion that,

‘in this section we set the policy context for safeguarding adults’.

We do not believe that this is the case. The Chapter highlights a selection of policy issues which have not been derived from the pre-consultation process, but instead reflect a Government perspective on policy priorities. It would have been more transparent to set the chapter in this context.

For example, other relevant policy initiatives would include the National Dementia Strategy, the National Stroke Strategy, the new Carer’s Strategy, The Mental Capacity Act 2005 and the role of Independent Mental Capacity Advocates, the impact of the Mental Health Act 2007 and the Health and Social Care Act 2008, the reports from the Health Select Committee inquiry into elder abuse in 2004 and the joint committee on Human Rights in 2008, the discussion paper ‘The Case for Change’ published by the Government last year, and of course the impact of the new Care Quality Commission. We highlight these, not to focus upon the limitations of this chapter within the consultation, but to highlight the complexities associated with reviewing No Secrets; it is a colossal piece of work.

Personalisation:

We are firmly committed to the principle that every person receiving support in every setting, and through whatever mechanism, should have choice and control over their care and support. This should include the ‘cash for care’ model, traditional domiciliary care, residential care, hospital environments, and all other permutations.

We are also firmly committed to the application of the principles contained within the MCA and which can be translated into the Disability Rights assertion that ‘anything about us must involve us’. This is not incompatible with the right to exercise choice without experiencing unnecessary risk of abuse.

We are concerned therefore that, despite the opening statement in this chapter that ...

‘This means every person receiving support in every setting having choice and control over their care and support’.
... the consultation events undertaken by the DH have concentrated exclusively on the ‘cash for care’ model of personalisation and have not addressed the more global approach to this principle, or the challenges inherent in blending safeguarding with the MCA principles. From our perspective this chapter (and (Chapter Four) would have benefited from considering these principles, and through them personalisation, rather than pursue the simplistic approach which has been adopted.

In that context, while the consultation has focussed upon one aspect of the Putting People First concordat, it has not drawn attention to, or adequately addressed, the two clear statements within that document which relate to safeguarding and adult protection:

- The Concordat refers to the development of
  
  ‘Systems which act on and minimise the risk of abuse and neglect of vulnerable adults’.

- The Concordat additionally states a commitment to
  
  ‘always fulfil our responsibility to provide care and protection for those who through their illness or disability are genuinely unable to express needs and wants or exercise control. However, the right to self-determination will be at the heart of a reformed system only constrained by the realities of finite resources and levels of protection, which should be responsible but not risk averse’.

Despite the commitments given in June 2007 the consultation has not addressed the changes - both potential and immediate - arising from the implementation of the Mental Capacity Act 2005; the growing influence of the Human Rights Act 1998 and its associated impact on care provision; the impact of the Safeguarding Vulnerable Groups Act 2007 on care - including on Health; the development of the NHS Constitution; or the developing strategies around Hate Crime, around forced marriages, and within the domestic violence arena.

We have to note therefore that this chapter reflects a selective and incomplete overview of the policy context within with safeguarding and adult protection operates.

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8 Putting People First: a shared vision and commitment to the transformation of adult social care, DH, 2007
Chapter Three: Leadership, prevention and outcomes.

Leadership:

While the initial part of Chapter Three accurately portrays and questions the role of safeguarding/adult protection coordinators, and the current difficulties inherent in the role within a local government context, it loses its way in subsequently listing the roles and functions of a myriad of other organisations, without attempting to draw any potential conclusions from that list.

The Chapter implies that there are only two groupings under which this situation is being considered:

- As regulators, CSCI, the Mental Health Act Commission and the Health Care Commission are now being subsumed within the new Care Quality Commission and the role of this new body, (in conjunction with the Nursing and Midwifery Council and the General Social Care Council, which are not mentioned) would benefit from more in depth consideration as they have clear safeguarding functions.

- The Office of the Public Guardian, the Official Solicitor, the Magistrate system (not mentioned), the Crown Prosecution Service, and the police link to Crime and Reduction Disorder Partnerships and Community Safety Partnerships, form another clear grouping that merit further attention.

However, this suggests that the Chapter has only considered social/health care regulation and the criminal justice system, from the perspective of leadership. But we know from our helpline and from the Prevalence Study that the majority of elder abuse (64%) arises within a domiciliary context⁹, with the greatest percentage of abuse (46%) perpetrated by family members. And this needs to be considered in the context of the additional research undertaken by University College London, which suggests that abusive behaviour by family carers towards people with dementia is common, with a third reporting important levels of abuse and half some abusive behaviour, with a prevalence range of 12 to 55%¹⁰.

The researchers expressed concern that the No Secrets review may concentrate exclusively on the formal paid social care sector, and we would share that concern. In terms of those agencies that interact with victims of abuse, we need to remain focussed upon abuse in the community, perpetrated by people who do not occupy a paid role, and consequently consider prevention from the perspective of agencies who may peripherally have contact with victims of abuse.

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⁹ Hidden Voices: older people’s experience of abuse: AEA, 2004
¹⁰ Abuse of people with dementia by family carers: representative cross sectional survey, Cooper et al, BMJ, 01 2009
including considering primary care and community based initiatives, none of which are addressed in this context within the Chapter.

How effective is their role (that of adult protection/safeguarding coordinators) and how wide do we want it to be?

How effective is the role?

It is clearly impossible to comment upon how effective a role may be unless there is an agreed form of measurement and quantifiable outcomes that are universally accepted. Given the fact that these roles have evolved from local needs and resources, with limited national guidance or focus, there is no common base and it would not be possible to undertake such an assessment. We can say that the roles are affected by whether or not they are strategic or operational (or a combination of both), whether they are dedicated, full or part-time, and whether they have adequate budgets and surrounding infrastructure.

In terms of effectiveness from the perspective of adults at risk of abuse, the DH sponsored research conducted by AEA and published in March 2006 indicated that 23.8% of outcomes for victims were recorded as ‘increased monitoring’, with a further 12.5% recorded as no further action. This suggests that the process, as distinct from the role of adult protection/safeguarding coordinators, may not be sufficiently effective.

How wide do we want it to be?

The No Secrets guidance established a coherent process for investigating allegations of abuse along with protecting and improving the quality of life of those adults deemed vulnerable. However, in a number of situations the actual investigation processes used under Adult Protection existed long before the guidance was launched. For example, the police have always investigated crimes under criminal laws, and employers have always investigated complaints and allegations made against their employees through the disciplinary process, under employment law.

Adult Protection brings investigation and protection together in a multi agency framework and for this process to work it is of paramount importance that there is a clear understanding across all agencies of the various roles and the responsibilities that they are required to meet. This is why it is so important to define clearly any coordinating/lead role, and to site it within a strategic and developmental context rather than an operational one.
What could local leadership mean in terms of safeguarding?

As with any complex situation - such as child protection or domestic violence - there are varying levels of leadership, depending upon the specific requirements.

Firstly there has to be a level of leadership that ensures the engagement of key agencies and stakeholders in the overall process, including the agreement of multi-agency protocols, work plans, strategic and operational priorities and resources, and the appointment of representatives to Safeguarding Adult Boards who have the delegated authority and responsibility to take forward issues. This responsibility should clearly rest with Chief Constables and the Chief Executives of relevant Agencies.

The CSCI Safeguarding Adults Report in 2008 highlighted the value of this level of involvement,

‘Where there is a political champion for safeguarding and the chief executive of a council and the director of adult social services are actively involved in raising the profile of safeguarding, there is a greater likelihood of engaging other major players in primary care trusts, hospitals and police authorities’.

Secondly, there has to be day to day management and leadership provided by the Safeguarding Adult Boards, contributing to the development of strategic planning and inter-agency communication, assuring the delivery of multi-agency training, developing, monitoring and reviewing protocols, undertaking analysis and research, networking, proving public information, and publishing the annual report. For this reason, the issue is not just about ensuring attendance at these meetings by all key agencies, but is about ensuring attendance at an appropriate level of seniority to allow decisions to be made and the commitment of time and resources.

Thirdly, there are the operational strategic meetings to address specific abuse situations, and involving various practitioners and individuals according to need and circumstance.

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11 Safeguarding Adults, CSCI, 2008
What is the role of the wider local government?

In 2004 AEA and Better Government for Older People published a discussion paper entitled, ‘Placing elder abuse within the context of citizenship’\(^{12}\). In that paper we suggested that,

\[\text{The factors identified by older people as contributing to their quality of life clearly extend beyond the remit of health and social care, to include: housing and the home; neighbourhoods; income; social activities and networks; getting out and about; and information}\]

Local authorities have responsibility for community leadership and the promotion of the well-being of local communities, and they therefore must ensure that safeguarding is embedded within ‘whole system’ approaches to older people’s services. Being abused or at risk of abuse does not deny one the right to social inclusion and participation. A policy shift to a ‘whole system’ citizenship approach will ensure that safeguarding and adult protection does not remain a marginalised specialism. This will contribute to a reduction in the isolation and vulnerability of many older people, increase the understanding and ‘ownership’ of adult abuse across communities, and ensure the empowerment of front line professionals.

Should the leadership be in a central place in local government, able to bring together all the different parts of the council?

The assumption that the leadership of adult protection/safeguarding should be sited within a social services context needs to be tested. While there are clear arguments that justify the placement of child protection in such a context, these are not necessarily sustainable in an adult context.

There are a number of factors that merit consideration:

a) a number of adults (particularly but not exclusively from a disability perspective) have experiences of social services intervention and social care provision that has been disempowering. This hampers their potential ability to interact positively with a safeguarding service that is linked with social work or commissioning activities;

b) MARAC, MAPPA, Public Protection Units, Crime and Disorder Reduction Partnerships, and Community Safety Partnerships all have relevance to adult protection and safeguarding work and all sit outside a social services context.

\(^{12}\) Placing elder abuse within the context of citizenship: a policy discussion paper, AEA/BGOP 2004
We clearly need to site safeguarding where it can operate most effectively and be most accessible to adults at risk of abuse.

Has the local authority chief executive got an interest in safeguarding, and a relevant part to play?

Yes. See previous answer.

1a Where should leadership for safeguarding adults lie nationally and how should the various national organisations work together?

Leadership must lie at Ministerial level, either within the Department of Health or the Home Office, but this leadership role should also include a oversight by a cross government steering group to develop, oversee and monitor a national adult safeguarding strategy. Other government departments should include Ministry of Justice, and the Department of Communities and Local Government.

Whether or not leadership rests within the Department of Health or the Home Office is dependent upon the strategic approach adopted toward abuse.

The current approach primarily addresses abuse from the perspective of care or health provision, and does not take congnisance of the reality of abuse which places the majority (64%) within a home environment, perpetrated by a family member. It also defines such abuse from a social policy perspective rather than a criminal one (e.g. financial abuse instead of theft), and sites the cause with the vulnerability of the victim not the actions of others or the situation and circumstances that generate the abuse.

From an adult protection/intervention perspective, placing this function within a Home Office context would re-position both the understanding of abuse, and the strategies of response; aligning it perhaps more appropriately with domestic violence rather than child protection initiatives.

1b Where should it lie locally? If within local government, then where in local government?

There are a number of options:

a) It could be removed completely from local government and placed within a wider regulatory context, sited within the Care Quality
Commission. The advantage would be that it would link the current expertise within adult protection with the similar expertise held by Commission inspectors, across the social care, mental health and general health fields. The drawback is that it places adult protection within a social/health care provision arena, while the majority of abuse occurs outside of that environment.

b) It could be sited within Primary Care Trusts, with direction and oversight coming from strategic health authorities and ultimately the Department of Health. This would address the potential for GP’s being a primary means of identifying and triggering responses to abuse. Again however, it places adult protection within a social/health care provision arena, while the majority of abuse occurs outside of that environment.

c) It could remain with local government, but be sited outside of social services. The Crime and Disorder Reduction Partnerships are one model of this type, and siting adult protection in this arena may offset any previous negative experiences of service users in relation to social or health care provision. As the Chief Executive would be part of a wider Chief Officers leadership group as detailed previously this would retain the ability for multi-agency collaboration.

1c Do we need a template for ‘a local safeguarding job description’ and national procedures for use locally?

There clearly needs to be some consistency guaranteed at local level, but this needs to be balanced against equally legitimate local requirements. Consequently we would advocate a minimal level of national direction on key objectives, supported by local flexibility on detail.

For example, we believe that the primary role of the safeguarding/adult protection coordinator role should be a strategic and developmental one, in support of the Safeguarding Adults Board. It should not be routinely operational. Key responsibilities in this regard could therefore be set out nationally in statute.

Beyond that point, the manner in which such responsibilities should be met needs to be left to local discretion, taking account of local organisational frameworks etc.

Additionally, a national framework for local procedures would be beneficial as it would ensure consistency in approach across the country and would have the added benefit of ensuring that actions taken in response to abuse were balanced and appropriate. The framework would need to
allow sufficient flexibility to meet local requirements, but could define certain activities and responses e.g. in a social care context it could define acceptable circumstances under which a local authority could/should suspend placements to a care home.

**1d. How do we know if a safeguarding board is working effectively? To whom should it be accountable?**

We would propose the model identified previously, whereby a Chief Officers committee provides ownership and leadership, and to which the Safeguarding Adults Board should be accountable.

Safeguarding Adult Boards must be independent of local government and other partner agencies. It is however important that such a structure has a statutory basis, reinforced with a duty to cooperate, clear governance arrangements and lines of accountability to both partners and also to Government. We do not believe any discretionary model, based on guidance, will work.

As stated in relation to a previous question, it not possible to assess the effectiveness of a role unless there is an agreed form of measurement and quantifiable outcomes that are universally accepted. In this regard we can clearly learn from the experiences within child protection, both in terms of what has worked effectively and what has not done so - and Haringey would be a good starting point in that regard. It is worth noting however that the Safeguarding Adults document, produced in 2008 by CSCI, assessed the effectiveness of Safeguarding Boards against the ADASS good practice guide and suggested that only half were working effectively.

Additionally of course we can consider what is learned from Serious Case Reviews and other investigations to guide us as to what can be considered ‘failings’. For example, in Cornwall the conclusion from the joint investigation at the Cornwall Partnership NHS Trust observed that...

> ‘Cornwall County Council, as the leading agency for the protection of vulnerable adults, failed to coordinate effective inter-agency arrangements. The council did not play a sufficiently active role in managing referrals, and many social workers were too ready to accept, without challenge, the opinion of staff at the trust’

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13 Joint investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust, Health Care Commission/CSCI 2006
There are a range of measurable outcomes that can be used to assess performance of both the Chief Officers committee and that of the Safeguarding Adults Board, and these obviously include practical outcomes such as the production of annual reports, attendance levels at meetings, production of monitoring information and protocols etc.

However, less quantifiable matters include aspects contained within the AEA report on Adult Protection Data Collection and Reporting. These relate to matters such as outcomes for victims, the effectiveness of reaching victims, and the engagement in preventative work. Such measurements would need to be informed by a number of factors, not least of which should be conclusions from Serious Case Reviews.

1e Where should leadership for NHS safeguarding issues lie? Do we want national procedures for the NHS?

Leadership:

At Government level it should rest with the relevant Minister, and this should be within the Department of Health.

Again, we would suggest that Strategic Health Authority Chief Executives should form an integral part of any Chief Officers Committee, with operational leadership provided by primary care trusts at the Safeguarding Adults Board level.

In our view, the engagement of the NHS can only be guaranteed through a statutory duty to cooperate, and the active engagement in safeguarding processes. In that context, we have noted that the new NHS Constitution contains principles relating to abuse14, including the right to be treated with dignity and respect, in accordance with human rights. It emphasises this by confirming the duty of NHS staff to

\[\text{'accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body'}\]

and suggests that they should maintain the highest standards of care and service, taking responsibility not only for the care they personally provide, but also for their wider contribution to the aims of their team and the NHS as a whole.

While we would readily support these aspirations, which are effectively a re-statement of the status quo, the question must arise as to what

\[\text{14 NHS Constitution, Department of Health, 2009}\]
additional steps need to be taken to convert such aspirations to reality? It is in this context that we should consider NHS leadership.

**National procedures:**

As indicated in question 1(c) a national framework for local procedures would be beneficial as it would ensure consistency in approach across the country and would have the added benefit of ensuring that actions taken in response to abuse were balanced and appropriate. The framework would need to allow sufficient flexibility to meet local requirements, but could define certain activities and responses.

Such an approach however should be relevant for all key agencies, including the police, the Crown Prosecution Service, and regulators etc., and it is in this context that both questions need to be considered. A balance needs to be maintained between those responses or actions which need to be integrated across multiple agencies, (and which require national direction) and the operational methodology to achieve specific objectives which can be acceptably influenced either by local needs or individual agency approach.

Where should leadership for safeguarding in the care home sector lie? What can be done to strengthen this?

The question is not accurate. It should relate to care providers, both within the care home sector, the domiciliary care sector, and supported living i.e. the provision of regulated social care.

Care provision is governed by the Care Standards Act 2000, the Health and Safety at Work Act 1974, employment law and a range of other legislation. Ultimately, there is a duty of care placed on all staff and managers, and vicarious liability on owners for the actions or failings of their staff. Consequently, leadership must firstly rest in law with the owners of businesses, and then with registered managers.

However, we believe that the question should not just relate to where such leadership should lie, but rather why such leadership is not acknowledged or recognised within current structures and why care providers are not engaged as positive partners in such processes?

There are two aspects to this. Firstly, there is the safeguarding preventative role which can be employed by care providers – and in this context we again raise the question as to why the consultation has failed to include such providers in the discussions around personalisation.
Secondly, there is the role of care providers in adult protection intervention work, how they are engaged in investigations, and what role commissioning has in the overall process. And the commissioning role can be crucial, as noted by the joint investigation into the Cornwall Partnership NHS Trust, which stated,

‘The trust has blamed the three PCTs in Cornwall for failing to commission appropriate services for people with learning disabilities and, while this does not lessen the trust’s culpability, the criticism is accurate’.

The CSCI Safeguarding Adults report suggested that some adult protection actions assume Provider Managers to be automatically complicit in abuse, regardless of circumstances. This was a matter highlighted in the AEA 2006 report on Data collection and monitoring and needs to be resolved. Too many adult protection systems and processes fail to engage care providers consistently in safeguarding systems and processes. They often have an expertise and commitment that could be usefully used to better plan the safeguarding of people at risk of abuse but this is rarely utilised, and they are too often perceived as the perpetrators of abuse when the causes are more complex. We consequently believe that Care Providers should be involved operationally in relevant strategy discussions as well as strategically on local safeguarding committees.

We believe that the failures of quality commissioning, which has focussed too much on driving down costs and insufficiently on stimulating quality care is a major factor in this disenfranchisement, and is encouraging inappropriate and disproportionate responses to abuse scenarios e.g. punitive ‘blocks’ on admissions, or referrals which are ultimately damaging to service users.

We need a greater understanding, and accountability, by commissioners for abuse that arises as a consequence of their commissioning practices, and we need to reconsider the benefits of the inspection regime to ensure that it focuses upon the quality of care and not the availability of forms and procedures.

1g Given that there are multiple ‘chains of command’, how do we ensure that formal leadership roles are accompanied by appropriate authority levels?

Firstly, we do not believe that such accountability can be achieved by any other means than through a statutory framework for adult protection. Guidance has failed to deliver this requirement and there is no evidence
available to suggest that further guidance would be effective in this regard.

Secondly, we believe that there needs to be a statutory framework that includes the commitment, involvement and ultimate ownership by Chief Officers of safeguarding adults work.

As indicated previously, we envisage that there has to be a level of leadership that ensures the engagement of key agencies and stakeholders in the overall process, including the agreement of multi-agency protocols, work plans, strategic and operational priorities and resources, and the appointment of representatives to Safeguarding Adult Boards who have the delegated authority and responsibility to take issues forward. This responsibility should statutorily rest with Chief Constables and the Chief Executives of relevant Agencies.

There has to be day to day management and leadership provided by the Safeguarding Adult Boards, contributing to the development of strategic planning and inter-agency communication, assuring the delivery of multi-agency training, developing, monitoring and reviewing protocols, undertaking analysis and research, networking, proving public information, and publishing the annual report.

There should be operational strategic meetings to address specific abuse situations, and involving various practitioners and individuals according to need and circumstance.

Preventing Harm:

The Consultation document rightly states that,

‘Safeguarding is about learning from adult protection cases, for example about the ‘grooming’ of people leading to financial abuse or sexual abuse, and deciding what we can do to educate, prevent and alert’.

For this reason we would again encourage the DH to undertake a review of adult protection Serious Case Reviews, and to also prioritise the implementation of the Data Collection and Monitoring process which was originally committed by Liam Byrne, then Minister for Social Care, in March 2006.

However, prevention must also include an understanding of the causes and dynamics of abuse, and we believe that this requires a reconstruction of societal systems, infrastructure and attitudes in a similar manner to that adopted toward domestic violence. It is insufficient to perceive prevention exclusively from the
perspective of adult protection cases as this is retrospective and will fail to ‘mainstream’ safeguarding into planning and policy.

- For example, if a risk assessment (based upon what is known about abuse) had been undertaken into the introduction of ‘chip and pin’ as a replacement for pension books it would have identified a risk of fraud and theft that could then have been addressed in advance. This would have avoided the need for a reactive response to thefts which are now occurring as a consequence.

- For example, if a risk assessment (based upon what is known about abuse) had been undertaken into the introduction of ‘cash for care’ personalisation prior to the attempted roll-out it would have identified a risk of fraud and theft that could then have been addressed in advance. This would have assisted the transition of personalisation and, more importantly, ensured that the policy was being introduced in a measured and safe manner.

Most Partnerships for Older People’s Projects do not integrate safeguarding issues into older people’s projects. As these pilot projects are rolled out, do we need to undertake this more explicitly?

This question actually highlights the failure of the current approach, which has not mainstreamed safeguarding into the planning and development of social and health care policy and initiatives. The answer is that we obviously must have a preventative approach built into all developments that have the potential to create (avoidable) risk of abuse or criminal acts. The Serious Case Review into the death of Steven Hoskin made a significant statement in this regard, which we believe should be used as a constant caution and reminder in every scenario where the argument for choice and control is used as a justification for not considering or adequately addressing safeguarding issues,

‘It is essential that health and social care services review the implications of acceding to people’s ‘choice’ if the latter is not to be construed as abandonment’.15

That is not an argument for denying choice and control, but is an argument for ensuring that choice and control does not equate to avoidable abuse and crime.

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15 The murder of Steven Hoskin: A serious Case Review, Cornwall Adult Protection Committee 2007
2a Should we be doing more work on prevention? If so, where should we concentrate our efforts? If you are doing effective preventive work, please tell us what it involves.

This question is limited to the context of safeguarding from an adult protection perspective, and yet the consultation document has itself acknowledged that preventative work is wider than this (see Chapter Two on Community Empowerment, etc).

As indicated earlier, a preventative approach must include the reconstruction of societal systems, infrastructure and attitudes so that people deemed potentially vulnerable to abuse are not made so by the environment, systems or people around them. Consequently, it is insufficient to perceive prevention exclusively from the perspective of adult protection as this is exclusively retrospective and will fail to ‘mainstream’ safeguarding into planning and policy.

We have indicated previously our belief that leadership on safeguarding must lie at Ministerial level, either within the Department of Health or the Home Office, and that this leadership role should also include a oversight by a cross government steering group to develop, oversee and monitor a national adult safeguarding strategy.

In terms of a long-term approach to safeguarding, Government initiatives need to be measured against criteria that assess the potential risk to adults and which seek to mitigate against such risk, whenever it is reasonably avoidable. ‘Chip and pin’ and ‘cash for care’ are good examples of where the Government has failed itself to mainstream a safeguarding approach into its planning and thinking. And the failure over the last several years to introduce the Protection of Vulnerable Adults list into the National Health Service would be an example of where the Government chose expediency over safeguarding. Preventative work must therefore start with Government, and there must be accountability for decisions or actions which give rise to abuse.

- For example, while the Dignity in Care campaign is to be welcomed and could be seen as a Governmental preventative strategy, it is insufficient by itself. A campaign which encourages care or health staff to abide by their own code of conduct is limited in impact if it does not simultaneously address why the care or health worker is not acting appropriately in the first place. In some cases this is about circumstances which may be within the remit of the Government e.g. staffing and resource levels on wards, funding of care home placements etc.
At the next level, which would include Chief Officers, Chief Executives, Chief Constables etc, there is a responsibility to examine strategic decisions and actions to ensure that a preventative approach is mainstreamed across services. Clearly, greater collaboration and sharing of information and experiences would be useful, particularly where similar issues are being addressed e.g. hate crime, forced marriages etc. This would also include public awareness campaigns, management and construction of housing and housing estates, commissioning and the provision of care, and the operation of primary and secondary health care services etc.

At a wider level, the construction and delivery of care provision needs to be considered and this is where person-centred care, personalisation and regulation can play a part. It is accepted that it is not possible to regulate in a manner that guarantees the elimination of abuse and the promotion of quality, but there is a role for the dissemination of good practice in a manner that sets levels of expectation. There are many examples of systems, approaches and training that promote quality of care and wider awareness of such success would be preventative in nature. In this context the significant failure of commissioning to influence the delivery of quality care must be considered and addressed as it represents one important facet in the development of abusive practices and regimes.

Equally, the Disability Rights assertion that ‘anything about us must involve us’ is certainly relevant to the question of preventing abuse. Understanding why abuse occurs, the factors and dynamics associated with it, and the desires of victims are pertinent to understanding how to prevent abuse. And this clearly indicates a need for a level of quality advocacy that is based on an understanding of abuse.

And this needs to be considered in the context of what is known about abuse. The thrust of Government legislation has been aimed at paid social care, with limited impact on the NHS, and with community based abuse addressed through the guidance of No Secrets. And yet, the evidence from the AEA helpline (see Hidden Voices), the DH sponsored prevalence study, and the recent University College study into abuse of people with dementia, is that the overwhelming prevalence of (elder) abuse is within the community.

Consequently, preventative work must be led by Government, with clear messages to regulatory and other statutory bodies that prevention of abuse is a central theme that is to be rolled out through the commissioning and inspection processes, and through community engagement strategies and the introduction of a clear legislative base for
safeguarding work within communities. Actions must be informed by an understanding of the factors that give rise to abuse (hence the need for robust data collection, monitoring and analysis), with outcomes that not only benefit any single individual but that are used to inform and develop social and health policy and planning. If Government is genuine about preventing abuse of adults it must mainstream it into its strategies and actions.

In terms of prevention, AEA are consistently raising public and practitioner awareness of the nature and extent of abuse, and this acts as a catalyst for greater community awareness and caution, thus reducing the potential for abuse. We provide a public good practice database to encourage the sharing of skills and experience. We provide training to basic grade staff to influence their practice and raise their awareness of abuse. We provide conferences on specific themes to encourage the sharing of information and debate. And we work closely with third sector, statutory, and private organisations to facilitate greater priority and understanding of elder abuse.

2b Should we develop a national prevention strategy for adult safeguarding which includes, for example, links with neighborhood policing, with a human rights agenda, and with Health and Well-Being?

Given the diverse structures across England it is difficult to envisage how a national prevention strategy would be effective, although there is a clear role for Government in setting levels of expectation and involvement of all Agencies. Our view is that this should occur through the enactment of framework legislation, which defines roles and responsibilities, and places duties to collaborate and share information.

Presuming that effective leadership can be established at local level (and we have outlined a proposed model) it would be clearly useful to ensure that safeguarding is effectively linked into relevant partnerships locally e.g. Crime and Disorder partnerships as part of that process.

2c Are whistle-blowing policies effective? What can we do to strengthen them?

Firstly, whistleblowing in the context discussed within this Chapter refers exclusively to such acts taking place within formal paid employment, and does not consider such acts by members of the public or, for example, by a Personal Assistant employed under ‘cash for care’ initiatives.
Whistleblowing needs to be seen in its widest context.
Secondly, we note that the consultation has not taken account of the experiences of Public Concern at Work in relation to effective whistleblowing, or the experiences of other contact points such as the AEA helpline.

Although most services have whistle blowing procedures, they do not always work effectively when safeguarding issues are raised; some of this is due to peer group pressure, fear of reprisal, and a failure at local level to own and implement whistle-blowing effectively.

There are two aspects to this: a failure to create a culture in which the content of the whistleblowing (abuse) is of greater concern than the consequence, and the failure of the legislative infrastructure to provide sufficient encouragement and protection. We believe this is because whistleblowing is perceived as an unusual act performed by an individual, often against an employer. Whereas it should be seen as an expectation that has greater consequences and implications if the disclosure is not made i.e. if abuse is subsequently uncovered and a staff member was aware but failed to disclose, there should be a penalty associated with a failure in their duty of care.

However, by themselves whistle blowing polices are not effective. A culture of openness is essential so that staff, service users and carers are able to raise concerns, complaints and allegations without fear of reprisal and in the knowledge that something will happen. For this reason, AEA have entered into an agreement with Southern Cross Healthcare, the largest provider of residential care in the UK, whereby staff, residents, relatives, visitors etc may whistleblow directly to the charity in the knowledge that the matters raised can be safely pursued.

Outcomes:

Firstly, outcomes must be considered from the perspective of the victim of the abuse or crime. Has an action been in their best interests, proportionate to their circumstances or needs, supportive of the Human Rights, and in keeping with the law? Has it affected, changed or stopped the abusive or criminal act? Has it improved or worsened the situation? And is it what the victim wanted or would have wanted?

RADAR has articulated the purpose of adult safeguarding in three ways, all of which are grounded in the needs and experiences of victims or potential victims. We agree with this fundamental approach,
- The effective prevention of exploitation, violence and abuse against people living in situations/circumstances which put them at heightened risk, who are at greater risk of discriminatory abuse
- To ensure instances of exploitation, violence and abuse are identified, investigated and where appropriate prosecuted, in ways which protect and promote the autonomy and dignity of victims.
- To ensure comprehensive support for victims\(^{16}\)

Consequently, the mechanisms by which those outcomes are achieved must be established and quantified, and many of the outcomes outlined in this section of the Consultation document actually fall into this category. Indeed much of this section focuses upon ‘outputs’ rather than ‘outcomes’ and it is important to make this distinction.

In terms of defining acceptable outcomes from adult protection intervention, we believe that we should consider and integrate the principles contained within the Mental Capacity Act 2005 into the decision making and intervention process i.e. that ‘an act done, or decision made, for or on behalf of a person...must be done or made in his best interests, and that before an act is done or decision 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 or freedom of action.’\(^{17}\) It is this approach that would increase the potential for the views and wishes of a victim to be placed central to the decision making process, and to more clearly define outcomes as relating to the experience of the abuse victim.

Other matters:

The remainder of this Chapter skims over a number of issues that merit much greater analysis and discussion, and this is perhaps the greatest failing of the Review. The issues associated with safeguarding and adult protection are extensive and they cannot be effectively addressed within a three month timeframe that concentrates in part on some complex concepts, interspersed with consideration of great detail, and marginalizes others. It would perhaps have been more effective to have addressed this Review in a number of stages, commencing with the consideration of a number of key themes and subsequently working on specific detail. We have previously suggested that a better approach was utilized in developing the National Dementia Strategy and that this issue required an equally comprehensive strategy for engagement.

\(^{16}\) Presentation to the AEA seminar on legislation, Caroline Ellis, Joint Deputy Chief Executive, RADAR, 2008
\(^{17}\) Mental Capacity Act 2005, HMSO
Performance Indicators

The Chapter raises questions about Performance Indicators, but fails to acknowledge that Liam Byrne, then Minister for Social Care, gave an agreement in principle to introduce an indicator on adult protection when he spoke at the AEA National Conference in March 2006. It links the debate on Performance Indicators with Data Collection and Monitoring (which is an entirely different process) and gives an example of the challenges of producing an appropriate indicator (an example which has its origins in 1990 and indicators relating to Child Protection).

To put this in context, the Health Select Committee inquiry into elder abuse, recommended in 2004 that...

‘...performance indicators be established as soon as possible to enable accurate measurement to be undertaken. In addition we recommend that the Department uses No Secrets as a baseline to enable progress to be determined in tackling the issue of elder abuse.’

In direct response the Government indicated that AEA's work on national recording systems would be used to launch a national data collection on adult abuse, which in turn would be used to generate a performance measure. It was a consequence of this work that led to Liam Byrne's commitment, which remains outstanding.

The reality is that, whether we like them or not, Indicators have currently proved the most effective method of encouraging action by statutory agencies and it remains of concern that the commitment given three years ago by the Minister has yet to be actioned.

Annual Reports

The Chapter mentions the existence of annual reports, and then asks some basic questions, without indicating any significant analysis of the content, impact or usage of such reports. It makes no attempt to assess the content of existing reports against the requirements described in paragraph 3.18 of No Secrets:

• an evaluation of community understanding - the extent to which there is an awareness of the policy and procedures for protecting vulnerable adults;

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18 House of Commons Health Committee Elder Abuse Second Report of Session 2003–04 Volume I Report, together with formal minutes Ordered by The House of Commons to be printed 24 March 2004
• links with other systems for protecting those at risk – for example, child protection, domestic violence, victim support and community safety;
• an evaluation of how agencies are working together and how far the policy continues to be appropriate;
• the extent to which operational guidance continues to be appropriate in general and, in the light of reported cases of abuse, in particular;
• the training available to staff of all agencies;
• the performance and quality of services for the protection of vulnerable adults;
• the conduct of investigations in individual cases; and
• the development of services to respond to the needs of adults who have been abused.

Again we would argue that, unless the content of such reports are defined by statute, it will not be possible to ensure consistency in production or content.

Training

Paragraphs 5.2 and 5.3 of No Secrets gave clear guidance on the range and type of training that should be provided by Agencies in relation to adult protection. While the chapter recognises the value and worth of training it suggests that numbers and volume tell us nothing about the outcomes, quality and consistency of the training provided. We would agree with this observation.

No Secrets basically suggested that training should fall into three categories; basic awareness of the nature of abuse, more detailed awareness coupled to an understanding of individual responsibility, and then training for people who had specific responsibilities assigned under the adult protection procedures.

Awareness training in part is covered by expectations defined within NVQ, and this is further enhanced by NMC and GSCC codes of practice and, to some extent, these are the simpler elements to address as they relate to care practice and employment expectations. However, what is missing from this debate is consideration of training in a wider context e.g. what training is provided to nurses and to GP’s.

The report from the Health Select Committee Inquiry into elder abuse addressed this matter in part when it recommended,

‘We are concerned that the area of elder abuse does not currently form a mandatory part of the training for nurses and care workers. Given the scale of the problem, and the fact that care of older people will increasingly feature in nurses’ work given the ageing of the population, we recommend
that this omission is corrected as soon as possible and that the identification of abuse of older people and other vulnerable adults and the actions to take upon detection are instituted into the nursing curriculum'.

The Government response was to defer responsibility to regulatory bodies, indicating that it is not usually appropriate for the Department of Health to provide direction on the content of nurse training.

Service Inspections

The section relating to the role of CSCI and Health Care Commission considers their role exclusively from an inspection perspective, and does not make any clear link between their regulatory functions and adult protection interventions, although this is referenced in a blue box on page 20 of the document without observation or consideration. There is no reference to the work of the Mental Health Act Commission.

There is a fundamental difference between the regulatory role undertaken by a body such as CSCI as this is defined by legislation, (the Care Standards Act 2000), and opposed to that of adult protection, which is covered by the No Secrets guidance. As a consequence CSCI have powers and duties that place it currently in a unique position in relation to the investigation and pursuance of abuse within care environments, and it is this difference which would benefit from exploration by the consultation process. In that regard, there are multiple factors that influence the way in which an issue of abuse is addressed within the care environment:

- What actions are taken by CSCI
- What actions are taken by adult protection
- What actions are taken by the Local Authority Commissioners
- What actions are taken by the Local Authority complaints department
- What actions are taken by the care provider under employment law
- What advice is supplied by the care provider's insurance company in relation to employment law
- What actions may be subsequently taken by other bodies such as the NMC or the GSCC

All of these factors have a bearing on the investigation, consideration and outcome of an abuse situation arising within a care environment.
Funding

It is of great concern that no attempt has been made to adequately define the manner in which adult protection work is funded, which agencies should contribute, what role central government should take, and what impact this situation has upon the effectiveness of safeguarding and adult protection.

This is a major issue, noted by CSCI in their report last year on safeguarding,

‘some front-line teams are trying to handle massive increases in referrals without increased resources or support.’

The Government funded a prevalence study into the extent of elder abuse within communities (excluding people with dementia) and established that at least 4% of the older population experienced such abuse. Based on additional research relating to people with dementia, and failings in the methodology used in the original prevalence study we know that this is an underestimate. Nevertheless that figure allowed each local authority to conservatively quantify how many of their older population are likely to be victims of abuse, and it is not difficult to correlate this with data from adult protection annual reports, indicating that adult protection services are failing to reach an overwhelming majority of older people.

Additionally, research undertaken by Mind indicated a significant proportion of people with mental health problems tell no-one, (or we might argue, are unable to tell anyone because of systems and structures that are not sufficiently effective), The report, ‘Another Assault’, noted that,

‘30% of respondents who had been victims in the community told no-one at what had happened to them; 45% who had been a victim of a crime in hospital did not tell a member of staff; 36% who did not report a crime did not think they would be believed; 36% did not want to go through the process; and 60% who did report a crime felt that the appropriate authority did not take the incident seriously.’

It is in this context that the funding and operation of adult protection should be considered. Regardless of its effectiveness when actively engaged in an abuse case (which the CSCI Safeguarding adults report suggests is questionable) it is failing to reach the majority of people who need intervention and support.

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19 Another Assault, MIND 2007
Would more clarity about the intended outcomes help to raise the profile of safeguarding adults work, and lead to greater priority and resources being dedicated to it?

It is difficult to understand the proposed link between clarity of outcome in contrast to profile, priority and resources? If we accept as legitimate the list of outcomes identified in page 19 of the consultation document, it must raise the question as to why these by themselves have not been sufficient to influence profile, priority and resources? And of course the conclusion must be because there is no link between them.

In our view the only effective strategy to positively influence profile, priority and resources is to (a) place adult protection work onto a statutory basis and establish a duty on agencies to engage proactively in the prevention and detection of adult abuse, with appropriate intervention in keeping with the principles of the Mental Capacity Act 2005; (b) influence the culture and actions of care and health organisations to establish and abuse as unacceptable; and (c) to undertake a major publicity campaign to raise levels of public awareness. In our view, to effect change will require a combination of these three strategies operating simultaneously.

Have we got these (annual Reports) right? Do the annual reports evaluate or do they simply describe? How do we learn from safeguarding experience at the local level? How does each multi-agency partnership improve what it is doing?

Paragraph 3.18 of No Secrets indicated that that the Annual Reports should evaluate some issues and describe others. In many cases reports also quantify, in terms of numbers of referrals etc. The question therefore is not sufficiently precise. The ‘audit’ report (as this is described in No Secrets) was intended to monitor and evaluate the way in which policies, procedures and practices were working and provide information for wider annual reports from what were then Directors of Social Services. Paragraph 3.19 of No Secrets indicated the quantifiable data that should be collated as a ‘learning experience’ and this was to have included user/carer views on how well the policy worked for them. This requirement appears to be rarely included in annual reports. Additionally, it is not clear how many adult protection teams fail to produce the annual report, and of those who do so, how many seek reports from individual member agencies. Consequently the Annual Report system is weak.

It is our view that the content of such reports and their frequency should be statutorily required, with a duty on agencies to collaborate and provide
the required information. This should be linked to the promised national data collection and monitoring process so that independent public evaluation may take place.

The 2007 ‘Partnership in regulation and adult protection’ recommended,

‘Annual reports on adult protection activity, including data collection on referrals and outcomes should be sent to, disseminated and monitored by the Department of Health.’20

We would agree with this view.

It has been suggested that an educational framework should be introduced across agencies and disciplines, covering both pre- and post-qualification adult protection practice and assessed competence. Would such a framework be helpful? How would it operate in practice?

It is unclear what is meant by an ‘educational framework’ in this context?

Certainly, in order to introduce a national approach to training it would be necessary to establish core competencies, and measurable levels of knowledge and skills. This perhaps could be achieved in terms of knowledge and understanding of abuse e.g. recognition of signs, causes and consequences, and basic level of action to be taken.

However, it is difficult to envisage how this could be done with regard to the more complex matters relating to adult protection processes unless a national structure and standardised procedures were established e.g. at the very least the roles of ‘alerters’, ‘fact finder’ and ‘investigator’. See 3d below.

3a Would an outcomes framework for safeguarding adults be useful? If so, which indicators should we use within the wider responsibilities of local government, the NHS and the police force?

Yes. There is a need for an outcomes framework to be developed using national data collected from each area. Such data collection should be mandatory and not optional, as is currently being proposed.

The purpose of the framework should be to clarify unequivocally the types of outcomes to which adult protection should seek to achieve. As indicated previously, outcomes should be considered from the perspective of the victim of the abuse or crime. Has an action been in their best

20 Partnership and regulation in adult protection; Penhale et al, 2007
interests, proportionate to their circumstances or needs, supportive of the Human Rights, and in keeping with the law? Has it affected, changed or stopped the abusive or criminal act? Has it improved or worsened the situation? And is it what the victim wanted or would have wanted? Outcomes should be based on an assessment of risk and reduction of risk.

Secondly, the mechanisms by which those outcomes are achieved must be established and quantified, and many of the outcomes outlined in this section of the Consultation document actually fall into this category. Indeed much of this section focuses upon ‘outputs’ rather than ‘outcomes’ and it is important to make this distinction.

The Adult Protection Data Monitoring report produced by AEA and funded by DH should continue to be used as the template for such data collection and Performance Indicators should be based upon outcomes for victims.

It is important to note that the Health Select Committee inquiry into elder abuse in 2004 recommended that ‘performance indicators be established as soon as possible’ and the Government gave a commitment to this. In 2006, AEA recommended the introduction of a clear performance measure across NHS and Social Care, based on the reduction and elimination of risk to vulnerable adults suffering abuse, and this was agreed ‘in principle’ by Liam Byrne, then Minister for Social Care.

3b Should we encourage local annual reports to be more evaluative?

As indicated previously, they need to be a combination of evaluation, factual reporting, and quantative reporting. Each key agency should contribute an analysis against goals identified and set the previous year, based upon experience and identified weaknesses and setting targets which address issues of concern – thus allowing monitoring against progress. An overall evaluation should be written which places the work of the Safeguarding Adults Board into both a local needs and a national context.

3c How can we learn from people’s experiences of harm and their experiences of the safeguarding process in order to improve safeguarding?

Ask them. Record what they say. Disseminate their views. Evaluate what they have said, and re-configure the process accordingly. Disabled Rights groups articulate this as ‘Nothing about us without us’, and they are clearly right. Safeguarding processes must be developed and designed based upon the experiences and of people who are either
potentially most likely to experience abuse, or who have had such experiences.

The DH sponsored report in 2007, ‘Partnership and regulation in adult protection’, undertook a number of focus groups in this regard and summed up the general views as,

‘Overall it was notable that respondents had few positive comments to make about their experiences of adult protection.... What is markedly different about these accounts compared with those of the professionals ... is the sense of personal disappointment characterising contact with both individual professionals and adult protection processes. The incidents of poor communication, marginalisation, negative attitudes and bad practice overshadow any sense of improving relationships between agencies towards more effective adult protection.

These are impacts that are not simply transitory but long-term in their implications and it is an awareness of the tangible effects of substandard adult protection processes and systems that is most evident from these respondents’ accounts. These are respondents who have ‘done’ adult protection, been affected personally by the outcomes, either on an inter-personal level or in relation to interaction with the bureaucracy of care organisations. The clear message that resonates from their accounts is that they feel adult protection fails to do what it says it should do.’

As part of this consultation process AEA undertook a series of telephone interviews with people who had previously sought assistance through our helpline, and asked a range of questions associated with the review. The overall message from that exercise reinforced the conclusions highlighted in the 2007 report (quoted above), but also provided a useful insight into specific difficulties and experiences of victims and their families.

A report on the responses is attached as Appendix A to this document. These responses do not necessarily represent the views of AEA but we contribute them as legitimate in their own right, representing a body of opinion that we believe should have a significant voice in this process.
3d Should we review current arrangements for delivery of safeguarding adults training? Should we have national occupational training standards across all agencies?

A national review of safeguarding education and training would assist in quantifying what is being provided, by whom and to whom, but it would need to evaluate the value and impact of the content to be meaningful.

As indicated previously, there are at least two types of training currently being provided: awareness raising, and training to undertake specific roles defined within adult protection processes. The former is already covered by NVQ qualifications within social care but is not covered within a health context. In addition, care provider umbrella groups and charities such as AEA provide such training.

It is the latter that may benefit from the development of Occupational training standards, but this presupposes a level of standardisation across areas e.g. in terms of the role of alerters, the role of investigators, the role of chairs of strategy meetings, minute takers etc. However, this requirement cannot be overstated, as the consequence of failing to clarify roles and responsibilities can be profound. In response to this point the joint investigation into the Cornwall Partnership NHS Trust recommended that the Trust should,

‘ensure that representatives of the board and senior management who ‘lead’ on the protection of vulnerable adults are properly trained and informed of their specific roles and responsibilities for that work; establish mandatory training for staff on procedures for protecting vulnerable adults.’

3e Should we have a national database of recommendations from serious case reviews at a national level? Should we review the effectiveness of serious case Reviews as learning tools? What should trigger a serious case review, and how should the conclusions be disseminated?

To make a national database useful there would need to be clarification as to when and how such reviews should be triggered, how they should be established and conducted, who should participate, and how their conclusions should be disseminated and used e.g. would they become recommendations or requirements at local level, and would this have national implications? In our view this would require SCR’s to be placed on a statutory basis, on the same level as ‘part 8’ Reviews for children, and in that context, a national database would be extremely useful.
Currently it is not possible to review the effectiveness of SCR’s as they are sporadic, and initiated according to local priorities and needs. There is no national consensus as to how or when they should be convened, and no clarity as to content and purpose, although ADASS has recently provided some useful guidance in this regard.

In our view, they should be convened where serious harm or abuse has been caused to an adult, or death has resulted from suspected or known abuse, and one or more Agencies or a Chief Officer expresses the view that statutory failings may have contributed to the outcome or lessons could be learned. Or as directed by a relevant Minister.

In general, Serious Case Reviews have been initiated to:

- to establish whether there are lessons to be learned from the circumstances of a particular case about the way in which local professionals and agencies worked together to safeguard vulnerable adults;
- to review of the effectiveness of procedures, both multi-agency and those of individual organizations;
- to inform and improve inter-agency practice;
- to improve practice by acting on learning.

Dissemination should be through circulation to Chief Officers by the Department of Health.

It is worth noting that a recommendation arising from the Serious Case Review into the death of Steven Hoskin was that,

*The Chair of the Cornwall Adult Protection Committee raises with the Department of Health the need for a statutory duty to cooperate with Serious Case Reviews. Although the critical role of primary care is well established in addressing the physical and mental sequelae of abuse (BMA 2007), this text makes no reference to the lead agency role of local authorities in England and Wales in respect of the connection with safeguarding vulnerable adults (i.e. ADSS 2005), yet it is important to remember that the obligations to respect the confidentiality and privacy of vulnerable adults apply similarly in health and social care domains. This means that the obligation is not absolute and may be over-ridden when disclosure is necessary to protect a person from the risk of harm. A person termed a vulnerable adult is regarded as being at such a risk and so information sharing, insofar as it is necessary to safeguard against that risk, is required. It was not until three-quarters of the way through the Review that the Primary*
Care Trust could access Steven’s patient records, so unpractised is the process of scrutiny of patient records with respect to Serious Case Reviews. Delays in information-sharing highlight the lack of familiarity with the process of Serious Case Reviews with respect to vulnerable adults (as compared to the processes for protecting children).

3f Should we develop joint inspections to look at safeguarding systems as a whole? Should this include the police (Her Majesty’s Inspectorate of Constabulary) – as for inspecting local children’s services?

Yes this would be useful.

The current situation where CSCI has completed a comprehensive assessment of the safeguarding performance of local authorities but HMIC does not inspect police forces for their performance around safeguarding is not helpful, and more importantly creates the impression that there are differing levels of priority given to safeguarding by different agencies. Safeguarding is a multi agency process and this should be reflected in the relevant inspection regime, not least because it contributes to

3g What are the desired outcomes of safeguarding work?

Outcomes should be considered from the perspective of the victim of the abuse or crime. Has an action been in their best interests, proportionate to their circumstances or needs, supportive of the Human Rights, and in keeping with the law? Has it affected, changed or stopped the abusive or criminal act? Has it improved or worsened the situation? And is it what the victim wanted or would have wanted? Outcomes should be based on an assessment of risk and reduction of risk.

Within the above parameters, the desired outcome of safeguarding work should be to protect people who are vulnerable to abuse from significant harm, improve their quality, and provide options to protect them from future abuse.

3h Should there be national safeguarding adults guidance that incorporates training, outcomes and multi-agency procedures? How would this be integrated into the personalisation agenda discussed in chapter 4?

Guidance:

The question is confusing. No Secrets is currently the national safeguarding adults guidance, and the ADSS/ADASS document provides
an additional good practice framework. Further guidance, regulation and
good practice examples could improve what already exists.

However guidance cannot provide the impetus required to ensure full
cooporation by all agencies or the necessary framework to guarantees the
required profile, priority and resources for adult protection.

Fundamentally, the question that arises is what drivers will ensure
Agencies collaborate, work together, share information and give equal
priority to adult protection work. Guidance has failed to do so, and no
alternate options have been proposed that would achieve this objective,
other than legislation.

To put this statement in context, the Serious Case Review into the death
of Steven Hoskin noted that,

> ‘each agency focused on single issues within their own sectional
remits and did not make the connections deemed necessary for the
protection of vulnerable adults and proposed by No Secrets’

**Personalisation:**

It is inaccurate to ask how safeguarding can be integrated into the
personalisation agenda. Safeguarding should already be an inherent part
of any such agenda, and in that regard personalisation is no different than
any other variation on health or social care provision and the processes
for achieving this are essentially the same.

People cannot take control of their lives and the services they receive if
they are not, or do not feel, safe. The effective provision of a
personalised service depends upon comprehensive risk assessments, the
sharing of relevant information to ensure informed choice, and
proportionate and where necessary robust interventions as required.
People want to exercise choice and control AND want to be free of abuse.
The two objectives are not mutually exclusive.

We will address this point in more detail in relation to the questions posed
in Chapter Four.
How much does adult protection currently cost? How is it funded? What evidence is there, if any, that increased funding would lead to better outcomes?

When *No Secrets* was launched in 2000 it had no ring fenced finances attached to it, and equally importantly, no mechanism by which Agencies could be encouraged or required to provide funding. Consequently, primary funding has fallen to local authorities as the lead agency for coordinating adult protection activities. As indicated in the Consultation document, some areas have succeeded in achieving contributions from health or the police but this is not the norm. Effectively, the work is underfunded and research last year by AEA suggests that funding has remained static while referrals have increased.

The sporadic and uneven development since the launch of *No Secrets* can be attributed to these factors. There is no consistency of funding and services reflect this inconsistency. In those authorities where multi agency funding has been achieved there are significant teams working on both strategic and operational matters and extra support is given to practitioners working on safeguarding cases and the work is seen as having a high priority and important.

As indicated previously, the Government funded a prevalence study into the extent of elder abuse within communities (excluding people with dementia) and established that at least 4% of the older population experienced such abuse. That allowed each local authority to quantify how many of their older population are likely to be victims of abuse and it is not difficult to correlate this with data from adult protection annual reports, indicating that adult protection services are failing to reach an overwhelming majority of older people. It is in this context that the funding of adult protection should be considered.

The DH sponsored report, *Partnership and regulation in adult protection*, produced in 2007, indicated that,

> ‘Limited resources (human and financial) were an area of concern and led to problems in delivering an effective adult protection service: Lack of personnel (including adult protection co-ordinators, trainers and administrative staff) hampers the effective and efficient operation of adult protection; and insufficient resources for training impacts on a number of areas, such as staff in partner agencies being unaware of what constitutes abuse and which procedures to follow. This leads to the fragmenting of partnership working in some areas.’
Consequently, it is plainly ridiculous to ask what evidence there is, if any, that increased funding would lead to better outcomes. Any system requires to be adequately funded, and the issue is not just about better outcomes for those people who may come to the attention of current processes, but is also about ensuring access by those which the process currently fails to reach. And, in older people’s terms, we estimate that in excess of 93% of people experiencing elder abuse do not come to the attention of current adult protection systems.

The starting point is to ask what adult protection is to achieve and to then assess the degree to which it is achieving those objectives. Is it sufficiently well publicised and therefore known to those who may need such intervention? Is it sufficiently linked into other similar systems, including domestic violence, hate crime, child protection, victim support etc? Are agencies working effectively together and, if not, to what extent is this a consequence of underfunding? Is adequate training being provided? Is sufficient time being allocated to investigations and outcomes? And, most importantly, is it reaching the majority of those in need of support?

Better funding will contribute to better systems, infrastructure, publicity, information and training. This will lead to an increase in referrals and an improvement in outcomes.
Chapter Four: Personalisation and Safeguarding.

We remain concerned that ‘personalisation’ has been singled out as a separate and distinct policy objective within this consultation process, instead of being seen in the wider context of empowerment, person-tailored services, and intervention. The fundamental underlying principles associated with the provision of social or health care, however constructed or delivered and in whatever environment or circumstances, is that people want to manipulate services to fit their lifestyles and personality, want to be treated with dignity and respect, and do not want to be abused or be the victims of a crime. It is inconceivable to suggest that someone seeking to control their own budgets and services would want anything less. And it is in this context that the debate on safeguarding should occur.

It is indeed likely that most, but not all, people want to exercise choice and control over their lives and services. They want to ‘personalise’ care in a manner that suits their lifestyle and preferences, wherever and however that care is organized. However, it is not true that they want to do so in a manner that results in avoidable abuse, and it is not acceptable that statutory agencies should seek to discharge their ‘duty of care’ by suggesting that it is sufficient to educate people about the risks associated with care provision and take no further action. Our argument is that we should apply what is known about the nature and dynamics of abuse, and what is known about abuse risk, to all forms of care provision in order to construct care packages that are acceptable to service users and are safe, and that where safety is compromised by choice, it should be based upon an informed choice that includes monitoring and/or interaction that allows periodic review.

While there is no doubt that the demographic profile of the UK is changing, with an increasing number of older people, it is not clear how the statements in this chapter relating to prevention and the early identification of risk equate to the personalisation agenda? Personalisation is not necessarily prevention.

We need to acknowledge that ‘risk’ is much greater within a domiciliary environment, more so than within institutions, and this was adequately articulated in the report from the Health Select Committee Inquiry into elder abuse in 2004,

‘Abuse in domiciliary settings is the commonest type of abuse, but the most difficult to combat. Contact between victims of abuse and statutory services may be limited, and those abused will often feel under threat, or obligation, to those abusing them. The only measures likely to have much impact here would be ones which increased the climate of awareness of the problem, making health and social care professionals more aware of the issue, and
those which empowered older people to report abuse more easily, recognising the reasons for their reluctance to do so’.

While the Chapter acknowledges the various concerns expressed by ‘safeguarding professionals’ it appears to do so in a manner that suggests these observations are borne of resistance to change, rather than experience of abuse. To be clear: we need to employ the knowledge and experience of the dynamics and factors that lead to abuse, and an understanding of the environments or circumstances which cause abuse, to create structures, systems and processes that reduce the potential for abuse occur. This is more than just risk assessment, or enabling people to make informed choice about risk. It is about constructing services that are inherently as safe as is possible, and systems through which advocacy can occur and regular monitoring takes place when necessary.

People may make an informed choice to accept a particular risk today, but circumstances and people change. A risk considered acceptable today, may be a problem tomorrow, and statutory agencies have a consequent responsibility to regularly monitor and respond to changing circumstances. Personalisation does not mean a statutory agency has permanently discharged its duty of care on the basis of an informed decision taken at a single point in time. This was a key point of the Serious Case Review into the death of Steven Hoskin,

‘Steven wanted friends. He did not see that the friendship he had so prized was starkly exploitative, devoid of reciprocity and instrumental in obstructing his relationships with those who would have safeguarded him.’

The Putting People First concordat made two clear statements which relate to safeguarding and adult protection, and both of these need to be central to considering this issue.

The Concordat refers to the development of

‘Systems which act on and minimise the risk of abuse and neglect of vulnerable adults’.

and states a commitment to

‘always fulfil our responsibility to provide care and protection for those who through their illness or disability are genuinely unable to express needs and wants or exercise control. However, the right to self-determination will be at the heart of a reformed system only constrained by the realities of finite resources and levels of protection, which should be responsible but not risk averse’.
In that context it is too simplistic to state, as the Consultative document does, that...

‘it should be their choice - the informed choice of ordinary people - who they trust with collecting their pensions, or who they pay to help them take a bath or administer their medication, and it should be their choice if they wish to manage the payments for their personal budgets or if they wish someone else to do it for them’.

Such a statement ignores the implications of ‘undue influence’ and the known strategies adopted by abusers who target their victims, and which can be summed up as: isolate, create a siege mentality, foster dependence, create powerlessness, and exaggerate fragility. Abuse, and abusers, are more complex than the statement above implies. In that context, it is true that the Mental Capacity Act 2005 has enshrined in law the right to make decisions if a person has capacity to make a specific decision, including the right to make decisions that others may consider unwise. However, that does not give authority to statutory organisations to create and provide options that are inherently dangerous, or to ignore those dangers on the basis of service user choice. That would represent a failure in the duty of care.

Again, to draw on the Serious Case Review into the death of Steven Hoskin,

‘While no service, whether health or social care, which support adults with learning disabilities advertises its aims in terms of ‘admit no restraints...adopt an attitude of non-interference...promote unfettered independence’ (Keywood et al 1999), effectively, this is what happens when ‘choice’ is advanced as a rationale for setting aside a duty of care and/or discontinuing a service.’

Currently the situation remains unsatisfactory, with the 2009 CSCI report on the state of social care in England, reporting21.

‘Although the issue of risk was widely articulated across the councils, there was little evidence that clear risk strategies designed to address the move towards personalisation were available or in the process of development. This is consistent with the findings in several CSCI inspections and in a recent CSCI study.’

‘Not enough thought had been given to protecting people using self-directed support. CRB checks on potential employees were not offered automatically to each vulnerable person, but only if they specifically asked.

We believe that the current ‘tension’ is borne out of a misrepresentation of ‘personalisation’ as a narrow group of mechanisms (‘cash for care’) rather than from the principle of seeking to ensure that a citizen is in control of the totality of their life (as much as any of us can be), coupled to a misrepresentation of safeguarding as an exclusive goal that must be innately restrictive. It is this narrow focus on ‘cash for care’ models which is preventing the much wider debate about citizenship rights in the context of social and health care. The Concordat envisaged a wider model of empowerment that included traditional models of social care provision, and it is of concern that this is not being acknowledged and the implications, in relation to safeguarding, not taken into consideration.

4. What aspects of safeguarding do we need to build into personalisation? What training, risk assessment and risk management should we use? Please tell us what you are doing locally and what more needs to be done.

We need to be clear that rights to choice and control are not incompatible with a right to protection. Once again the question implies that safeguarding and personalisation are opposed or in conflict and this is not the case. People cannot organise their own care and support, or accept such care and support, if they do not feel safe and consequently a ‘personalisation’ approach must have safeguarding as an integral part of its operation.

Consequently, we must start from the premise that any service (or package developed to provide a service) must be as intrinsically safe as is possible, constructed with a full understanding of the nature of abuse, its dynamics, and the factors that may give rise to exploitation. That is not the same as arguing that we should remove risk, because to do so would make living impossible. It is the application of experience to a prevention agenda.

Where risk of abuse will inevitably remain within such packages, and it is the nature of the ‘cash for care’ model that this will arise, this should be drawn to the attention of the service user and options considered (if they exist) to mitigate those risks. If they cannot be mitigated, or the service user considers them to be acceptable, they should be accepted insofar as the user has made an informed choice. However, in our view, such a decision does not remove the duty of care inherent in the provision of a care service directly or the provision of the (financial) means to achieve
that care service, and this risk should be the subject of routine monitoring and management involving the service user and the statutory agency.

A recommendation from the Serious Case Review into the death of Steven Hoskin was that,

‘The Chair of the Cornwall Adult Protection Committee raises with the Department of Health that the shift to self-directed care for vulnerable adults living alone (e.g. Direct Payments Recipients and those receiving Individual Budgets), should always be accompanied by the monitoring of their personal safety. To be vulnerable is to be in circumstances defined by the continuous possibility of harm or threat (e.g. Flynn 2005). ‘No Secrets’ makes it clear that monitoring safety is a multi-agency responsibility. The key to protecting and safeguarding vulnerable adults is sharing information, so any professional – who comes into contact with a vulnerable adult should be able to determine immediately if, and when, other agencies are involved and has a duty to share concerns. There were no such consequences arising from the numerous instances when Steven and Darren came to the notice of NHS services or the police.’

Specificially with regard to the employment of staff, effective information sharing about levels of risk posed by potential workers is essential. The continued exclusion of workers employed through direct payments, individual budgets etc from vetting and barring systems is of concern from the perspective of those adults who are least able to manage and coordinate an employee. The current situation whereby it is argued that a service user has a ‘right’ to employ whomever they choose is not in question; it is the manner in which this is addressed that is of concern. For example, a system that automatically ‘vets’ a potential employee against CRB and against the new vetting and barring system, unless a service user indicates a positive decision not to do so, would be preferable to the current arrangement as it would address the safeguarding needs of the majority, while simultaneously respecting the rights of the minority to choice and control.

Additionally, proper well-funded advocacy seems essential to provide effective safeguarding for adults arranging their own services, yet this is barely mentioned within the consultation document. And it is this approach to personalisation that is of such concern. Clearly there is an obvious need for brokerage systems within the process, but these are not considered or addressed and their potential to provide a safeguarding framework are not explored. Who will undertake brokerage? What will be
their role? If, as is suggested, they may take on the ‘employer’ role, what will this mean in practice?

Significantly, the divergent position of the Government toward the regulation and management of paid social care, as opposed to that of Personal Assistants employed through ‘cash for care’, needs to be explored and questioned. Why does a domiciliary care worker provided through an agency require to have a CRB and POVA check, be registered with the GSCC, have NVQ training, be supervised, and be seen as a crucial part of whistleblowing, while the same individual, performing the same activities under the guise of ‘cash for care’ does not need to do so? What is the difference, and what was the point of introducing such measures in the first place if they are unnecessary? Such questions do not presume that the current systems work well, because they do not do so. But it is the foundation of these decisions - and what amounts to a major lurch in Government strategy - that we are questioning.

The Prevalence Study in 2007 indicated that nearly 10% of abuse was perpetrated by domiciliary care staff, representing 20% of financial abuse and 13% of neglect. The evidence from prevalence report was one of the justifications used for the review of No Secrets and consequently these are key factors that must be taken into consideration when developing ‘cash for care’. Either regulation works or it does not. Would those abuse figures be greater without regulation, or has it make no difference whatsoever? The introduction of unregulated Personal Assistants make such questions legitimate to explore, and the potential abuse implications of the current strategy make these questions urgent.

We note that individualised budgets are not transferable between authorities. An adult at risk of abuse may decide to move authorities to escape abuse, to minimise the risk of abuse and yet will find that there services are not transferable. This is clearly not an acceptable position and needs to be addressed.

Finally, this is not about training staff to be more accepting of ‘cash for care’, or finding better ways to encourage older people to accept this approach. It is about getting the system right so that it is fit for purpose and safe for people to access and use.
5. What aspects of personalisation – greater independence, choice and control – can we build into safeguarding? How do we better reflect service users’ informed choices? How do we facilitate informed self-determination in risky situations and in the safeguarding process? How can we move forward on this agenda?

It is this approach that causes us the greatest concern about the consultation document’s statements on safeguarding and personalisation. It assumes that every ‘citizen’ starts with an ability to exercise choice and control and that the ‘risks’ involved are simple ones. Effectively, it ignores the experiences of abuse articulated through domestic violence, through regulation, through adult protection and through the experiences of the AEA helpline. This is dangerous and inaccurate.

To be clear, there are aspects and types of abuse where a victim can exercise choice and control about what they wish done. Equally, there are aspects and types of abuse where it would be impossible for any ‘citizen’ to influence, control or manage their situation without active external support and frameworks of protection. And there are aspects and types of abuse where they would never be able to do so. This is neither paternalistic nor anti ‘choice and control; it is the reality of abuse and abusers.

In some situations, for example a worker stealing from a service user, the situation is clear cut; the user wants a prosecution and the return of their money. Notwithstanding the fact that, at the time, they can be embarrassed by being ‘duped’, with advocacy and support they can assert their civil rights and obtain redress. But, is this the case if the thief is a family member?

At times, it can be difficult for someone trapped within an abusive relationship to exercise informed choice. A proper assessment of risk must be the determining factor in deciding what action must be taken, and this should include the full participation of the victim, in accordance with the principles of the MCA. However, (and this may be controversial) while the wishes of a victim are important, they are not and cannot be the sole criteria for deciding whether or not to take protective action; this is a very clear message from domestic violence strategies where the police can and do prosecute against the wishes of a victim. The CPS policy on prosecuting crimes against older people states,

’Sometimes, a victim will ask the police not to proceed any further with the case, or will ask to withdraw the complaint after the suspect has been charged. This does not necessarily mean that the case will
automatically be stopped. As a general rule, we will prosecute all cases where there is sufficient evidence and there are not any factors that prevent us from doing so. If the victim has decided to withdraw support for the prosecution, we have to find out why. This may involve delaying the court hearing to investigate the facts and decide the best course of action.\footnote{Crimes against older people – CPS prosecution policy, CPS 2008}

The cost of failing to employ such an approach in terms of human misery has been well documented and we should not blindly repeat these tragic mistakes within the arena of safeguarding. People do not choose to be abused and it is not the sole responsibility of victims of abuse and crime to take protective action.

Clearly, situations differ according to the circumstances, ability and needs of victims and it is for this reason that a ‘person centred’ approach is so crucial in safeguarding. And it is why it is also so crucial in determining when a ‘cash for care’ model is appropriate and when it is not. But we would go further and suggest that, even where ‘cash for care’ is inappropriate, that does not mean that service users should be denied the personalisation rights to choice and control, and it is for this reason that we are insisting that this agenda should extend into more traditional forms of social and health care provision.
Chapter Five: Health Services and Safeguarding.

This Chapter commences with a list of possible reasons for the ‘gradual’ increase in the involvement of health in safeguarding, but it ignores the question as to why health has not been engaged in safeguarding since the inception of No Secrets in 2000.

This must rest clearly and firmly with the consequences of Government decisions to effectively ‘protect’ the NHS from the safeguarding agenda. The POVA list was introduced solely into social care, despite repeated assurances by Government that it would be extended to NHS employees and despite the irrefutable evidence that it was relevant to that arena; the National Services Framework for Older People excluded any reference to abuse; and the Dignity Campaign seeks to encourage nurses to act in accordance with their codes of conduct, without exploring why they are not doing so in the first place. Meanwhile, we have witnessed increasing issues of institutional abuse, including the Gosport War Memorial, Rowan ward in Manchester, Cornwall, Sutton and Merton, ‘Death by Indifference, the Patient’s’ Association survey indicating a failure of pain management, the BMJ report indicating that GP’s regularly discriminate against older patients, and the recent Help the Aged survey of British Geriatric’s society members, which indicated that,

‘Two thirds (66 per cent) of doctors specialising in the care and treatment of older patients agreed that in their experience, older people are less likely to have their symptoms fully investigated. Seven out of ten (72 per cent) geriatricians said older people were also less likely to be considered and referred on for essential treatments’.23

There is no doubt that this lack of a safeguarding profile has contributed to some abuse situations. For example, the joint investigation into the Cornwall Partnership NHS Trust suggested a complete lack of understanding of the nature of abuse,

‘Our analysis of the trust’s investigations at Budock Hospital reveals that the trust had saw abuse as something that resulted from individual deviant behaviour. It had not addressed the underlying problems in the culture, policies and practices that had created a climate in which abuse could take place. The trust had failed to consider whether people who had previously used its services might have been exposed to abuse. It also failed to

recognise that it should review its practices to make sure that such practices were not occurring in other parts of the trust.’

Mencap have been clear on their views in this regard, within the report ‘Death by Indifference’, where they observe,

‘...it is our belief, and that of their families, that their deaths (of six young people) were avoidable and that institutional discrimination is the underlying cause. We believe that they occurred because of discrimination, indifference, lack of training and a very poor understanding of the needs of people with a learning disability’.24

The solution is not just the appointment of Safeguarding leads, however committed and important they may be to individual circumstances and situations. It is about triggering a culture change within a massive organisation that can address obvious abuse as well as issues of dignity and respect. And that requires a significant commitment and lead from central Government to drive that change. The fact that the Consultation document can cite examples...

‘where people are given trays of food but are not helped to eat, and other forms of neglect - where staff, for example, do not know how to make ‘best-interests decisions’ and may leave patients untreated and in pain because they are ‘un-cooperative’.

...is a damning indictment of the situation that indicates a need for far greater investment in change than is evident in strategies to date. This is simply unacceptable.

While we welcome establishing basic principles relating to dignity and respect within the new NHS Constitution, these are already articulated as expectations in codes of practice and public expectation, but are not a general reality for too many older patients. The question arise therefore as to what strategy is employed to convert those aspirations into reality?

6a How is the No Secrets guidance being implemented and applied to ensure that it enables staff in the NHS to recognise, investigate and act on abuse? Are local arrangements effective? What more should be done?

Arrangements are variable. The majority of Acute Trusts and Primary Care Trusts have signed up to local procedures but at an operational level there is a distinct lack of knowledge of the issue or referrals for safeguarding

24 Death by Indifference, Mencap, 2007
concerns. A cursory examination of adult protection Annual Reports will confirm this situation.

In that context, it is important to separate the recognition of abuse from subsequent actions taken to investigate and respond. The very existence of the Dignity in Care campaign is evidence of a lack of recognition as to what constitutes abusive practices and circumstances within the NHS; actions that would be immediately recognised and acknowledged in other settings such as residential care. To that extent, double standards apply.

In terms of action and response, there is still an approach that often perceives alerts of abuse as complaints to be channeled through the NHS complaints procedures, with insufficient notification to and interaction with adult protection services. A good example of this approach is highlighted in the Mencap report, *Death by Indifference*. In response to the death of Martin, who went 26 days in hospital without food, the situation was investigated by the hospital themselves under the complaints procedure, and concluded ...

> ‘there had been a multidisciplinary communication failure, which resulted in the doctor being “under the impression” that the nurses had been feeding Martin via a naso-gastric tube when this was not the case’.

In a care home environment this would have been the subject of an adult protection investigation, a strategy meeting, and possibly a police investigation. The site of an abusive act should be irrelevant to the safeguarding response, but the NHS appears to be continually exempt from such accountability. Why is this? Unfortunately, the new NHS Constitution is unlikely to help focus health institutions onto a safeguarding agenda as it only makes reference to the NHS complaints procedure.

However it would be wrong not to acknowledge that significant progress has been made within health organizations and many areas of good practice exist throughout the country. Nevertheless, safeguarding has not and still does not sit high enough on the priorities of the Healthcare Commission, despite a substantial profile rise in the last twelve months. The National Patients Safety Authority and the Health Services Ombudsman have perhaps been more prominent at times in that regard.

Safeguarding needs to be a priority for the Care Quality Commission in order for real progress to be made across all health organizations, and we believe that the establishment of (a) safeguarding onto a statutory footing
and (b) the establishment of Chief Officers/Chief Executives/Chief Constables accountability for safeguarding would contribute to an improvement in interaction. However, this presupposes a strong central Government lead.

6b Are health organisations able to work with and adopt multi-agency guidance, or is it essential to develop operational guidance that adapts procedures into language, culture and structures appropriate to healthcare?

There has to be a clear distinction between strategic goals, objectives, monitoring, and accountability, and how these are subsequently translated into operational realities. To that extent an established ‘Chief Officers’ group could ensure ownership, accountability and priorities in any particular area, while local guidance and protocols could ensure delivery of the identified objectives, while still remaining agency specific. We see this now in how care providers produce individual guidance and procedures that are appropriate for their business while meeting the requirements of area adult protection systems.

In terms of language, culture and structures we need to be clear on what this means. Language and culture needs to be measured against safeguarding objectives, rather than the other way around, and we need to be clear about what are acceptable practices within health environments. Having said that, there are issues of clinical governance reporting systems, complaints, SUI’s etc., which need to be considered and integrated into safeguarding processes.

We believe that with better health participation, via a statutory duty to cooperate and a ‘Chief Officer’ level accountability, it should be possible to get better NHS participation in the development of guidelines and therefore make them more ‘health’ compatible. Furthermore existing good practice within health organisations shows that it is possible for health organisations to effectively work within existing safeguarding polices and procedures.

6c What are the responsibilities of the NHS safeguarding leads – are they champions, professional leaders, awareness-raisers, data collectors and reporters? Can one person fulfill all these roles? If not, how should these responsibilities be shared?

The question implies that safeguarding is an addendum to the NHS instead of a mainstream process that is incorporated into the general activities of primary and secondary health care. If this is not a central
strategy it will not be possible for safeguarding to become a routine part of health. No single post should be responsible for the range of duties highlighted in the question; instead there should be corporate responsibility for the promotion of a safeguarding approach integrated into management and medical structures.

Any safeguarding role must firstly have the objective of preventing abuse and facilitating intervention where appropriate. This suggests that NHS leads act as an ‘interpreting’ interface between a health establishment and the wider adult protection processes, providing internal advice and guidance on duties and responsibilities and providing external liaison with other Agencies. As a central point of expertise they will almost certainly become ‘champions’, but this should not be a function that is exclusive to them.

The NHS is a broad and diverse organisation. How many leads are required will depend on the organisation; for example while a single full time dedicated person may be adequate for an acute hospital site this model may not work for a large rural PCT with 20-30 miles apart. It would also not address the critical role of GP’s and District Nurses who are often the first point of contact for older people who are experiencing abuse.

6d Is there a need for regional safeguarding forums where health organisations can share good practice and learning? If so, what would they look like?

It is unclear what is intended by the concept of regional forums in this context. Are they a training resource, a development vehicle or a means of achieving peer group support? Or would they have a more structured responsibility within a safeguarding structure e.g. monitoring incidences, referrals or outcomes etc?

The ADASS adult protection network is one model, but the central meeting is being converted into an ADASS policy group so this has evolved beyond the function of sharing information and consulting on actual or potential developments. Many of the regional groups already include some health representation but these could benefit from being broadened, with perhaps amore formalised structure to them e.g. as a consultative and policy development forum, and a means to identify points of difficulty or challenge. However, while these regional forums are useful they do need to be appropriately resourced and funded to ensure they are effective.
A possible way forward would be to mirror this approach within the NHS, linking them to strategic health authorities and with a lead officer appointed to coordinate the forum. An interaction with the ADASS structure would then be beneficial.

6e How do procedures for investigating serious untoward incidents (SUIs) fit into the multi-agency context of safeguarding?

Serious untoward incidents can include a range of issues that are not necessarily related to adult safeguarding. It is important therefore to perceive them as a mechanism which may identify potential or actual abuse, and which therefore needs an interface into the safeguarding structures.

However, the processes have different intents and potentially different outcomes and consequently it is critical to establish when an incident should be investigated as a SUI and when the investigation should occur under safeguarding procedures. We would perceive this discussion as linked to the debate on when and what triggers a Serious Case Review, what should be defined as a complaint, what is an expression of concern, and what is an adult protection referral.

6f Are adult safeguarding systems within the NHS effective? If not, what are the specific challenges that need to be addressed?

Adult safeguarding systems across the NHS are variable according to geographical area and are not as effective as they should be. While there are individual areas of good practice it is often patchy and lacking in consistency.

Particular challenges include:

- The majority of NHS organisations do not have proactive leadership at Board level. Where this level of leadership does exist, systems within those organisations are more robust;
- Current safeguarding systems do not fit neatly with other NHS processes, for example clinical governance, complaints SUI’s etc. Work needs to be undertaken to clarify the roles of different processes and how safeguarding fits within these;
- There are too many examples of NHS establishments failing to recognise abuse and re-defining it as poor practice or accepting it as an inevitable consequence of staffing shortages etc. For example, consistently leaving a patient in a soiled continence pad would be unacceptable in a care home and reported as a
safeguarding concern, but within a hospital environment would be unlikely to even merit an incident report.

Government has a clear role here. It is insufficient to operate a dignity campaign without (a) analyzing and responding to the roots causes of why such a campaign is needed and (b) not simultaneously promoting a zero tolerance to abuse.

6g Are any parts of the NHS or healthcare sector less engaged and more in need of assistance to get on board with safeguarding?

It is probably accepted and common knowledge that GPs are a significant problem for adult safeguarding in the NHS, with too many consultants similarly disengaged. Less than 1% of safeguarding referrals are from GP's, and yet they are the health professionals that have the closest contact with the vulnerable adults within their communities.

6h Is the role of GPs a crucial role for safeguarding in the NHS? Where is the existing good practice and what can be learnt from it?

See above.

One of the obvious conclusions that can be drawn from the Prevalence Study into elder abuse is that GP’s, and District Nurses, have a crucial role in identifying and triggering appropriate responses to elder abuse and this, coupled to the BMJ report indicating that GP’s regularly discriminate against older patients, should be a clear indicator that this group needs to be targeted for development and involvement in adult protection work.

Good practice is limited but in areas where GP's are involved in safeguarding, either through reporting or involvement in individual cases, there have been clearly defined positive outcomes.

In view of this, greater work should be done with the General Medical Council to engage GP’s around safeguarding.

6i Are there particular issues in relation to safeguarding and mental health? If so, how should these be addressed?

Yes. Although there are improvements, many mental health professionals remain detached from safeguarding systems and processes, and some even see Community Psychiatric Assessment as an alternative to engaging with safeguarding. The situation could be summarized as a sector that
relies too heavily upon the Mental Health Act and insufficiently on the Mental Capacity Act; it is about empowerment, culture and approach.

Violence within secure units needs to be addressed and victimisation and hate crime continue to significant issues for people with mental health difficulties, without any obvious interaction within a safeguarding context. Many of these issues are well documented in Mind’s ‘Another Assault’ report.

Additionally, there are traditionally held practices by psychiatrists etc in relation to the use of neuroleptic drugs and patients who have Alzheimer’s Disease, and a consistent failure to implement the requirements of the Mental Capacity Act 2005 in respect of best interest and proportionate actions. Such drugs are not licensed for use with this disease and yet are widely prescribed and administered.

However, it has been encouraging to see the development of safeguarding policies and procedures within a number of Mental Health Trusts.

6j What central leadership role should there be (if any), and what function should it have (Healthcare Commission, Department of Health, General Medical Council, Nursing and Midwifery Council, strategic health authorities)?

This question is simply a variation on previous themes. Clearly, the Department of Health and the relevant Minister must have a strategic role in setting expectations and addressing failings derived from cultural of historical attitudes to Mental Health. At the next level, ‘Chief Officers’ must have ownership and accountability for the services and decisions within their remit.

The Healthcare Commission is being subsumed into the Care Quality Commission, but this new body clearly has a similar function to other regulators such as the NMC, in terms of ensuring compliance with the law and established standards, and bodies such as the GMC (and RCN, RCP etc) have a role in ensuring compliance with codes of conduct etc. All of this relates to varying forms of leadership and direction.

6k What are the main drivers for standards in the NHS that safeguarding should be linked to?

Drivers should relate to the commissioning of quality services, and the delivery of health services that are in keeping with codes of conduct and the MCA.
Chapter Six: Safeguarding, Housing and Community Empowerment

It is an accepted reality that the built environment can have a significant influence on the safety and security of citizens, and particularly adults at risk of abuse e.g. reducing the potential for people becoming isolated, designing loitering areas out of existence, providing adequate lighting, building to lifetime home standards etc; principles which apply to the community at large and not only vulnerable adults. Consequently there is a clear safeguarding element to the medium to long term planning of housing and this needs to be established as integral to Government planning.

However, the housing sector is also a human resource and one which provides many more services than just building and design. Specialist housing support staff are often the only professionals who see service users on a regular basis, and are likely to have a trusting relationship with service users. There is therefore a role for housing, and particularly sheltered housing and supported living, as potential places of safety for people who have experienced or are at risk of abuse, in a similar manner to places of safety for children but from an adult perspective. This is a strategy that would comfortably link with developments in new technologies that allow outreach contact into individual homes within a community.

In this regard it should be noted that one of the points identified in the Serious Case Review into the death of 78 year old Margaret Panting in Sheffield related to the failure of social workers to engage the sheltered housing warden as a key component within the care planning and protection process, despite the fact that she had a unique relationship with Mrs Panting. This was one of the critical points that contributed to the failure to provide adequate protection.

Greater policy links between organisations are needed (e.g. joint working protocols on information sharing) and increased mutual respect of each other’s input. There should also be clear links between the array of guidance/briefings etc and their status, together with a consolidation of the various components of the legislative framework (such as it exists) to support this area.

The main issues are the need for:

- greater recognition of the role that non statutory organisations can make;
- greater co-operation and joint working;
- a consistency of approach across all authorities;
- clarity on Data Protection issues; and
- acknowledgement and assistance in dealing with the conflict of employees rights/service user rights and needs.
In addition to seeking recognition of voluntary organisations’ contribution at national level, there needs to be stronger emphasis on the responsibilities within the third sector for prevention and alerting, emphasising that abuse is everyone’s business.

7a Do we need stronger policy links between safeguarding and community development and empowerment? How can this be achieved at the national and the local levels?

To a large degree community development and empowerment has evolved from a desire to engage people as active citizens within their communities, and the closest consideration of safeguarding in that context has been from the perspective of Community Safety. The question therefore arises as to (a) what community development can offer in terms of safeguarding? (and this must obviously relate in part to the built environment and its influence on the safety and security of citizens) and (b) the manner in which citizens can be empowered to take ownership of their communities.

As indicated previously in this document, in 2004 AEA and Better Government for Older People published a discussion paper entitled, ‘Placing elder abuse within the context of citizenship’. In that paper we suggested that,

‘The factors identified by older people as contributing to their quality of life clearly extend beyond the remit of health and social care, to include: housing and the home; neighbourhoods; income; social activities and networks; getting out and about; and information’

Local authorities have responsibility for community leadership and the promotion of the well-being of local communities, and they therefore must ensure that safeguarding is embedded within ‘whole system’ approaches to services. Being abused or at risk of abuse does not deny one the right to social inclusion and participation. A policy shift to a ‘whole system’ citizenship approach will ensure that safeguarding does not remain a marginalised specialism. This will contribute to a reduction in the isolation and vulnerability of many older people, and increase the understanding and ‘ownership’ of elder abuse across communities and the empowerment of front line professionals.

However, there needs to be a recognition of the disempowering impact of abuse on individuals, and it cannot be assumed that providing a model of community empowerment will result in victims being easily in a position to
assert their rights or independence. Rather, this should be seen as a preventative strategy that seeks to address some of the more common factors that contribute to abuse e.g. loneliness, isolation, discrimination.

7b How can housing providers contribute to safeguarding? What could housing departments, housing associations and supported housing/living providers do to enable their tenants and residents to live safer lives?

Like all other providers that interact with adults either experiencing or at risk of abuse, housing providers have obvious roles:

- alerting statutory authorities regarding concerns, allegations, suspicions of abuse
- Helping to prevent abuse e.g. through awareness raising campaigns with tenants
- Contributing to strategy meetings and investigations of abuse – drawing on extensive knowledge of service users’ lives, circumstances and wishes
- Monitoring abusive situations and reporting back to the adult protection team if circumstances change
- Supporting victims of abuse and advocating for them
- Using statutory powers relating to tenancy agreements, injunctions etc to protect tenants
- Ensuring that Safeguarding is part of the strategic and business plans of local authorities and housing associations, with appropriate training and policy framework set by councillors and board members
- Regularly reviewing tenancy agreements and including specific clauses relating to safeguarding
- Including safeguarding as part of housing strategy documents and developing appropriate policies in this area
- Reviewing the approach to re-housing to support applications from vulnerable individuals and families; supporting individual access to Choice Based Lettings, but also considering multi agency Panels
- Reviewing allocations and re-housing policies to facilitate the re-housing of victims
• Providing a safe refuge from abuse, e.g. sheltered and supported housing

• Reviewing which staff will need to be registered with the Independent Safeguarding Authority from 2009

Housing departments, housing associations and supported housing/living providers could ensure the following to enable tenants and residents to live safer lives:

• Establishing positive working relationships with local adult protection teams, with housing providers being represented at local multi-agency adult protection meetings

• Training housing association board members in safeguarding

• Extending skills development and specific training to all staff, including community based workers, contractors and caretakers (ie everyone who visits people or gives frontline help & advice)

• Training for all staff, not just support staff, in adult protection and safeguarding issues and particularly in recognising the signs and indicators of abuse. Knowing how to handle a disclosure of abuse and how to report abuse

• Training for all staff in the Mental Capacity Act 2005, to understand their own and others' decision-making powers and responsibilities, and to also understand the hierarchy of legal authority which applies to tenants

• Including Safeguarding in all relevant procedures for all staff, and not just support staff

• Synchronising internal adult protection procedures with the local area multi-agency policy and procedure on adult protection / Safeguarding

• Addressing the lack of feedback from adult protection teams after referrals by housing staff

• Taking policy issues to local multi-agency adult protection meetings to clarify thresholds in which a client's refusal to allow a referral can be over-ruled, and identify barriers to effective joint working.
This Chapter commences by suggesting that *No Secrets* gave leadership on safeguarding to social care – rather than to the criminal justice system. This is not strictly accurate. *No Secrets* indicated that,

> ‘The lead agency with responsibility for co-ordinating such activity should be the local Social Services Authority but all agencies should designate a lead officer’.

This was a coordinating role at a strategic level and was not intended to marginalize the expertise of other Agencies, and elsewhere the document indicated that the purpose of the multi-agency framework was to identify roles, responsibilities, authority and accountability with regard to the action each agency and professional group should take to ensure the protection of vulnerable adults. It envisaged a partnership approach that relied upon the strengths of the individual partners. However, it is worth noting that no responsibilities are placed on any other statutory agency, other than Local Authorities, by section 7 of the Local Authority Social Services Act 1970.

There is ample evidence that adult protection is not well-resourced and this includes the level of contribution from police forces. Although there is no doubt that many forces have pro-actively engaged in safeguarding work, partly as their knowledge and expertise in other fields such as domestic violence has improved, there is nevertheless inconsistency across forces. This is compounded by the reality that the police must respond to statutory requirements, and this has led to adult protection investigations being suspended as a consequence of child protection issues arising elsewhere.

While this chapter has concentrated on the role of the police and the courts, and in particular special measures, it has not clearly considered the need to train judges to understand the nature and dynamics of abuse, the role of regulators in investigating and providing evidence of criminal acts, the function and role of the Health and Safety Executive, and the function and role of the Office of the Public Guardian in relation to financial abuse. These are all areas that impact upon the experiences of an adult at risk of abuse, and the statutory responses to criminal acts.

8a How can safeguarding vulnerable adults be better integrated into the mainstream criminal justice arena?

A transferable model of good practice could be the police/CPS response to the investigation of rape and serious sexual offences. Following the 2006 HMIC Thematic inspections a series of action plans have been rolled out
clearly articulating responsibilities for the police and CPS. Performance has been driven upward and forward under the aegis of the ACPO Rape Working Group. If safeguarding adults is to be better integrated in the major criminal justice arena then this could be a useful model for doing so.

Inevitably criminal justice agencies are performance orientated and therefore it is vital that key performance indicators are established, perhaps as part of the 3 to 198 LAA indicators. Safeguarding adults has, for quite some time, been on the margins of the criminal justice arena, particularly as regards the police. One of the key drivers for police performance has been the very successful series of NPIA documents. It would therefore be useful to commission work from the NPIA in order that practitioners can refer to a body of knowledge from which to develop and build practice.

The legislative duty to cooperate already in place for MAPPA, and also for safeguarding children under section 11 of the Children's Act, needs to be placed upon those from whom cooperation is sought and expected for safeguarding adults.

Further progress within the police force has been seen in the development of safeguarding policies that clearly define and outline roles and responsibilities, such as those contained within the MPS abuse in care settings policy. Additionally, the Crown Prosecution Service Crimes against Older People policy has for the first time delivered a set of high level statements, principles and priorities for how such offences will be charged.

The police have responsibility for investigating possible criminal offences and safeguarding policies and procedures should reflect this. The vast majority of safeguarding referrals will be potential crimes and should be investigated as such. Criminal offences should not be investigated by other agencies.

8b Are police units adequately staffed to respond to the increased reporting of adult protection issues? If not, what changes are needed?

Public Protection Units are now established throughout the Country and are regularly highlighted as a potential site for the police element of adult safeguarding work. However, anecdotal evidence suggests that these units are actually in danger of collapse as a consequence of their own success and because of the scale of the issues they are covering e.g. forced marriage, honour based violence, stalking and harassment, MAPPA,
domestic abuse, child abuse investigations and paedophile/internet investigations.

While the majority of these units have remained static in terms of size and funding, their responsibilities have grown many times over. They are overwhelmed with a raft of new laws, guidance procedure and policy drivers and to introduce safeguarding adults as an additional responsibility would simply dilute the response to these other important business areas.

As long as safeguarding adults does not have the same legislative basis as other areas, such as child protection and domestic violence, it will not enjoy the same level of status and resources as these other areas. However it is worth recognising the progress that has been made by criminal justice agencies over the last nine years and the commitment and dedication of many officers working within public protection units.

8c  Is there a need to develop a more formal system, as in MAPPA and MARAC, with regular police-led safeguarding meetings for serious cases?

The *No Secrets* guidance provides a clear process in this regard. However, it would make sense for the police to lead safeguarding meetings where a criminal investigation is taking place. This would ensure that proper assessments of risk occur, that evidence is preserved and that the immediate safety of the victim is prioritised.

It is worth noting that safeguarding cases can and are currently referred to both MARAC and MAPPA and therefore it would be potentially confusing to create a new formal system. Furthermore MARAC and MAPPA are only for high risk cases.

8d  Is there support for multi-disciplinary teams/joint investigation teams working together at the same location to assess intelligence, risk assess situations, take decisions on immediate action to safeguard vulnerable adults, decide whether a crime has been committed and whether the allegations should enter the safeguarding adults process? What are the advantages and disadvantages of joint investigations or joint investigation teams? What helps a joint investigation to work well?

Creating multi-disciplinary investigation teams involving the police and other agencies may be an ideal option, but there is no evidence that it would necessarily be justifiable or more effective than joint investigations themselves. The real issue is about individual Agencies having the resources and the necessary compulsion to establish joint investigations. In that context, there is an established model in relation to child abuse
investigations that could be readily transplanted into the safeguarding adult arena.

Joint investigations work well when there is appropriate access to records, established and agreed protocols and systems, and joint training.

8e Police officers have considerable experience of risk assessment and risk management. Has that been sufficiently integrated into adult protection work and shared with the multi-agency partners, or should that be further developed? How should this be taken further?

Generally speaking, our experience is that the police would rather work with specific risk assessment models such as RM2K, OASYS, and the SPECCS in relation to domestic abuse. However there is little evidence that these skills have transferred into adult protection work and this may be because such models are not directly transferable. Consequently, there may be merit in considering whether a further model is required or whether existing models could be applied to adult safeguarding cases.

8f Should information about the safety of a person be passed between health and social care organisations, the ambulance service, GPs, the CSCI and the police? If so, can it happen now or does it need legislation? Should such information include incidents not amounting to abuse, but which may provide early indicators of the likelihood of abuse?

The general approach toward the sharing of information is that it should be limited to what is necessary in order to achieve an appropriate and legal purpose. The DH consultation document on the Common Assessment Framework describes the legal situation as follows,

‘A right to confidentiality is provided under common law and essentially requires that information held in confidence should not be disclosed or used for purposes that the individual concerned has not consented to. Confidentiality may, however, be set aside in the public interest or where statute requires it.\textsuperscript{25}

Consequently, it may be possible within existing law, to achieve this in some circumstances through an agreed protocol between the police and partner organisations, in order that information essential to an investigation can be shared at the earliest opportunity. This however would have to be within the boundaries of the Data Protection Act 1998 and this at times may be problematic.

\textsuperscript{25} Common Assessment Framework for adults: a consultation on proposals to improve information sharing around multi-disciplinary assessment and care planning, DH 2009

AEA response to the consultation on the review of No Secrets
A number of high profile cases have shown the tragic consequences of not sharing information, usually as a consequence of a failure to collaborate and communicate or as a consequence of misunderstanding the data protection act. For example, the Serious Case Review into the death of Steven Hoskin noted,

‘Not all staff receiving and collecting information made it available to others in their organisations or, as importantly, to partner organisations. Individual agencies did not have access to what other parts of their organisation and other agencies knew. Each held a piece or pieces of a jigsaw puzzle without any sense of the picture they were creating, or indeed the timeframe within which the puzzle had to be completed. Communication is an interactive process. Information senders need to know that their information has been received and should confirm to what use it has been put. It is not enough to send or ‘leave’ a message. This leads to the error of assuming that information that has been passed on or shared will be ‘known’ by recipients. This error prevailed in Cornwall.’

In view of the serious nature of safeguarding and adult protection we believe that this should be clarified by new legislation which amends the Data Protection Act 1998 and defines how and when information should be shared and in what circumstances.

Nevertheless, this is a difficult issue. There is a clear need to balance the right of citizens to privacy against the need to share information in circumstances where there is reasonable belief that abuse is or may be occurring. We are also aware of the value the police place upon ‘soft intelligence’, gained through various means. And there are also examples, such as in the situation of Steven Hoskin, where information sharing between agencies about visits to A&E etc., would have resulted in increased awareness that he was potentially at risk.

Consequently, we need to define what information should be shared, in what circumstances, and for what purpose. In that regard there is a useful precedent in terms of the routine recording of incidents within the domestic violence arena.

8g Should we have guidance on if and when information should be shared, even when the victim expresses a wish that it is not shared?

As indicated in 8g above, the situation is not that simple.
There may well be circumstances in which guidance would be useful, particularly in considering the circumstances in which it may be appropriate to override a service user’s wishes (as discussed in 8f above). But it is unlikely that guidance by itself would overcome the obligation to abide by an individual’s wishes, unless it was an exempt action under the Data Protection Act 1998. This implies that clarity will be required through legislation rather than guidance.

8h Should we look at ways of making it easier for people who may be vulnerable to report abuse?

Undoubtedly yes. Very few safeguarding referrals are received directly from the person being abused, and the elder abuse prevalence study suggested that none of the older people identified in that study had contacted adult protection services. There may be many reasons for this, including threats, blackmail, coercion, being frightened, or simply not knowing who to talk to. On the whole people know how to report child or animal abuse but have no idea about how to raise concerns about (for example) the elderly next door neighbour.

A national media campaign alongside an adult version of Childline would definitely help in this area. Such an approach would enable adults to seek independent advice and if necessary report abuse.

8i Would the proposal to have an annual analysis/review of all information held on each care/nursing home by all relevant agencies be likely to gain support from agencies, the public and the independent sector providers?

This question should relate to all care providers, and not just care home providers.

An annual review is unlikely to add significantly to the safeguarding of adults in care services. However, a consistent and systematic ongoing information sharing process between all partner agencies could make a significant difference.

In many areas regular meetings are now held between CSCI and local commissioners to share information about homes/agencies where concerns exist or where poor levels of care are being delivered (for example zero rated homes). Furthermore, existing risk assessments for adults at risk of abuse in care homes should be reviewed regularly to ensure that people are not being placed at risk unnecessarily.
Financial abuse appears to have increased steadily and to have diversified.
Is there a need to explore the most common types and most effective responses? Should this include preventive strategies in consultation with the Financial Services Authority and the British Bankers’ Association?
Should banks, building societies and the Financial Services Authority be encouraged to share information that suggests financial abuse of vulnerable adults?

We are not sure that there is evidence available to suggest that financial abuse ‘appears to have increased steadily and to have diversified’?
Certainly, because of the publicity engendered by AEA we have engaged organisations such as Help the Aged, the Financial Services Authority, the British Banking Authority, and researchers in the subject and this interest may give an illusion of increased activity? The elder abuse prevalence study suggested this was the second highest reported form of abuse, but both neglect and psychological abuse were undercounted in that survey for operational reasons. In terms of calls to our helpline, it remains consistently the second highest referral of abuse.

Again, we do have to be careful to balance the right of citizens to privacy against the need to share information in circumstances where there is reasonable belief that abuse is or may be occurring. If a potential fraud investigation is underway, then there is a clear need to share information as part of that process but we suspect the Banking Institutions have a greater role in preventative work rather than intervention.

A great deal of experience and knowledge is available from the USA, where such institutions have engaged in training of their staff to recognise signs of abuse, trigger mechanisms to reduce the potential for abuse, and protocols for joint working. Further exploration of this area within the UK would be welcomed, particularly if it can be done in collaboration with financial organisations to enable appropriate intervention strategies to be explored and introduced.

It is worth noting that work on this matter is currently underway, involving researchers, banking institutions and charities such as AEA. The current review of the Mental Capacity Act should also provide a useful opportunity to raise these issues.
8k What strategic links should there be between homicide reduction strategies, crime reduction partnerships, children’s safeguarding boards, adult safeguarding boards, domestic violence forums and disability hate crime?

There is a widespread consensus that every multi agency group should be strategically linked to every other multi agency group and that each of them should have links into key strategies such as the Homicide Reduction Strategy. In that context there is ample evidence of routine links between child abuse, domestic violence and elder abuse.

To some extent the problem would be considerably simplified if the police element of safeguarding adults responsibility was transferred to a public protection unit, because within that protection unit there will already be people that are lead professionals in LSCBs, MARACs, MAPPA, and most usually have established links between domestic abuse and the Homicide Reduction Strategy.

8l What else is needed to increase the ability of the police to participate fully in adult protection/safeguarding?

The key issue is one of resource/capacity and this issue needs to be addressed.

In order to improve the service delivered to victims of adult abuse we need a greater level of training in order to develop safeguarding investigators that are akin to child abuse investigators. If this is accepted as a model it would follow that a body of doctrine is developed by the NPIA and a specialist adult abuse investigator’s course developed.

We also need basic grade police officers to have some understanding of the nature of adult abuse and accepted actions to follow in response. Certainly, if we continue to consider that mainstream CID officers have the necessary skills to improve safeguarding to adults then there will be a danger that investigations will be hampered if they do not receive appropriate training.

Finally, we cannot escape the fact that there is a link between legislation, inspection and resources. Without these processes and requirements being backed up by legislation, safeguarding cannot gain the necessary status and priority within the police force.
8m What can be done to improve identification of vulnerable adults by criminal justice practitioners? For example, could local arrangements be made to provide the police with local groups who might be able to offer advice?

This cannot be just about local groups offering ‘advice’ to the police, any more than groups could improve child protection by offering such advice. This is a specialist field and, while there is obviously something useful that can be gained from discussions around prevention, the reality is that this requires training and detailed consideration of the dynamics of abuse and intervention options.

All police officers should have mandatory training looking at issues related to safeguarding adults and understanding key issues related to this area, and this is relevant at all levels of the force; an investigation can be seriously hampered if the officer first on the scene fails to recognise or understand the circumstances of the abuse that has occurred. Work is currently being undertaken between AEA, Voice UK, ACPO and NPIA to address the training that is provided to all police officers and staff, and AEA will be commencing the development of guidance on these matters in the new financial year.

8n What more can be done to raise awareness in local areas of the availability of intermediaries to assist vulnerable adults with communication difficulties in criminal investigations and trials?

There would appear to be some confusion over ownership of intermediaries i.e. whether this rests with the Force strategic lead or criminal justice? Does it sit with the Force lead for investigative interviewing, or does it sit with the Force lead for achieving best evidence? Some guidance on this point, and the promotion of an identified point of contact/sponsor, would be helpful.

8o What else do you think would make a difference?

It would be beneficial to break down the silo thinking that appears to exist between safeguarding, domestic violence and other areas. At the moment we are in danger of offering differing services based on age, vulnerability etc. We should begin to develop responses and strategies to violence and crime that, while are appropriate to the particular circumstances of a case, also offer baseline minimum standards, protections and interventions.
It would be beneficial for a training and promotion process to be linked to documents such as the CPS guidance on prosecuting crimes against older people. We must increase awareness that many of the circumstances of abuse constitute crimes and would, if all matters were equal, result in criminal investigations and prosecutions. Re-defining such situations as ‘abuse’ because of age or disability etc, is not helpful and creates inappropriate cultures and thinking.
Chapter Eight: Guidance and legislation

This Chapter causes us great concern.

Apart from the fact that the commitment last June 2007 was that the review would have a *particular reference to the legislation underpinning adult protection policy* and this has not occurred, the Chapter reads as a critique of the Adult Support and Protection Scotland) Act 2007, drawing its primary questions from powers conferred on social workers by the Scottish Parliament. We would argue that this is an unhelpful, and somewhat misleading, starting point.

It is our view that, while guidance has been effective in facilitating the creation of some form of adult protection system in all local authority areas, it has failed to deliver on a number of important issues, e.g. there is a lack of consistency and equality across areas in terms of the construction and level of adult protection systems provided; there is variable collaboration across statutory agencies; there are significant funding and staffing deficiencies in many areas; there is no consistency in the timing and duration of investigations; and there is no power to ensure access to victims, or to ensure safe outcomes.

The latest report on the state of social care by CSCI indicates that, after eight years of guidance, adult safeguarding systems remain fragile,

*A recent CSCI study into the effectiveness of arrangements to safeguard adults from abuse found uneven progress. In almost three-quarters of council inspections unacceptable variability was found in the standard of practice when supporting someone who has experienced abuse in at least two of the following: a clear chronology of events and core information; risk assessment; protection plans; and case recording*.

This is the reality of guidance, with overarching issues of concern including the lack of governance, accountability and performance monitoring, which some frontline staff interpret as a lack of commitment by senior managers (across all agencies). While there has been a variable level of investment in staffing, governance frameworks have not been clearly defined or implemented. In assessing the current situation, therefore, it seems unlikely that guidance alone can effectively ensure participation and commitment to such governance arrangements.

In 2007 the DH sponsored report *‘Partnership and regulation in adult protection’* noted,

*‘Some lack of commitment to partnership working; Agencies not providing the resources required (financial or human resources) with little evidence of*
joint-funding arrangements; Lack of clarity about the roles and responsibilities of each agency; Insufficient information sharing; Different priorities in relation to adult protection amongst agencies; Delays in decision making at both strategic and operational levels, which were often linked to differing priorities between Agencies’

And it suggested that the barriers or causes were,

‘The lack of adequate resources (human and financial) for adult protection work; The lack of specific legislation to protect vulnerable adults; A concern that some agencies do not view the ‘No Secrets’ / ‘In Safe Hands’ guidance as a ‘must do’ but a ‘may do’ and in some ways as optional; Uncertain commitment from all agencies at local levels to undertake adult protection work and participate fully in partnership working’.

A year later the CSCI report Safeguarding Adults, noted (after seven years of guidance),

‘Progress on establishing effective safeguarding arrangements is uneven both across and within council areas and between different service providers. Some groups in the community are still under-represented in referrals, including black and minority ethnic people and people using mental health services. More needs to be done to ensure people with high support needs or without support from trusted family or friends get help that truly results in better outcomes for them... This study found that the building blocks of prevention and early intervention are not consistently in place in every council.’

And this month CSCI, in its report to parliament on the state of social care, observed that 20% of councils surveyed were poor on safeguarding, half were only adequate and none could be described as excellent.

A primary argument in favour of guidance, contained in the No Secrets consultation document, is that

‘guidance has the advantage of being able to be broad, and to be flexible. We can review and add to guidance every couple of years or so.... We can change guidance as we learn lessons from our experience with personalisation, our experience with community empowerment and our experience with the use of special measures in the criminal justice system. Guidance is more immediately useful; it is more up-to-date and is more integrated to wider policy.’
However, this does not address the points made when Scottish legislation was being considered and, equally importantly, it does not reflect the experience of the *No Secrets* guidance over the last eight years, as confirmed by both the CSCI and PRAP observations highlighted above. The Consultation document acknowledges this in the introduction, indicating that *No Secrets* was a good start but, almost ten years later, it is *time to take stock* and consider how it might be updated. But it has remained un-amended during this period, despite serious difficulties being articulated by both statutory and Third Sector organisations and the conclusions of Serious Case Reviews, and there is no evidence that there has been a willingness to hear or respond to those concerns. Consequently, the claim that guidance would provide a more flexible option is highly dubious.

The Policy Memorandum, which supported the argument for a Scottish Act in 2006, noted that

> 'what is required is a strengthening of expectation that when there are allegations of abuse these will be taken seriously and pursued stringently. Evidence suggests that when allegations are made, social work staff will make efforts to establish the facts. If, however, they do not get access or the alleged victim refuses contact then active pursuit may not follow. Some local procedures acknowledge that having no right of entry adversely affects their ability to intervene26.'

This analysis is equally relevant within the other three Nations of the United Kingdom, and reflects some of the frustration articulated by adult protection staffs who feel unable to effectively intervene in abusive situations or provide a protective plan for some adults in vulnerable situations.

Of equal importance, in relation to the option of guidance, the memorandum noted,

> ‘while this may offer some improvement compared to the current position there are likely to be problems with this approach. Aside from effectiveness, as agencies may be more inclined to follow guidance that is based on a legal requirement, there would be a concern about how long it would take for all the relevant central authorities to agree the content and format of guidance and to whom it should be addressed. This presents a real risk that abuse could continue without appropriate assessment or investigation. In addition, without an explicit duty for agencies to share information, there is a risk that some vital information will not be shared, or it will be shared too

26 Adult Support and Protection (Scotland) Bill: Policy Memorandum, SPCB 2006
late, or that agencies receiving information on suspected abuse from another agency may give a low priority to the response.

Again, as an alternative to the specific power to intervene and exclude, guidance could be issued to all agencies, and particularly the police, about the availability of alternative measures which exist under current legislation (such as the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Adults with Incapacity (Scotland) Act 2000) with a clear explanation of how, when and in which circumstances of abuse or vulnerability these existing powers can be used. However, this approach does not provide parity for all adults at risk. While it may result in more targeted and effective use of existing legislation for those adults whom it covers, it does nothing to improve the levels of protection for those adults who are subject to or at risk of harm but who have no apparent mental disorder or incapacity’.

The No Secrets consultation document acknowledges that many of these concerns and difficulties are applicable in England, (without making reference to the Scottish work) where adult protection staff told civil servants that:

‘implementation was slow and inconsistent; joint working was patchy and some partners were unwilling to ‘come to the table’ and that ‘it did not lead to a strong and effective universal system for preventing, recognising and responding to adult protection issues’:

Fundamentally, the arguments in favour of guidance are not sustainable. There is no historical evidence that it has been more flexible to change, it would not strengthen the expectation that when there are allegations of abuse these will be taken seriously, and it is difficult to envisage how it could create a right of entry to interview an adult who is potentially at risk, or ensure the adequate sharing of information. The obvious question that arises is why, if guidance is the preferred option, it has not been similarly preferred in relation to child protection, domestic violence or animal cruelty?

A strongly held view within adult protection is that guidance is weak because it implies an optional response, and/or is open to local interpretation with the consequence of a postcode lottery of response and outcomes. This was adequately described by the Serious Case Review into the death of Stephen Hoskin which noted,

‘The safeguarding systems for children and adults are poles apart in terms of profile, performance and working in partnership. Getting child protection practice right is a key performance concern for local authorities but safeguarding adults is a poor relation in terms of profile, funding and resources.’
We know from the international data\(^{27}\), calls to the AEA helpline, and the UK study into the abuse and neglect of older people that the majority of elder abuse occurs within the community, and specifically within people's own homes. In *legislative* terms however the primary thrust of Government protective policy has focussed upon the much smaller number of people in receipt of social care, and this has been regulated primarily through the Care Standards Act 2000 and more latterly the Safeguarding Vulnerable Groups Act 2006. Abuse within the community, unless perpetrated by paid domiciliary workers, is addressed through the *No Secrets* guidance. To a large extent, therefore, the list of Parliamentary Acts quoted at the beginning of this Chapter are misleading, in that none of them directly focus upon the frameworks, structures, duties or powers involved in adult protection intervention.

The Consultation document argues that people have expressed support for the concept of legislation, but have been unable to articulate what is wanted. That has not been our experience. We have heard people clearly articulate two aspects concerning legislation (a) underlying principles; and (b) the need for a statutory adult protection framework. We would add a third (c) the need to define responsibilities for the promotion of welfare. And in that overall context we would note that the DH sponsored report, *Partnership in regulation and adults protection*, observed,

> ‘Most respondents from phases 1 and 2, and some from phase 3 called for specific legislation relating to adult protection. Reasons for this clearly stated view were: Standardisation of policy and practice needed nationally; The need for an ability to hold agencies to account and to clarify their roles and responsibilities; The need for a statutory requirement for agencies to participate in order to ensure that sufficient priority is accorded to adult protection issues; The need to give adult protection equivalent status to child protection.’

The report went on to recommend that, *‘Serious consideration needs to be given to the development of specific legislation in adult protection, including a duty to cooperate for all agencies involved in this area of work.’*

Additionally, the report published by Scope in 2008, and called ‘Getting away with murder\(^{28}\), observed...

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\(^{27}\) The National Center on Elder Abuse reports that roughly two-thirds of those who take advantage of the elderly are relatives, most often the victim's adult child or spouse. National statistics also show that between 1 million and 2 million Americans older than 65 have been exploited or mistreated by someone whom they relied on for care.

\(^{28}\) Getting away with murder, SCOPE, 2008
'The current framework that is supposed to protect disabled adults from harassment fails them... It is not fit for purpose....In adult protection for disabled and older people, the lack of a statutory duty of care and a culture of silo working often prevents the joint working between police, housing associations and community groups that is urgently needed'.

In the circumstances, it is difficult to understand how DH civil servants have failed to hear these statements.

(a) Underlying principles of legislation:

Any legislative intervention must have the effect of positively supporting people who are experiencing, or are in danger of experiencing, abuse. For this reason a careful balance needs to be established between intervention that protects and enhances the quality of life of an individual as opposed to intervention that addresses the immediacy of abuse but effectively creates further difficulties for that individual either at that point or at a later date.

The principles contained within the Mental Capacity Act 2005, in terms of (a) establishing mental capacity with regard to an individual exercising choice and control over their lives and (b) ensuring that acts or inaction relating to an individual or individuals should only occur within the parameters of what is in their ‘best interest’, must be fundamental to the development of any adult protection legislation.

Additionally, the principles of the Human Rights Act 1998 (HRA) sit at the heart of adult protection and define positively an individual’s right to dignity, respect and a life free from cruelty, exploitation or degrading treatment. These principles are the fundamental rights which adult protection should seek to safeguard. However, there must be a recognition that not all human rights are absolute, and that intervention will at times result in one right (or one person’s right) taking precedence over another. Consequently the HRA principles should not be a barrier to intervention but should instead be a guide to intelligent intervention.

(b) The need for a statutory adult protection framework:

The Adult Support and Protection (Scotland) Act 2007 has enshrined the basic requirements of adult protection into comprehensive legislation. It has established fundamental principles for State intervention and has changed the terminology of adult protection, introducing the concept of ‘adult at risk’ rather than vulnerable adult; it has established duties on local authorities to investigate and provided powers to gain entry and
interview; it has established duties on agencies to cooperate; and it has provided a range of potential actions, including options to remove adults at risk, and to ban perpetrators. Equally importantly, it has established Adult Protection Committees on a statutory footing, and defined membership and procedures. At least £15m has been earmarked for the first year of implementation. Although it is obviously too early to assess the impact of this legislation, the principle and need for legislation has been established and the secondary impact has been palpable.

In terms of ‘framework’ legislation we believe that there are four key aspects:

- **A statutory basis** for the construction and work of Safeguarding Adults Boards (SACs). *The seminar hosted jointly by Voice UK and AEA indicated that these Boards should have a local governance role from both preventative (safeguarding) and intervention (adult protection) work.*

- **A duty on agencies to collaborate**, actively participate at a senior level in SACs, and work together. *Key points are that this is about more than representation at meetings; it is about decision making and strategic overview/planning, and therefore requires sufficient level of authority. The SAC is different from strategy meetings, and therefore representation would be different.*

- **Data to inform policy planning.** *This would enact into the law the commitments given by Liam Byrne, Parliamentary Under Secretary of State for Care Services, in 2006 to introduce a standardised data monitoring and collection system on adult protection referrals and outcomes.*

- **Adequate funding** for safeguarding work. *Adult Protection receives no specific funding. Consequently the structures and systems across areas vary according to the individual commitment of statutory agencies and the pressures on their respective budgets etc.*

None of the above fall into the category of infringing individual human rights, or adversely affecting the well-being, choice or control of adults at risk of abuse. None of the arguments put forward to counter the case for new laws have been relevant to ‘framework’ legislation.

Additionally, there is also a need to establish clear timescales for investigation and intervention, define meaningful outcomes for the adult
concerned, and establish common definitions of which adults are covered, and what level of harm would trigger action.

(c) the need to define responsibilities for the promotion of welfare.

In a modern society it is reasonable to expect a level of intervention by the State which ensures the protection of its citizens in general. Such intervention should be proportionate to the levels of dependency and/or levels of vulnerability of the citizen, their ability to protect themselves from harm and their capacity to consent or participate in the process. The right to choice and control over life decisions which is an inherent, but not absolute, right of adulthood should not be in conflict with the right to protection, whether that protection is through the primary intervention of adult protection or through the secondary processes of care and health services, (and the consequent employment controls, regulation of care provision and monitoring applied to such services).

If it is illegal to cause an animal to suffer\(^{29}\), and it is illegal (either by action or omission) to cause serious harm to a vulnerable adult such that they die\(^{30}\), then it naturally follows that it should be illegal to cause an adult to suffer, including through acts which cause serious harm short of death.

While it could be argued that there is a range of criminal laws that could be brought to bear on such situations it is simultaneously recognised by the State that there are circumstances in which further action or impetus is required. This is clearly evidenced by the Domestic Violence, Crimes and Victims Act 2004, where criminal law has been insufficient to address the complexities and dynamics of partner abuse and violence.

The current social policy analysis that defines certain actions as abusive, rather than criminal, has been insufficient to address the scale and complexity of abuse, exploitation and neglect and has often served to lessen or marginalise the perception of the acts and their impact. Legislation therefore needs to emphasise the seriousness of such acts, in a similar manner to the approach adopted by the Crown Prosecution Service i.e. that abusive practices toward older people (and, by implication, other vulnerable adults) are crimes. Equally however it should seek to actively promote the welfare of adults who are in vulnerable situations.

\(^{29}\) Animal Welfare Act 2008  
\(^{30}\) Domestic Violence, Crimes and Victims Act 2004
In establishing the relationship and interaction between individuals (and consequent responsibility for their actions or inactions) the concept of duty of care should consequently apply as a legal obligation imposed upon an individual, requiring that they adhere to a reasonable standard of care while performing any acts that could foreseeably harm others. Where the duty of care is not defined by professional standards it should be based upon the reasonably expected actions of an average person i.e. it does not require perfection, but takes into account that an average person does not foresee every risk. The average person is not assumed to be flawless, but ordinarily careful and prudent. The Domestic Violence, Crimes and Victims Act 2004 has effectively established the principle of responsibility within clause (5) (in relation to an unlawful killing) but these need to be extended to situations that do not result in death but cause significant harm.

9a Do we need an updated and refreshed No Secrets guidance? If so, should it be one document for all multi-agency partners, or should there be separate documents for: the criminal justice system; the health sector; and local authorities, to include social care, housing and community safety?

We believe that there is a role for guidance and protocols, but that they can only be effective if they support a statutory legislative framework. What is not clear from the Consultation document is which aspects of No Secrets are to be updated and refreshed?

Apart from the definition, there has been no discussion in the consultation document about any other aspect of section 2 of No Secrets and we are consequently assuming that no changes are proposed, other than perhaps an update of terminology? However, there were valuable lessons within the elder abuse prevalence study in terms of the nature of elder abuse which might be useful to reflect in this section, for example the difference between passive and intentional neglect, and the potential links to the Carers Recognition Act 2005 and the wider preventative agenda relating to criteria for access to services.

Section 3 of No Secrets is clearly one that requires consideration and review. It covers the need for agencies to collaborate and work together, which agencies should be involved, the merits of setting up a multi-agency committee (and the DH subsequently issued further guidance on this follow the Health Select Committee Inquiry into elder abuse), defining roles and policies, the responsibilities of various roles, and the role of senior management, annual reports. The failings of the guidance can be summed up as:
a) Not all agencies identified as participants in section 3.3. of No Secrets are necessarily invited, or choose to participate in, the development of multi-agency frameworks;
b) The development of policies, procedures, systems and processes, as defined in section 3.6, have been sporadic and inconsistent;
c) There is no consistency in the establishment of lead managers in those agencies designated to participate in adult protection processes (section 3.12);
d) There is inconsistency in the participation of Chief Officers and Chief Executives (section 3.14); and
e) Audits are inconsistent (section 3.18).

The challenge of ‘engagement’ was clearly described by CSCI in their Safeguarding Adults report in 2008,

‘The priority given to safeguarding does not depend on the council alone, but also on key partners in health and police services who have numerous other responsibilities and priorities set by government. Negotiating a high priority for safeguarding adults in this context is not always easy. For example, some councils had difficulty in securing dedicated attention to safeguarding in the local police force. In only 17% of councils inspected was their performance in safeguarding rated higher than their overall performance across all their functions. Difficulty in engaging strategic partners was one of the major reasons for this generally lower performance’.

The question therefore arises as to how further guidance (defined as ‘advice and counselling’) can address these failings and ensure compliance? How will it compel participation and action, and what consequences or sanctions can it apply for failure to comply? These are not small points, because the issue is not necessarily about what No Secrets proposes or requires, but is about whether or not those requirements are actually delivered.

Section 4 of No Secrets proposes an outline of the policies that should be established, and outlines the principles that need to be applied. Fundamentally these are valid, but this section needs to take account of HRA and MCA imperatives so some re-writing would be helpful.

Section 5 outlines the strategy that should be considered when implementing No Secrets, and it should be noted that this includes,
‘joint protocols to govern specific areas of practice such as sharing of information or the conduct of joint interviews’

Considering the emphasis that the Consultation document appears to place on new guidance and protocols it is important to recognise that this is already proposed and encouraged by No Secrets, which again suggests that the issue is one of compliance rather than content. The section also addresses issues of training, the need for adult protection to be mainstreamed into commissioning, confidentiality and information sharing. None of this is particularly controversial or in need of major re-phrasing, but aspects are inconsistently addressed and delivered.

Section 6 lays out the procedure to be followed in response to an allegation of abuse. Fundamentally this remains a valid outline of expectations and principles, and it is worth noting that the principles of the MCA are loosely articulated in paragraphs 6.20 and 6.21. Finally section 7 covers recruitment matters which again seem reasonably current.

All of which reinforces the question as to what ‘refreshing’ and ‘updating’ is proposed in relation to the guidance? There are some issues of terminology, and reinforcement of HRA and MCA principles, but essentially the guidance remains relevant and applicable.

As an overarching statement of collective responsibility, establishing core definitions and general principles, a single document should be readily applicable to all agencies and environments. As suggested by No Secrets, additional annexes or supplements to cover particular issues for individual groups, or to cover specific themes or unique circumstances, might be helpful.

What guidance cannot do however is compel participation and collaboration in the face of prioritization of work and resources.

9b Is new legislation necessary and how would it help?

New legislation is necessary.

First and foremost it is crucial for society to send out a clear message that the abuse of adults in unacceptable and will not be tolerated. The Government has already accepted this in relation to other adult abuse scenarios and has made statements to that effect. Furthermore government has deemed legislation necessary and appropriate for victims of child abuse, victims of domestic abuse, victims of forced marriage and
victims of animal cruelty. There is a dichotomy between the Government position in relation to adult protection, and that of domestic violence or children.

Scotland stated in its Policy Memorandum that,

‘what is required is a strengthening of expectation that when there are allegations of abuse these will be taken seriously and pursued stringently’.

Secondly, it is generally acknowledged (and explicitly stated in Scotland) that,

‘agencies may be more inclined to follow guidance that is based on a legal requirement’

Guidance has failed to deliver key agencies, represented at sufficient seniority, to the adult protection arena and it is not acceptable to simply note that other drivers might finally be changing this reality. In the meantime adults suffer and in some cases die, while this process grinds onward. Clear duties placed by statutory instrument would address this matter immediately.

The CSCI report on Safeguarding Adults in 2008 noted,

‘In the discussions in study sites, staff from many statutory agencies agreed that the No secrets guidance had been the main impetus in bringing about improvement. However, many also thought that the rather ‘permissive’ nature of guidance on safeguarding adults, especially as applied to health and police, resulted in variable commitment and left partnership working relying too much on local negotiation rather than statutory duties’.

As indicated previously, we are not proposing new criminal legislation as we believe that a sufficient amount already exists, although we accept that there are gaps that need to be addressed. We believe that framework legislation should be developed that:

- Places safeguarding boards on a statutory footing
- Provides a duty on agencies to co-operate
- Provides a duty on agencies to share information
- Provides a compulsory collection of data on safeguarding referrals
- Provides a right to access adults at risk of abuse facing significant harm
• Clarifies funding

This would address the key issues that have emerged over the nine years since the *No Secrets* guidance was introduced.

9c Should legislation to place safeguarding on a statutory footing be introduced? Should it include a duty to commission and contribute information to serious case Reviews?

Yes to both questions.

Safeguarding Adult Boards need to be placed on a statutory footing because:

a) The structure and role of boards is different across the country. Legislation setting out clear roles and responsibilities would remove this inconsistency, and ensure a standardized approach and guaranteed attendance.

b) Boards currently struggle to attract membership and funding because they are not recognised as statutory bodies requiring participation (unlike Safeguarding Children Boards, Crime and Disorder Reduction Partnerships etc). If legislation were to set out clearly both the role of the Board and of the organisations required to participate this would make a significant difference.

c) Boards currently have little influence over partner agencies other than what can be achieved through goodwill and ‘coercion’.

d) Participation in Case Reviews, and the collection of meaningful safeguarding information to take forward the safeguarding agenda, can only be achievable through legislation.

As indicated previously, we envisage three levels to this process.

Firstly there has to be a level of leadership that ensures the engagement of key agencies and stakeholders in the overall process, including the agreement of multi-agency protocols, work plans, strategic and operational priorities and resources, and the appointment of representatives to Safeguarding Adult Boards who have the delegated authority and responsibility to take forward issues. This responsibility should clearly rest with Chief Constables and the Chief Executives of relevant Agencies.

Secondly, there has to be day to day management and leadership provided by the Safeguarding Adult Boards, contributing to the development of strategic planning and inter-agency communication,
assuring the delivery of multi-agency training, developing, monitoring and reviewing protocols, undertaking analysis and research, networking, proving public information, and publishing the annual report.

Thirdly, there are the operational strategic meetings to address specific abuse situations, and involving various practitioners and individuals according to need and circumstance.

9d Should we introduce a wider duty to cooperate in relation to safeguarding? Who would this apply to, how would it improve outcomes and how would it be enforced?

Yes.

A wider duty to cooperate would be a major step forward in safeguarding work. It is a duty used regularly in other arenas, for example MAPPA, to remind partners that their co-operation and assistance is not discretionary but is being sought as part of a statutory responsibility.

A duty to cooperate would relate to different people in statutory Agencies at different times and in different circumstances. It would apply to others according to contracting and commissioning arrangements, and consequent employment requirements. It would apply to Chief Officers in terms of their participation at strategic management level, to those delegated to participate in Safeguarding Adults Boards, and others in terms of their employment responsibilities to cooperate with investigations and comply with outcome decisions.

It would improve the current situation by (a) ensuring attendance at Safeguarding meetings and (b) by ensuring that investigations were meaningful and conclusions implementable.

If this duty to cooperate is part of a process that has been mainstreamed into the systems and operations of Agencies e.g. led by a (Chief Officers group) then it would be enforced through accountability to the relevant Government Minister and through normal employment law. Question: how did Ed Balls ensure compliance with the investigation at Haringey? How did he change the senior management? How did he ensure an inquiry?
Should there be a power to enter premises where it is suspected that a vulnerable adult is being abused? Should this power apply to: the police only; or social workers and other professionals as well?

Existing powers under Section 17 of the Police and Criminal Evidence Act are often not sufficient for the cases that regularly come to the attention of safeguarding processes. This power could usefully be developed to cover the majority of safeguarding cases.

The nature of many abusive relationships involving older people includes a coercive interaction between victim and perpetrator which adversely affects the opportunity for informed choice and control. 'Undue influence' is brought to bear either directly or indirectly and this results in numerous occasions in which adult protection staff have to rely upon the cooperation of the abuser to gain access to the victim;

We do not believe that a 'power of entry' should be routine or available to health or social care workers, other than through accompaniment of a police officer. Any intervention powers should be limited in scope and operation, should be validated by an external source, and should be encompassed within current legal roles and responsibilities.

As with any situation in which the State assumes the right to intervene in the life of an adult there must be safeguards, checks and balances to ensure it is used appropriately.

Our starting point is that the principles contained the Human Rights Act 1998 (HRA) and the Mental Capacity Act 2005 (MCA), must form the foundations and basis of any adult protection intervention. In particular, the MCA provides a good sense of direction in this regard when it indicates that An act done, or decision made, for on behalf of a person .... must be done, or made, in his best interests and that, before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is least restrictive of the person's rights and freedom of action. The Code of Practice issued by the Lord Chancellor on 23 April 2007 states that, prior to performing an act, consideration must be given to whether a less restrictive option is available.

Our view is that these principles should provide guidance as to whether or not someone (including health worker or social care worker - 'the worker') should insist on seeing and speaking with an adult, if they have 'reasonable belief' that they are at risk of abuse. In that context, there must be some clearly accepted definition as to what constitutes 'reasonable belief' that an adult is at risk and such belief must be
subjected to an objective test, which we would suggest should be through a magistrate’s court or a similar type of arrangement.

It is reasonable that, prior to seeking a warrant from a magistrates court (or other validating mechanism), the worker should attempt to obtain the consent of the adult to a visit that allows a confidential conversation/interview. The fundamental issue is whether the adult potentially at risk may be considered to have been unduly pressurised to refuse to consent to the visit and that:

- the harm which the visit is intended to assess is being, or is likely to be, inflicted by a person in whom the adult at risk has confidence and trust, and
- there is an identifiable risk to the person as a consequence of an unsupervised risk.
- that the adult at risk would consent to the visit if the adult did not have confidence and trust in that person.
- In such circumstances the worker would need to apply to a magistrates court and demonstrate:
  a) that the worker had reasonable cause to suspect that the person in respect of whom access was sought was an adult at risk who was being, or was likely to be, seriously harmed,
  b) that the assessment was required in order to establish whether the person was an adult at risk who was being, or was likely to be, seriously harmed,
  c) that there was reasonable belief that the adult at risk was being unduly pressurised to refuse consent, and
  d) that there were no steps which could reasonably be taken with the adult's consent which would protect the adult from the harm which the assessment access is intended to prevent.

In such circumstances a warrant to gain entry would be granted to a police officer and the worker would accompany that officer. The actual power of access would therefore remain within current systems.
Should such a power apply when an adult has mental capacity and may be self-neglecting or self-harming?

Self neglect is not a straightforward issue and we need to be cautious about automatically linking it to adult abuse. This is equally true in terms of self-harm.

Whenever consideration is given to powers that have the effect of intervening in the lives of adults, or curtailing the actions of adults, we immediately create risks of inappropriate or excessive use. There is an inevitable balance to be achieved between intervention that has the effect of improving and enhancing someone’s safety and well-being, and intervention that has the effect of being intrusive, unwarranted and detrimental to someone’s chosen lifestyle. There is a difference between legitimate intervention intended to address abuse, and intervention intended to force conformity of someone’s lifestyle with wider social values. We should not let one be confused with the other.

Should the State assume the right of intervention because an old woman’s lifestyle is defined by neighbours as self-neglect? At what point does self-neglect become the concern of anyone other than the ‘neglectee’? Should we not make a distinction between self-neglect resulting from lack of choice (e.g. insufficient pension income, physical inability or mental health problem) and self-neglect resulting from a chosen lifestyle? One justifies intervention and one does not.

Equally, should we not make a distinction between self-harm that occurs as a consequence of previous life experiences, self-harm arising from a mental health problem, and self-harm cause through an addiction to drugs or alcohol?

And it is this balance that must sit at the heart of adult protection. Any actions taken in this context should be based upon principles similar to those expressed within the Mental Capacity Act 2005 relating to choice and control, and an assessment of ability, risk and vulnerability.

Fundamentally, there should be a balance between any intervention by the State and the right of the individual to exercise choice and control over their lives, insofar as any individual is entitled to do so. The right of the citizen should in most normal circumstances (and within the boundaries of current law) take precedence over the right of the State; we have both the Human Rights Act 1998 and the Mental Capacity Act 2005 as clear foundations for such an approach. But, simultaneously, we must not ignore the message from the Serious Case Review into the death of
Stephen Hoskin that,

'It is essential that health and social care services review the implications of acceding to people's 'choice' if the latter is not to be construed as abandonment.... 'Steven Hoskin had lost all control of his own life within his home. He had no say, choice or control over who stayed or visited the flat. He had no voice or influence over what happened within the premises'.

9g If a power of entry is supported, which means to obtain entry should be introduced (e.g. authorisation by a senior police officer or magistrate or other means)?

See 9E

9h Should an offence of ill-treating or neglecting a vulnerable adult with capacity be introduced?

Yes.

In a modern society it is reasonable to expect a level of intervention by the State which ensures the protection of its citizens in general. Such intervention should be proportionate to the levels of dependency and/or levels of vulnerability of the citizen, their ability to protect themselves from harm and their capacity to consent or participate in the process. The right to choice and control over life decisions which is an inherent, but not absolute, right of adulthood should not be in conflict with the right to protection, whether that protection is through the primary intervention of adult protection or through the secondary processes of care and health services, (and the consequent employment controls, regulation of care provision and monitoring applied to such services).

If it is illegal to cause an animal to suffer, and it is illegal (either by action or omission) to cause serious harm to a vulnerable adult such that they die, then it naturally follows that it should be illegal to cause an adult to suffer, including through acts which cause serious harm short of death.

While it could be argued that there is a range of criminal laws that could be brought to bear on such situations it is simultaneously recognised by the State that there are circumstances in which further action or impetus is required. This is clearly evidenced by the Domestic Violence, Crimes and Victims Act 2004, where criminal law has been insufficient to address the complexities and dynamics of partner abuse and violence.
The advice provided by the Crown Prosecution Service in terms of prosecuting crimes against older people, indicates that

‘Neglect may amount to a criminal offence under section 44 of the Mental Capacity Act 2005 or section 127 of the Mental Health Act 1983. But in cases where the victim has not died, and does not have a loss of capacity under the Mental Capacity Act 2005 and is not being treated as a patient for the purposes of the Mental Health Act, prosecutors may find it difficult to identify an appropriate criminal offence’31.

The current social policy analysis that defines certain actions as abusive, rather than criminal, has been insufficient to address the scale and complexity of abuse, exploitation and neglect and has often served to lessen or marginalise the perception of the acts and their impact. Legislation therefore needs to emphasise the seriousness of such acts, in a similar manner to the approach adopted by the Crown Prosecution Service i.e. that abusive practices toward older people (and, by implication, other vulnerable adults) are crimes. Equally however it should seek to actively promote the welfare of adults who are in vulnerable situations.

In establishing the relationship and interaction between individuals (and consequent responsibility for their actions or inactions) the concept of duty of care should apply as a legal obligation imposed upon an individual, requiring that they adhere to a reasonable standard of care while performing any acts that could foreseeably harm others. Where the duty of care is not defined by professional standards it should be based upon the reasonably expected actions of an average person i.e. it does not require perfection, but takes into account that an average person does not foresee every risk. The average person is not assumed to be flawless, but ordinarily careful and prudent. The Domestic Violence, Crimes and Victims Act 2004 has effectively established the principle of responsibility within clause (5) (in relation to an unlawful killing) but these need to be extended to situations that do not result in death but cause significant harm.

Should there be a power to remove an adult who does have capacity and who does not consent, but who is thought to be being subjected to harm?

We do not feel that this is an appropriate question.

31 Guidance on prosecuting crimes against older people, CPS 2008
As has been previously stated, decisions to take action should be based on an accurate assessment of risk and the principles established within the MCA. The wishes of the individual are important but are not the sole factor in deciding whether or not to take positive action in response to an abusive situation, and this position is already well established in relation to domestic violence. There are occasions when the risk is so great that action must be taken which is contrary to the express wishes of the victim. The nature of coercive abusive relationships is such that people are often unable to make informed choices and are trapped within a narrow range of confining options. Consequently, the responsibility for taking action against abuse should not lie solely with the victim.

**9j** Should force be used to remove a person who is self-neglecting or self-harming?

See 9i above.

**9k** If a person is removed, where should they be taken, for what purpose and for how long?

Firstly, we should be mindful that it can be an objective of an abuser to remove their victim from the home. Secondly, we should be mindful that the enforced move of an older person can kill them. In keeping with the MCA consequently, if consideration were given to such an option, it should be as a last resort when all other options had been tried and exhausted. There is a lack of suitable refuge provision for adults with care needs. There are a number of properties funded through ‘supporting people’ that provide specialist services for adults with care needs who are escaping abusive situations and relationships. We therefore need to consider the role of care homes, respite care, sheltered housing, supported living etc could be used in such circumstances.

**9l** Is current care standards legislation sufficient for closing down poorly performing care homes in a timely and effective manner?

On previous occasions the magistrate process has proved unhelpful to both the regulator and the care home, and this needed addressing. The Health and Social Care Act 2008 however gives the Care Quality Commission additional powers, including a power to remove, vary or suspend conditions of registration with immediate effect from serving the notice where there is risk of harm to people who use services.
Additionally, however, magistrates need training in understanding the Care Standards Act, the role and function of care homes, and the vulnerability of care home residents.
Chapter Nine: The Definition problem

The use of the term 'vulnerable adult' to encompass a large number of different people, with varying levels of disabilities, dependence and abilities, has proved counter-productive to the safeguarding agenda, and in particular to the protection of those adults who are potentially most dependent or vulnerable to abuse. As a construct it places the focus on the individual as the ‘vulnerable person’ and not on the circumstances that give rise to that vulnerability, and it ‘captures’ individuals who have no wish to be labelled ‘vulnerable’ and who are adversely affected when this occurs. Scope, in their report ‘Getting away with murder’ observed,

‘The culture and language of adult protection also creates barriers to reporting and tackling disability hate crime. If a disabled person reports a crime to the police, it is (hopefully) investigated and action is taken to address it. However, if a disabled person tells a social worker that they feel vulnerable or at risk, because of harassment, verbal abuse or violence, it triggers Safeguarding Adults procedures which are designed first and foremost to protect someone from harm. The Safeguarding Adults process can be extremely disempowering for a disabled person as they are frequently unable to control what happens to them once the process is triggered. Decisions are made in case conferences, and involve reviews by care managers and other professionals which rarely involve the disabled person. Terms like ‘vulnerable adult’, ‘protection’ and ‘safeguarding’ all serve to remove disabled people's agency and make them passive recipients of services who have things ‘done to them’.

In 2004 the Government failed to accept the recommendation from the Health Select Committee inquiry into elder abuse and stated,

“No Secrets” relates to abuse or neglect experienced by vulnerable adults no matter their age or living arrangements. It defines a vulnerable adult as “a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation”. This definition is wide and includes individuals in receipt of social care services, those in receipt of other services such as health care, and those who may not be in receipt of care services. Any wider definition that includes individuals who are well able to look after themselves would sweep all cases of domestic violence and other forms of harm into a scheme meant to protect vulnerable adults. Too wide a definition of abuse would dilute what the Government is trying to achieve.
via its policies of protection for vulnerable adults and confuse professionals and the public alike\(^{32}\).

But of course the situation is even more confused by the multiple definitions of ‘vulnerable adult’ established by Government policy. For example, the Domestic Violence, Crimes and Victims Act 2004 defines a vulnerable adult as,

“vulnerable adult” means a person aged 16 or over whose ability to protect himself from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, through old age or otherwise’.

While the Safeguarding Vulnerable Groups Act 2006 defines a vulnerable adult as,

‘A person is a vulnerable adult who has attained the age of 18 and is in residential accommodation, and/or sheltered housing, and/or receives domiciliary care, and/or receives any form of health care, and/or is detained in lawful custody, and/or 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 (c. 43), and/or receives a welfare service of a prescribed description, and/or receives any service and/or participates in any activity provided specifically for persons who fall within subsection (9), and/or payments are 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 requires assistance in the conduct of his own affairs.’

Both these definitions are in addition to the one outlined in No Secrets.

Scotland however has taken a different view and has addressed this problem by using the term ‘Adults at risk’ and defining the circumstances that give rise to that risk i.e. adults who are unable to safeguard their own well-being, property, rights or other interests, are at risk of harm, 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.

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\(^{32}\) The Government’s response to the recommendations and conclusions of The Health Select Committee’s Inquiry into Elder Abuse June 2004
Should the *No Secrets* definition of a vulnerable adult be revised? If so should the revised definition do the following, and if so, how? Should it:

- enable practitioners to decide which groups of people they believe require special support?

A definition is intended to describe or state something clearly and unambiguously, in this case the group of people who should be eligible for adult protection intervention. Consequently, the definition should enable everyone, not just practitioners, to understand which adults experience abuse, and the conditions which give rise to that abuse. The definition needs to be sufficiently explicit to avoid being ‘all encompassing’ and capturing other arenas that already have their own processes and procedures.

It should switch the focus from the individual as the ‘vulnerable person’ and place it on the circumstances that give rise to that vulnerability. While we accept that there is a probable need to describe adults at risk of abuse as a consequence of age or some form of disability, we do not believe that this should be the sole factor and that it should be linked to a risk of harm or abuse, as a consequence of circumstances, environment or the actions of others.

- provide clarity on what ‘wrongs’ we want the new *No Secrets* guidance to put right?

We are not sure this is a clear question.

The very nature of safeguarding is that it is intended to prevent undesirable consequences from happening i.e. to prevent somebody from being harmed, damaged or badly treated. If we accept the definition of abuse as...

> ‘a violation of an individual’s human and civil rights by any other person or persons’.

...then it must surely follow that this is the ‘wrong’ which the process seeks to put right.

- clarify how bad the ‘wrong’ has to be to warrant a response, i.e. define the threshold needed to justify a response?

A definition would not set such thresholds. However, paragraphs 2.18 and 2.19 already seek to link this issue with the Law Commission proposal that.
'harm' should be taken to include 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'.

and suggests that this should be considered in the context of the
vulnerability of the individual; the nature and extent of the abuse;
the length of time it has been occurring; the impact on the individual;
and the risk of repeated or increasingly serious acts involving this or
other vulnerable adults. We would seek to link this issue to the MCA
principles relating to ‘best interest’.

The Serious Case Review into the death of Steven Hoskin indicated
that,

‘Failure to take reasonable and appropriate steps to safeguard
individuals from abuse or life-threatening events is in breach of
Articles 2 and 3 of the European Convention on Human Rights. It
is important that adult protection is triggered when someone is
believed to be at risk of harm/abuse and not only at the point
where there is demonstrable evidence of harm. In order to
conform to their obligations under human rights law, agencies
have to be proactive in undertaking risk assessments (e.g.
Monahan et al 2001) to ensure that preventive action is taken
wherever practicable’.

• take into account those vulnerable by reason of a temporary physical
or mental condition

If we develop a definition that focuses primarily upon the situation and
circumstances that give rise to vulnerability then this situation would
be covered.

• distinguish between abuses carried out by a person in a position of
trust or power in relation to the victim and those committed by a
stranger?

The definition should focus upon who is experiencing or likely to
experience abuse, and not the actual or potential perpetrator.

There would be merit in separately considering the various scenarios
that give rise to abuse including passive/active neglect, wilful actions,
poor practices etc., as these help to consider and develop strategies in
response. However, we must be clear in defining abuse firstly from the perspective of the victim in order to validate their experiences, and subsequently from the perspective of the perpetrator.

- make reference to an adult being unlikely to be able to protect himself or herself from harm or exploitation

Most definitely, because it is this which defines the vulnerability aspect of abuse. Many people could well fit a definition based exclusively on disability, age or illness but would not need safeguarding processes, because they could take action for themselves e.g. criminal justice systems etc without external intervention.

10b What language should we use? Is ‘abuse’ always useful or should we change to ‘harm’ and ‘crime’? Is ‘perpetrator’ always useful (i.e. for neglect within families)?

Language is a powerful tool. It defines how people perceive the actions of others, and the importance placed by society upon those actions.

A fundamental principle of citizenship is that everyone is equal within the law. A crime perpetrated against you at the age of 25 years remains a prosecutable crime even if it is perpetrated against you again when you are 75 years of age. This is a self evident and incontrovertible principle, and consequently many ‘abuses’ are crimes. The CPS policy on prosecuting crimes against older people has been particularly helpful in reminding us of that fact. A crime is defined by the act itself and not by the age or circumstances of the victim.

‘Abuse’ is defined as an illegal, improper or harmful practice, while ‘harm’ is defined as an act that causes physical, mental or moral impairment or deterioration. A ‘crime’ however is an action prohibited by law or a failure to act as required by law.

The questions we must answer are these:

- Can we say that there are any situations in which financial abuse is not a crime? Is there any scenario in which it is not theft or fraud?
- Can we say that there are any situations in which sexual abuse is not a crime? Is there any situation in which it is not an incident that involves sexual contact that is forced on somebody or, in terms of sexual harassment, is not contained within the Sexual Offences Act 2003?
• Can we say that there are any situations in which physical abuse is not a crime? Is there any situation in which it is not violence, bodily harm, or physical contact with another person without their consent?

• Can we say that there are any situations in which psychological abuse is not a crime? Is there any situation in which it is not the wilful infliction of mental or emotional anguish by threat, humiliation, or other verbal and non-verbal conduct?

Regardless of the causes of these four types of abuse, or indeed the intention of the perpetrator, it is difficult to argue that crimes have not been committed. It is only when they are placed in a social policy context that the seriousness and impact is lessened. But the question remains, do we make a distinction between the physical abuse of a child and its status as a crime? And in none of the above situations could it be argued that the situation is different because the victim is an adult with choice, because adults do not choose to be abused or be the victims of a crime. In this context, there is no difference. Scope, in its 2008 report ‘Getting away with murder’, observed,

‘The culture of adult protection often means that professionals do not recognise incidents of hate crime as crimes and attempt to deal with them in-house rather than referring them to the police. This has an impact on the number of crimes, including hate crimes, against disabled people that are reported to the police. More fundamentally it fails to acknowledge that the individual has been the victim of a crime and should be entitled to appropriate redress through the criminal justice system, using euphemistic terms such as abuse and bullying to describe what are in fact crimes against disabled people.’

It is only when we consider neglect that the situation becomes more complicated, not because the impact on the victim is lessened, but because (a) we have not addressed in law the neglect of someone who has capacity but who does not die as a consequence of the neglect and (b) because we make a distinction between the passive neglect by a perpetrator as opposed to wilful neglect.

But, in definition terms, neglect is the failure to give the proper or required care and attention to somebody and, from the victim’s perspective, the motivation of the perpetrator is irrelevant. In that context we do need to consider the implications of the elder abuse prevalence report, which suggested that 62% of those neglecting older people were their own partners. This issue is wider than just definitions because it raises questions about who is responsible; is it the older
partner or society that has failed to adequately implement the Carers Recognition Act and which has routinely and repeatedly redefined social care criteria to exclude people from external support.

While we accept that the terminology used within this environment can be painful for some people, we must keep the focus firmly on the victim. The resistance in the care sector to talk about abuse but instead call these actions poor practice, and the reluctance of the Government to discuss abuse within the NHS and instead focus upon dignity, is about making the acts more palatable, but it does not resolve the issue. Resisting ‘labelling’ a family member a perpetrator (i.e. someone who commits or is responsible for something, usually criminal or morally wrong) is not a debate that would occur in the field of child abuse, whether or not the abusing family member was dysfunctional, inadequate or limited in emotional or physical attributes. If we want to change societal attitudes to abuse we have to face the realities, however uncomfortable, that comes with the task.

10c How do we enshrine within safeguarding the principles contained within the Mental Capacity Act 2005 and the Human Rights Act 1998?

By enshrining these principles within the adult protection framework legislation, and developing consequent codes of practice.
A Survivors’ Response to the No Secrets Review Consultation

“We seem to be at the beginning of public involvement in adult protection processes, particularly concerning the involvement of people with experience of using care services.’

‘How can we learn from people’s experiences of harm and their experiences of the Safeguarding process in order to improve safeguarding?’


Action on Elder Abuse was very keen to engage with service users, and more specifically for the purpose of this consultation, those service users who had experienced abuse, to ensure that AEA’s response to the above consultation was as comprehensive as possible. However, in doing so we recognised that not all victims of abuse are ‘service users’; the definition in No Secrets as to who is entitled to adult protection intervention very much relies on a service user criteria (who is or may be in need of community care services) and this remains a contentious issue.

It is arguably easy to respond strategically to policy documents: what we consider necessary however is to ensure we achieve a consultative outcome that has a real impact on real people. For this to work, we need to hear from the ‘real people’ themselves, and then build their experiences into the conclusions of the consultation.

The following document therefore is the result of engagement with service users who have been through the No Secrets process as a result of alleged or substantiated abuse, or who have not been able to access those processes because of shortfalls in the current system.

Issues this raises:

AEA are very aware of the complexities that can be associated with engaging service users, particularly around those service users who have experienced abuse. There are certain ethical concerns that we must mitigate: By the very nature of this process, we encourage individuals to talk about their experiences, and we must consequently ensure we do not re-victimise them. This re-victimisation would occur if we did not provide the appropriate offers/levels of support to those we ask to discuss what are often emotive and distressing
experiences. We addressed these implications as part of the process of engagement.

Where the information comes from:

The information is collated from information supplied to us through telephone surveys of those people that have previously called the Elder Abuse Response Line and have given consent to be contacted by us again in the future. The purpose of our contact was clearly explained and an attempt made to ask questions based loosely on those contained within the consultation document. However, they questions were only used as a general guide and it was often not appropriate to refer to them at all. The main objective was to encourage people to describe their experiences, what didn’t work and what they thought should change.

The Survivors’ Response

a) Leadership

What was clear from the responses received from survivors was that the system had failed them. Of course, the exact circumstances were different from case to case, and feelings differed somewhat in terms of who should lead both nationally and locally as a means of addressing these failings. But what was clear was that no agency had ‘led’ appropriately in terms of focus, outcomes and ongoing monitoring.

Many respondents felt that it would be better if the police took the lead role, although there was recognition that some abuse cases, particularly those not in regulated care settings, were far more complicated than a straightforward approach toward criminal law and prosecution. There were concerns that the amount of evidence needed for the police to intervene meaningfully in an abuse situation might be too great and many might not meet the criteria at all and so slip through the net. It was also noted that police involvement, or the suggestion of it, could be quite “scary” for victims and may be a further barrier to reporting or resolution.

However, if the lead agency was to become the police, it was suggested that they should risk-assess situations to determine the most appropriate intervention, whether that be a criminal justice one or otherwise. All respondents recognised the need for multi agency working with the most appropriate agencies then leading and being accountable, depending upon a comprehensive assessment of the situation.
b) Prevention

The overwhelming response was that not enough was being done in terms of prevention. There were various suggestions of prevention methods, in terms of what people thought might have helped avoid the situation they had been through. People felt that awareness raising among the public would be useful, both because it would help people spot abuse happening to others, and - particularly from those respondents who were also the victims (as opposed to those speaking on behalf of victims) - to educate them as to what could happen as a result of certain decisions made. This was felt to be particularly relevant around financial abuse and those instances where people are groomed.

It was noted that in some cases, no preventative methods could have helped but that did not mean that publicity would not help lessen potential abuse.

Better assurances for whistle blowers were clearly needed to help prevent further abuse of people by formal care workers. A theme emerged around recruitment policies. Despite the regulation of these, respondents felt that bad recruitment had led to the abuse of adults; it was felt that this was rife but very easily remedied by policies being robust and, importantly, live. It was felt that this adherence to policies could be easily monitored and enforced by the regulator.

There was also a very worrying theme that emerged around complaint making; that of ‘closing ranks’. Many people felt that once they had made a complaint, some agencies were actually obstructive in terms of the adult protection process. It seemed clear that there was no impetus to learn from mistakes, but rather it was better to deny them ever happening to ‘cover one’s back’. One respondent said he could accept that mistakes happened, and really wished there was more of a ‘no blame’ culture so that we could learn from them. (This has been one of the issues raised in serious case reviews). However, he did feel that there should be clear levels of accountability and that systemic failures should be the responsibility of senior members of staff.

There is, of course, a dichotomy here: to learn from mistakes, blame has to be apportioned, blame must be linked to accountability and so it is easy to see how “closing ranks” and cover ups can be a prevailing ethos.
c) Outcomes

From all respondents contacted there was a dearth of any evidence of outcomes based intervention, particularly as defined by the ‘best interest’ of the victim. People seemed to get lost in the process and the bureaucracy, and were often passed from pillar to post while little was being done to safeguard the individual victim. For example, one individual had to contact the health ombudsman, who after some time instructed he must go back to the Trust and discuss his concerns, despite the fact that his complaint was about the Trust in terms of the way they had handled his complaint!

It was felt that, often, the use of procedure was sacrificed in place of common sense, which did not help to resolve the matter. Outcomes often seemed to be in the best interest of the Care home owner, or the hospital, or the local authority, or the domiciliary care agency. Not one respondent was able to suggest what the outcome focus was in terms of the abused person, and none attributed any positive resolution of the problem to the Safeguarding process itself.

Respondents continually returned to the importance of ‘listening’ to the victim: both in terms of the alleged abuse and in terms of what resolution they wanted.

d) Managing Risk

There was an accepted feeling that that people should of course have as much choice and control as possible. However, it was suggested that there needed to be a much better risk-assessing culture and close monitoring of ongoing situations where the potential for abuse existed. Risk assessment it was felt, needed to be a rolling programme.

Also, people felt strongly that there should be much better information giving: i.e. people said they were often not aware of the risks they were taking and things would have been better if they had been armed with the relevant information to ensure that the risks taken were informed ones.

It was also felt that people needed to be expert in assessing risk so that the outcome was the least restrictive but still managed the risk: risk assessment should not be about dis-empowering but equally, should not be an excuse for allowing people to be abused as a consequence of encouraging and allowing choice. There was also mention made about the risk averse nature of institutions. Risks were minimised but in a very restrictive way.
It is important to note here that many of the respondents were speaking on behalf of victims, which is perhaps particularly pertinent to the question around risk. They may well see protection as the main objective, without being concerned about the disempowerment that may also occur. However, those respondents who were the victims seemed to have no issue around being risk assessed, providing it was done appropriately. What they really wished was that they had been made more aware of the possible repercussions of their actions before it was too late.

d) Personalisation

It was quite difficult to elicit responses on this area. Although the concept was explained to respondents, few had had any direct experience of ‘personalisation’.

When direct payments were discussed, respondents were surprised that employers were not legally bound to CRB check personal assistants. The respondents who had serious concerns about the recruitment procedures of agencies and homes as a result of their experiences felt this was a very bad idea; recruitment of ‘good’ and ‘appropriate’ staff being seen as key to preventing this type of abuse.

e) Health Services and Safeguarding

There was a strong feeling that the NHS did not engage with Safeguarding.

Initially many of the respondents felt that the NHS was there to ‘make people better’ but not in a holistic sense, so that it was not their role. Upon discussion however, of those cases where contact with the NHS featured, it was felt that things could have been better if NHS staff in health settings had been engaged with safeguarding procedures.

It was stated that the NHS did not look at ‘context’, which was felt to be a negative. For various reasons, particularly around discharging a patient to a place of safety, this could be a real problem. One of the respondents whose father was abused in a hospital suggested that the NHS proactively did not engage with safeguarding procedures for fear of being exposed; to the point that both the medical notes and the notes of the investigation into what happened were ‘lost’, leaving the victim’s son without answers to anything.

People suggested that the NHS needed to remember it was providing a service to people, not ‘doing them a favour’. There was mention of GPs...
not being aware of the quite dangerous situations some people were in. One respondent was still amazed that police photos of the physical abuse inflicted on his mother showed extensive bruising, while the GP’s written report said that there was ‘some evidence of slight rough handling’.

Also mention was made of GPs taking on board social workers analysis of a situation rather than listening to the victim or family; in fact, one respondent said the GP would not even come out to the care home to view her father.

g) Safeguarding, Housing and community Empowerment

People felt that it was important to empower older people in the community. A strong theme that came out of all the responses was that the views of older people themselves should not be dismissed.

One respondent felt that networks of older people leading on Safeguarding, housing and community empowerment should be formed to ensure that they were truly empowered. All respondents thought that every appropriate agency should be engaged with safeguarding.

h) Access to the Criminal Justice System

Unfortunately, from this sample, access to the criminal justice system had not been successful.

Various issues emerged: In most cases, the police were involved and yet, in all instances, for one reason or another there was no successful prosecution. Reasons for this varied from perpetrators jumping bail to the police deciding they could not prosecute as it was not a pre-meditated assault. This made for worrying analysis, particularly in one case where the police allegedly wrote a letter to the daughter of a man abused suggesting she keep quiet about the case, because in her quest for justice she had engaged the media.

A number of respondents felt the police were not always the most appropriate agency to deal with the abuse because, in their experience, the amount of evidence needed was too great for a court case. This meant arduous investigation and emotional ups and downs for the victims and families that often came to nothing. This sometimes had a detrimental effect on any further attempt to safeguard the victim as the ‘case was closed’.
i) Legislation

It was clear from all respondents that agencies did not effectively share information. All respondents thought legislation would help with this and also would encourage transparency and accountability.

Every respondent had the experience of being told ‘it was somebody else’s responsibility’. The lack of clarity around responsibilities was quite staggering.

Some respondents felt that complaints processes should have a legislative underpinning as many were left confused and frustrated at the responses their complaints were met with.

People certainly felt there was a lack of meaningful cooperation and thought that legislation would ensure that timescales would be adhered to.

Legislation, it was felt, should have an outcomes focus. For instance, it was suggested that it was less important that a room was a certain size than how the service user felt. This should also apply to abuse in a domestic setting, where outcomes for the older person should be at the heart of any intervention.

j) Definitions

Interestingly, this did not bother any of the respondents.

They felt that the definition should apply to anyone who might be less able to protect themselves than others. However, it was not appropriate that it should apply to all people, but just to those who, for some reason, may be more vulnerable to abuse.

Although many thought abuse should be described as crime, there was some concern, (as discussed earlier), that the police did not always understand the complexities of abuse situations and that the balance of evidence needed might be too great. Respondents were worried that if we called abuse a crime and it could not be resolved via the criminal justice system, then victims might be left with no resolution at all.

Almost all respondents felt a distinction needed to be made around the use of the word ‘perpetrator’ so that those carers struggling to meet care needs and buckling under pressure were not seen in the same as those
who chose to adopt a pattern of abusive behaviour and exploit the power dynamic in a relationship.

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