COIMISIÚN UM ATHCHÓIRIÚ AN DLÍ
LAW REFORM COMMISSION

REPORT

A REGULATORY FRAMEWORK FOR ADULT SAFEGUARDING

VOLUME 3

(LRC 128 - 2024 VOL. 3)

Report

A Regulatory Framework for Adult Safeguarding

(LRC 128 - 2024)

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Styne House, Upper Hatch Street, Dublin 2, D02 DY27

T. + 353 1 637 7600

E. info@lawreform.ie

W: http://www.lawreform.ie

Twitter: @IrishLawReform

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Mr Justice Frank Clarke, former judge of the Supreme Court

Commissioner (full-time):
Mr Richard Barrett, Barrister-at-Law

Commissioner:
Mr Justice Maurice Collins, judge of the Supreme Court

Commissioner:
Ms Justice Niamh Hyland, judge of the High Court (Member of the Commission until 1 February 2024)

Commissioner:
Dr Andrea Mulligan, Assistant Professor of Law at Trinity College Dublin, and Barrister-at-Law

Commissioner:
Ms Justice Eileen Roberts, judge of the High Court (from 1 February 2024)

Commission Staff

Law Reform Research

Director of Research:
Siobhán Ní Chúlacháin, Barrister-at-Law, LL.M, BCL, Teastas Eorpach na Gaeilge (NUI) (appointed January 2024)

Deputy Director of Research:
Leanne Caulfield, BCL, LLM, Prof. Dip. (NUI)

Access to Legislation

Manager:
Alma Clissmann, BA (Mod), LLB, Dip Eur Law (Bruges), Solicitor

Deputy Managers:
Fiona Carroll, BA (Mod), LLB, Solicitor
Dr Kate Doran, BCL, LLM (NUI), PhD (UL), Barrister-at-Law

Statute Law Revision

Statute Law Revision Programme Manager:
Matthew Doncel, BCL (UCD), LLM (UCC)

Administration

Head of Administration:
Bríd Rogers

Executive Officers:
Katie Conlon
Kevin Gibson
Gavin Walsh

Library and Information Services

Library and Information Manager:
Sarah Foley, BA (Hons) (UCC), PGDip ILS (Aberystwyth)

Legal Researchers

Aoife Enright, LLB (Dubl)

Colin Grant, BCL (UCD), BCL (Oxon), CIPP/E, Solicitor

Steven Marren, BA, LLB (UL)

Jenny McDonnell, BCL (UCC)

Síona Molony, LLB (Dubl), LLM (Harv)

Cameron Moss, LLB (NUI), LLM (EALT)

Morgane Nerrou, LLB, LLM (Toulouse), LLM (Strasbourg), MPhil

(NUI) Fiachra Ó Cochláin, BCL (UCD), Solicitor

Kiri O'Neill, BCL (UCD)

Katey Tolan, LLB (Dubl), LLM (NUI)

Caoilin Young, LLB (Dubl), LLM (UM)

Research Team for this Report

Coordinating Commissioner:
Dr Andrea Mulligan, Assistant Professor of Law at Trinity College Dublin, and Barrister-at-Law

Research manager:
Leanne Caulfield, BCL, LLM, Prof. Dip. (NUI)

Principal Legal Researchers:

Colin Grant, BCL (UCD), BCL (Oxon), CIPP/E, Solicitor

Clodagh Hunt-Sheridan, BCL (UCD), LLM (Amsterdam)

Síona Molony, LLB (Dubl), LLM (Harv)

Ciara O'Brien, LLB (Dubl), LLM (Edin)

Katey Tolan, LLB (Dubl), LLM (NUI)

With additional research support from:

James Egleston, LLB, MA (NUI)

Steven Marren, BA, LLB (UL)

Morgane Nerrou, LLB, LLM (Toulouse), LLM (Strasbourg), MPhil (NUI)

Kiri O'Neill, BCL (NUI)

Dr Sophie van der Valk, BCL (Law and German), LLM (Leiden), PhD (Dubl)

Caoilin Young, LLB (Dubl), LLM (UM)

With additional support on the plain English and easy-to-read versions from:

Matthew Doncel, BCL (UCD), LLM (UCC)

Aoife Enright, LLB (Dubl)

Jenny McDonnell, BCL (UCC)

External consultants:

Denis Healy, Solicitor

Legal Interns:

James Donohoe, LLB (Dubl)

Maureen Noonan, LLB (UL)

Jacqueline van Humbeeck, LLB (UCLouvain), LLM (York)

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Alex Davidson, Independent Chair, Inverclyde Adult Support and Protection Committee, Argyll and Bute Adult Support and Protection Committee, Orkney Public Protection Committee, Scotland

Allied Irish Bank

ALONE

Banking & Payments Federation Ireland

Clare Barry, Assistant Commissioner, Frontline Legal, Data Protection Commission

Bank of Ireland

Senator Frances Black

Georgeta Botas, Assistant Commissioner, Health, Voluntary, Local Government & Public Sector Data Sharing Consultation & Supervision, Data Protection Commission

Brothers of Charity National Advocacy Council

Jason Byrne

Care Alliance Ireland

Central Bank of Ireland

Child and Family Agency

Citizens Information Board

Mary Clancy

Frances Clifford, Principal Social Worker, CHO1 (Donegal, Sligo, Leitrim, Cavan and Monaghan), Health Service Executive (HSE)

Eimear Corcoran, Senior Case Officer, Data Protection Commission

Rebecca Coen, Director of Criminal Enforcement, Corporate Enforcement Authority (and formerly Director of Research at the Law Reform Commission from February 2020 to September 2023)

Paul Comley

Mary Condell, Legal Advisor, Sage Advocacy

Dr Sinead Connelly, Senior Lecturer, Department of Law and Criminal Justice, South East Technological University (SETU)

John Costello, Solicitor

Teresa Cronin, Director of Nursing, Health Service Executive (HSE) National Safeguarding Office

Anne Cunningham, Solicitor

Aileen Curry, Solicitor

Data Protection Commission

Department of Children, Equality, Disability, Integration and Youth

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Department of Social Protection (Safeguarding Unit)

Disability Rights Lawyers Network

Disclosure and Barring Service (England, Wales, the Channel Islands and the Isle of Man)

Professor Mary Donnelly, School of Law, University College Cork

Dr Sarah Donnelly, Assistant Professor of Social Work, School of Social Policy, Social Work and Social Justice, University College Dublin

Karl Dowling BL

Bernice Evoy, Solicitor, Head of Legal & Regulation, Banking & Payments Federation Ireland

Niall Farrell, Solicitor

Vinog Faughan SC

Mark Felton, Solicitor

Michael Foley, MSc, CQSW

Caoimhe Gleeson, National Programme Manager, National Office for Human Rights and Equality Policy, Health Service Executive (HSE)

Tim Hanly, General Manager, Health Service Executive (HSE) National Safeguarding Office

Denis Healy, Solicitor

Mary Healy Whitling

Michael Hennigan, Head of Function, Consumer Policy & Research, Central Bank of Ireland

Donal Hurley, Principal Social Worker, Health Service Executive (HSE) National Safeguarding Office

Áine Hynes SC

Garda National Protective Services Bureau (GNPSB)

An Garda Síochána Analysis Service (GSAS)

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Health Information and Quality Authority (HIQA)

Health Service Executive (HSE) CHO2 (Galway, Roscommon and Mayo) Safeguarding and Protection Team

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Justice and Community Safety Directorate, Australian Capital Territory Government

Colette Kelleher

Professor Brendan Kelly, Trinity College Dublin

Colm Kelly, Solicitor

Ann Kennedy

Liam Keogh, Social Work Manager, Daughters of Charity Disability Support Services Limited (Social Work Department, Dublin 7)

Martin Keville, Assistant Principal Officer, Safeguarding Unit, Department of Social Protection

Andrew Lacey, Superintendent, An Garda Síochána

Pauline Levins, Principal Social Worker, CHO2 (Galway, Roscommon and Mayo), Health Service Executive (HSE)

Kerry Loveland, Head of Safeguarding Unit, Disability and Older People's Directorate, Department of Health, Northern Ireland

Sarah Mahon, Principal Social Worker, Health Service Executive (HSE) National Safeguarding Office

Dr Kathryn Mackay, Lecturer in Social Work, University of Stirling

Attracta McLoughlin, Higher Executive Officer, Safeguarding Unit, Department of Social Protection

Maggie McNally, Principal Social Worker, CHO3 (Clare, Limerick, North Tipperary and West Cork), Health Service Executive (HSE)

Paula McNelis, Department of Health and Social Care, England

Mental Health Commission

Ministry of Justice, New Zealand

Deirdre Morgan

Mothers' Union

Eithne Muldoon

David Murphy, Deputy Commissioner, Public Sector Supervision, Data Protection Commission

Dr Deirdre Murphy

Kristen Murphy, Principal Social Worker, CHO6 (Wicklow, Dun Laoghaire and Dublin South East), Health Service Executive (HSE)

Mr Justice Kerida Naidoo, judge of the High Court

National Adult Literacy Agency (NALA)

National Advocacy Service for People with Disabilities

National Disability Authority

National Federation of Voluntary Service Providers

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Gareth Noble, Solicitor

Niall Nolan BL

Louise Norton, Law Commission, New Zealand

Nursing Home Quality Initiative

Robert O'Connor, Principal Social Worker, CHO5 (South Tipperary, Carlow, Kilkenny, Waterford and Wexford)

Office of the Director of the Decision Support Service

Office of the Director of Public Prosecutions

Office of Minors and Wards of Court

Office of Parliamentary Counsel, Tasmania

Professor Colin O'Gara

Professor Shaun O'Keefe, College of Medicine, University of Galway

Dr Maeve O'Rourke, University of Galway

Dr Roisín O'Shea, Mediator

Nora Owen

Laura Pauley, Acting Principal, CHO7 (Kildare, West Wicklow, Dublin West, Dublin South City and Dublin South West), Health Service Executive (HSE)

Bridget Penhale, Emeritus Reader, School of Health Sciences, University of East Anglia

David Petticrew, Strategic Planning and Performance Group, Northern Ireland

Professor Michael Preston-Shoot, Professor Emeritus (Social Work), University of Bedfordshire

Tina Quealy, Solicitor

Queensland Law Reform Commission

Rape Crisis Network Ireland

Brian Rigney

Rosemarie Rogers, Buddle Findlay, New Zealand

Alex Ruck Keene KC (Hon), 39 Essex Chambers, London

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Safeguarding Ireland

Sage Advocacy

Maura Seabrooke, Principal Social Worker, CHO8 (Laois, Offaly, Longford, Westmeath, Louth and Meath), Health Service Executive (HSE)

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Brian Spierin SC

Stephen Spierin BL

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Glossary

Term	Definition
Abuse	A single or repeated act or failure to act that has a negative impact on a person. Abuse can involve physical abuse, emotional abuse, sexual abuse or financial abuse. This is not an exhaustive list of the forms of abuse.
Adult at risk of harm/at-risk adult	A person who is not a child, and by reason of their physical or mental condition or other particular personal characteristics or family or life circumstance (whether permanent or otherwise) needs support to protect themselves from harm at a particular time.
Adult safeguarding	Measures that are, or may be, put in place to promote the health, safety and welfare of at-risk adults, minimise the risk of harm to at-risk adults, and support at-risk adults to protect themselves from harm.
Adult Safeguarding Review	A learning review to identify ways to improve the safety, quality and standards of adult safeguarding services in response to very serious adult safeguarding incidents that meet a high threshold. In Chapter 17, the Commission recommends that Adult Safeguarding Reviews should be established on a statutory basis in Ireland (i.e. contained in Irish legislation).
Adult safeguarding statement	A written statement prepared by a provider of a relevant service which outlines the policy, procedures and measures that the provider has in place to minimise the risk of harm to adults availing of the service including adults who are, may be, or may become at-risk adults. In Chapter 7, the Commission recommends the components of an adult safeguarding statement.
Approved centre	A service regulated by the Mental Health Commission under the Mental Health Act 2001 to provide in-patient treatment to people experiencing mental illness or mental disorders.
At-risk customer	An at-risk adult who is a customer of a regulated financial service provider.
Authorised officer	A person appointed by the Safeguarding Body to carry out functions of the Safeguarding Body under the Commission's Adult Safeguarding Bill 2024.
Autonomy	The right to make decisions and take actions that are in line with one's beliefs and values.
Barred lists	Databases containing details of individuals who are banned from working or volunteering with children or at-risk adults

	due to past behaviours (which may have fallen below the threshold for a certain criminal offence to have been committed) or because they have committed certain criminal offences. Barred lists are in place in other jurisdictions but are not currently in place in Ireland.
Capacity	Decision-making capacity as defined in the Assisted Decision-Making (Capacity) Act 2015. A person's ability to make decisions for themselves. This is based on the person's ability to make a specific decision about something, at a specific time.
Care plan	A plan that outlines the health, personal and social care needs of an adult availing of a service and how a service intends to meet those needs in line with the adult's preferences. This is usually developed between the service and the adult concerned following an assessment of care and support needs.
Care setting	The place where a person receives care, for example, a person's home, a hospital, a nursing home, a residential centre, or a day service.
Coercive control	A pattern of controlling and threatening behaviour. This is a criminal offence under section 39 of the Domestic Violence Act 2018 which criminalises a person knowingly and persistently engaging in behaviour that is controlling or coercive, has a serious effect on a person, and which a reasonable person would expect to have a serious effect on a person. In Chapter 19, the Commission recommends the creation of an offence of coercive control of a relevant person that extends to a broader category of relationships that the existing offence under the Domestic Violence Act 2018.
Coercive exploitation	A new criminal offence proposed by the Commission in Chapter 19. This proposed offence would criminalise a person who, without a reasonable excuse, controls or coerces a "relevant person" so as to get control or be able to exercise control over their property or financial resources to gain a benefit or advantage for themselves or another person.
Committee of the Person / Committee of the Estate	In the past, if a person was unable to make certain decisions because of capacity difficulties, they might have been made a ward of court. When a person was made a ward of court, a Committee was appointed to control their assets and make decisions about their affairs. This has changed since most of the provisions of the Assisted Decision-Making (Capacity) Act 2015 came into force in April 2023.

Community Health Organisations	Nine HSE structures providing primary care, social care, mental health, and health and wellbeing services across Ireland. Community Health Organisations are currently being replaced by six health regions as part of the restructuring of the HSE.
Cooperation	A range of bodies working together for a common purpose. It involves the sharing of information, shared decision-making and responsibility, the pooling of resources, and the sharing of expertise and best practice. In Chapter 15, the Commission recommends that the Safeguarding Body, certain public service bodies and certain service providers should have a duty to cooperate with one another to address adult safeguarding concerns.
CORU	The Health and Social Care Professionals Council, otherwise known as CORU, protects the public by promoting high standards of professional conduct, education, training and competence through statutory registration of health and social care professionals in Ireland. It regulates multiple health and social care professions including social workers, occupational therapists, physiotherapists and speech and language therapists.
Cross-sectoral legislation	Legislation that applies to a variety of sectors, instead of one specific sector.
Cuckooing	A practice where a person or many people take over an at-risk adult's home and use the property for anti-social behaviour or criminal activity.
Day services	Services provided to adults with disabilities and older adults in day centres where they participate in activities such as recreational, social, leisure and rehabilitation activities. These services are usually provided in the community and are non-residential.
Decision Support Service	A service established under the Assisted Decision-Making (Capacity) Act 2015 to support people who face difficulties and need support exercising their decision-making capacity. It is a part of the Mental Health Commission, but it has a separate role. The Decision Support Service promotes awareness of the 2015 Act, regulates and registers decision support arrangements, and supervises the actions of decision supporters.
Designated centre	A service or centre within the meaning of section 2 of the Health Act 2007 that is regulated by HIQA. These services or centres are inspected and monitored by the Chief Inspector of Social Services. It includes residential centres for older people and residential centres for adults with disabilities.

DSGBV Agency ("Cuan")	The Domestic, Sexual and Gender-Based Violence Agency, established on 1 January 2024. The legal name for the Domestic, Sexual and Gender-Based Violence Agency is An Ghníomhaireacht um Fhoréigean Baile, Gnéasach agus Inscnebhunaithe. It will be known as Cuan.
Empowerment and person-centredness	This includes the presumption of decision-making capacity; the facilitation of supported decision-making, where requested or required; ensuring informed consent; respecting the right to autonomy and the right to full and effective participation in society; the realisation of the right to independent advocacy; ensuring respect for will and preferences; ensuring respect for the right to have risks and options explained; and ensuring respect for the right to be consulted at every step of an intervention under adult safeguarding legislation.
Financial abuse	Theft, fraud, exploitation or pressure relating to wills, property, inheritance or financial transactions, including: (a) wrongful or unauthorised taking, withholding, appropriation or use of money, assets or property; (b) action or inaction to control, through deception, intimidation or undue influence, money, assets or property; or (c) wrongful interference with or denial of ownership, use, benefit or possession of money, assets or property.
Financial services	Services involving the investment, lending or management of money, assets or property that are provided by banks, post offices or credit unions.
Harm (civil)	Assault, ill-treatment, neglect or self-neglect in a manner that affects or is likely to affect health, safety or welfare of an at-risk adult, sexual abuse of an at-risk adult, or loss of, or damage to, property by theft, fraud deception or coercive exploitation. It may be a single, series or combination of acts, omissions or circumstances.
Harm (criminal)	Harm to body or mind which includes pain and unconsciousness, any injury or impairment of physical, mental, intellectual, emotional health or welfare, or any form of property or financial loss.
Health care assistant	These workers provide direct personal care and assistance with activities and daily living to patients and residents in a variety of health care settings. They work on implementing care plans and practices and work under the supervision of medical, nursing or other health professionals.
Home support services	Services providing care and assistance to older people and people with disabilities to allow them to live at home. This could include assisting older people and people with

	disabilities with their personal hygiene, their nutrition, or helping them take their medication or helping them to exercise.
HSE National Safeguarding Office	A national office established in 2015 in line with the HSE Social Care Division's Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures. The office oversees the implementation, monitoring, review and ongoing evaluation of the National Policy and Procedures. The office supports the work of the HSE's Safeguarding and Protection Teams.
HSE's National Policies and Procedures	The HSE's Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures published in 2014. It applies to HSE managed or funded disability services and older people's services, and to reports or allegations of harm in respect of adults living in the community who have disabilities or are over the age of 65.
Independent advocacy/ independent advocate	Advocacy support that is provided by an organisation or person who is independent from health and social care service providers and the family of the person receiving the advocacy support. An independent advocate can empower a person to express their will and preferences, communicate their perspectives and engage in decision-making processes that affect their lives.
Inherent jurisdiction of the High Court	A set of default powers, not contained in legislation, which arise from Article 34.3.1° of the Constitution. The powers have been used on a case-by-case basis to vindicate the fundamental constitutional rights of children and certain categories of adults.
International protection	Protection granted by the Government to someone who has left another country to escape being harmed or persecuted. This may include refugee status, subsidiary protection, permission to remain or temporary protection.
Issues Paper	The Law Reform Commission's Issues Paper on a Regulatory Framework for Adult Safeguarding (LRC IP 18-2019) which was published in January 2020.
Mandated person	People who are required by legislation to report actual or suspected abuse. The classes of persons (usually specific professions) who are subject to reporting requirements are generally listed in a schedule to legislation. In this report, where a mandated person knows, believes or suspects, that an at-risk adult has been harmed, is being harmed, or is at risk of being harmed, the Commission recommends that they should be under a statutory duty to report that knowledge, belief or suspicion as soon as possible to the

	Safeguarding Body. See the definition of "reportable harm" below.
Mandatory reporting	Requires the reporting of certain types of actual or suspected abuse or neglect or requires reporting of actual or suspected abuse or neglect in particular settings only, for example, a nursing home. It can also require the reporting of actual or suspected abuse by mandated persons.
Neglect	Neglect in a manner likely to cause an adult suffering or injury to their health or to seriously affect their wellbeing means a failure to adequately protect an adult under a person's care from preventable and foreseeable harm, a failure to provide adequate food, clothing, heating or medical aid, or in circumstances where a person cannot look after an adult under their care, a failure to take steps to have them looked after under relevant legislation.
No-contact order	An order proposed in Chapter 13 to be available under adult safeguarding legislation. If granted by the District Court, the order would prevent a non-intimate and non-cohabitating third party from engaging in one or more of the following behaviours: (a) following, watching, pestering or communicating (including by electronic means) with or about an at-risk adult for whose protection the order is made; (b) attending at, or in the vicinity of, or besetting a place where the at-risk adult resides; (c) approaching or coming within a specified distance of the at-risk adult. In addition to "full" no-contact orders, which may last for up to two years, the Commission recommends that interim and emergency no-contact orders be available in particular cases.
Permissive reporting	Permits people to report actual or suspected abuse or neglect of at-risk adults but does not require them by law to do so.
Personal plan	A plan specific to an adult availing of a service that reflects their needs, wishes, abilities and aspirations. Personal plans typically outline the goals an adult wants to achieve and how the service will support them in their personal development. They are tailored to the individual and developed between the service and the adult concerned.

Policing and Community Safety Authority	A body that will soon be established under the Policing, Security and Community Safety Act 2024. Its legal name will be An tÚdarás Póilíneachta agus Sábháilteachta Pobail.
Power of access to at-risk adults in places including private dwellings	A proposed power to allow authorised officers of the Safeguarding Body or members of the Garda Síochána, or both, to access at-risk adults in places, including private dwellings, to assess their health, safety or welfare. This power is exercisable on foot of a warrant issued by the District Court, which will be valid for three days.
Power of entry to and inspection of relevant premises	A proposed power to allow authorised officers of the Safeguarding Body to enter and inspect relevant premises to assess the health, safety or welfare of at-risk adults. The power is exercisable without a warrant, although a warrant may be obtained if entry and inspection is being obstructed. This would allow for accompaniment by a member of the Garda Síochána.
Power of removal and transfer	A proposed power to allow members of the Garda Síochána, accompanied by authorised officers of the Safeguarding Body, where possible, to remove an at-risk adult from where they currently are, and transfer them to a designated health or social care facility or other suitable place. The power would not allow for detention of an at-risk adult in the facility or suitable place. The power is exercised to assess the at-risk adult's health, safety and welfare, and assess whether any actions are needed to safeguard them, where this cannot be done in the place where the at-risk adult currently is. This power is exercisable on foot of an order issued by the District Court and is valid for three days.
Prevention	Proactive steps are taken to minimise the risk of harm to adults, including adults who are, may be or may become at-risk adults before harm occurs.
Relevant person	The term used to describe a specific category of at-risk adults against whom the Commission's proposed offences in Chapter 19 can be committed. A relevant person means an adult whose ability to guard themselves against violence, exploitation, abuse or neglect by another person is significantly impaired through (a) a physical disability, physical frailty, illness or injury, (b) a disorder of the mind, such as mental illness or dementia, (c) an intellectual disability, (d) autism spectrum disorder.
Regulated financial service provider	A financial service provider whose service is regulated by the Central Bank of Ireland or an authority in a country in the European Union, Iceland, Liechtenstein or Norway whose

	functions are comparable to the functions of the Central Bank of Ireland.
Regulated profession	A profession where access to, or the practice of, the profession is restricted to those who meet professional qualifications required by law.
Relevant premises	Certain premises in which adults, who may be at-risk adults, are likely to be residing in, and in receipt of care or services. This includes "designated centres", "approved centres", hospitals and residential centres for adults in the international protection process. The full list of premises is set out in Chapter 10.
Relevant service	Any work or activity provided by a person or organisation, a necessary and regular part of which consists mainly of a person or organisation having access to, or contact with adults, or adults who are, may be, or may become at-risk adults.
Reportable harm	Assault, ill-treatment or neglect in a manner that seriously affects, or is likely to seriously affect, health, safety or welfare, sexual abuse, or serious loss of, or damage to, property by theft, fraud, deception or coercive exploitation. This harm can be caused by a single act, omission or circumstances, or a series or combination of acts, omissions or circumstances. It excludes self-neglect where the person has capacity or is believed to have capacity to make personal care or welfare decisions.
Residential care settings	Where an adult who is, may be, or may become an at-risk adult is living in residential care, such as a public or private nursing home or a residential centre for people with disabilities, including a centre providing temporary residential respite care.
Rights-based approach	Ensuring that the rights of at-risk adults are respected, including their rights to autonomy, respect, dignity, bodily integrity, privacy, control over financial affairs and property, non-discrimination, equal treatment in respect of access to basic goods and services, and respect for their beliefs and values.
Risk assessment	A process to identify any risks arising in the provision of services to adults or adults who are, may be, or may become at-risk adults.
Safeguarding and Protection Teams	Teams of social workers established within the HSE, with responsibility for assessing and managing reports or concerns regarding abuse or neglect in HSE managed and

	funded services for older people and people with disabilities, and safeguarding referrals arising in the community. The teams support services in investigating reports, and directly assess complex cases. They also provide quality assurance, oversight and advisory support to HSE managed and funded services for older people and people with disabilities, provide training regarding adult safeguarding, and collate and publish data.
Safeguarding plan	A plan that is prepared where there is an adult safeguarding concern in relation to an adult availing of a service. It outlines the planned actions that have been identified to address the adult's needs and minimise the risk of harm to that adult or other adults within the service. It may be incorporated into a care plan or personal plan.
Self-neglect	Inability, unwillingness or failure of an adult to meet their basic physical, emotional, social or psychological needs, which is likely to seriously affect their wellbeing.
Serious harm	Injury which creates a substantial risk of death, is of a psychological nature which has a significant impact or causes permanent disfigurement or loss or impairment of the mobility of a body as a whole or of the function of any particular member or organ.
Social care	The planning and provision of services and supports to individuals who need them. This may include, for example, the provision of "Meals on Wheels", personal assistance, home care and home support, nursing care or residential services. It also encompasses delivery mechanisms and processes such as eligibility assessments and personal budgets.
Summary power of access to at-risk adults in places including private dwellings	A proposed power to allow members of the Garda Síochána to access at-risk adults in places including private dwellings, where the member reasonably believes there is a risk to the life and limb of the at-risk adult. This power is exercisable without a warrant, and is to be used when there is insufficient time to make an application for a warrant for access to the District Court. This summary power reflects the existing position under the common law, but adds clarity and strengthens the applicable safeguards.
Transitional care arrangements	Arrangements for young people as they move from the care of the State to aftercare, independent living, supported living or residential care. They can also be put in place when

	young people move from children's social care services to adult social care services.
Undue Influence	Exploitation of a position of power to cause a person to act, or not act, in a way that is detrimental to their best interests and which confers, or intends to confer, a benefit or advantage on another person.
United Nations Convention on the Rights of Persons with Disabilities ("UNCRPD")	An international agreement which aims to protect the human rights and fundamental freedoms of people with disabilities.
Universal mandatory reporting	Requires everyone to report actual or suspected abuse or neglect of at-risk adults, irrespective of the setting or profession.
Vetting	Enquires and examinations conducted by the National Vetting Bureau of the Garda Síochana, employers recruiting employees or bodies recruiting volunteers to determine whether or not a person applying for work or activity, a necessary and regular part of which consists mainly of the person having access to, or contact with, children or "vulnerable persons", has a criminal history or criminal convictions. has any This is required by Irish vetting legislation for some professions and volunteer groups.
Ward of Court	In the past, if a person was unable to make certain decisions because of capacity difficulties, they might have been made a Ward of Court to protect them and their property. When a person was made a Ward of Court, a Committee was appointed to control their property and finances and make decisions about their affairs, including their welfare. This has changed since most of the provisions of the Assisted Decision-Making (Capacity) Act 2015 came into force in April 2023.
Wardship	The legal practice of a person being made a Ward of Court. The purpose of wardship was to protect the person and their property and finances when they lacked the capacity to do so themselves. The arrangements under the Assisted Decision Making (Capacity) Act 2015 are now replacing wardship, and all existing Wards of Court are being gradually discharged from wardship.
Warrant	An order granted by a court, usually allowing named individuals (such as members of the Garda Síochána) to enter a particular place and search it. The Commission discusses warrants for access in the adult safeguarding context in Chapters 10 and 11.

The following abbreviations are used throughout this Report:

Abbreviation	Definition
ALRC	Australian Law Reform Commission
APC	Adult Protection Committee
ASPP	Adult Support and Protection Partnership
ASU	Adult Safeguarding Unit (South Australia)
CBI	Central Bank of Ireland
CCPC	Competition and Consumer Protection Commission
CEO	Chief Executive Officer
CFA	Child and Family Agency
CHO	Community Health Organisation
CIB	Citizen's Information Board
CIS	Care Inspectorate Scotland
CIW	Care Inspectorate Wales
CO	Chief Officer of the HSE Community Health Organisation
COG	Chief Officer Group in the HSE
CORU	Health and Social Care Professionals Council
CPC	Consumer Protection Code
CQC	Care Quality Commission
DBS	Disclosure and Barring Service
DHSSPS	Department of Health, Social Services and Public Safety in Northern Ireland
DPA	Data Protection Act
DPC	Data Protection Commission
DPO	Data Protection Officer
DSGBV	Domestic, Sexual and Gender Based Violence
DSS	Decision Support Service
ECB	European Central Bank
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EDPB	European Data Protection Board
EEA	European Economic Area
EU	European Union
GDPR	General Data Protection Regulation (EU) 2016/679
HCA	Health Care Assistant
HCCI	Home and Community Care Ireland
HCSA	Health Care Support Assistant
HETAC	Higher Education and Training Awards Council
HIQA	Health Information and Quality Authority
HIS	Healthcare Improvement Scotland
HMICS	His Majesty's Inspectorate of Constabulary in Scotland

HSE	Health Service Executive
HSENI	Health and Safety Executive for Northern Ireland
IASW	Irish Association of Social Workers
ICO	Information Commissioner's Office
IFSAT	Irish Financial Services Appeal Tribunal
IHA	Integrated Health Area
IPAS	International Protection Accommodation Service
ISCO	International Standard Classification of Occupations
LCDC	Local Community Development Committee
LCSP	Local Community Safety Partnership
LED	Law Enforcement Directive (EU) 2016/680
MABS	Money Advice and Budgeting Service
MHC	Mental Health Commission
NAS	National Advocacy Service for People with Disabilities
NDA	National Disability Authority
NGO	Non-governmental organisation
NHS	National Health Service
NISCC	Northern Ireland Social Care Council
NIRP	National Independent Review Panel
NMBI	Nursing and Midwifery Board of Ireland
NPHET	National Public Health Emergency Team
NMBI	Nursing and Midwifery Board of Ireland
NSO	National Safeguarding Office
OECD	Organisation for Economic Co-operation and Development
OPCAT	United Nations Optional Protocol to the Convention against Torture
PAS	Patient Advocacy Service
PHA	Public Health Agency
PSNI	Police Service of Northern Ireland
QQI	Quality and Qualifications Ireland
RFSP	Regulated Financial Service Provider
RQIA	Regulation and Quality Improvement Authority (Northern Ireland)
SAB	Safeguarding Adults Board
SAI	Serious Adverse Incident
SALRI	South Australia Law Reform Institute
SAO	Senior Accountable Officer according to HSE Incident Management Framework
SAR	Safeguarding Adult Review
SCR	Serious Case Review
SEC	Securities and Exchange Commission
SPT	Safeguarding and Protection Team

SPPG	Strategic Planning and Performance Group in Northern Ireland
SRE	Serious Reportable Event
SSSC	Scottish Social Services Council
SUSR	Single Unified Safeguarding Review (Wales)
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
VCPR	Voluntary Care Professional Register
WHO	World Health Organisation

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CHAPTER 17
ADULT SAFEGUARDING REVIEWS

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1. Introduction

[17.1] Various terms are used to describe serious incident reviews, such as patient safety reviews, adverse event reviews, sentinel event reviews, learning reviews, and serious case reviews.[1] These reviews are focused on learning from past incidents where things have gone wrong in health or social care settings to improve the quality and safety of services. The purpose of a review is to find out what happened, how it happened and what can be done differently to reduce the likelihood of a similar incident occurring in the future.[2] Serious incident reviews involving at-risk adults are conducted where an at-risk adult is seriously harmed or dies as a result of actual or suspected abuse or neglect. While their purpose is similar to general incident reviews, there is often an increased emphasis on identifying ways that agencies and organisations responsible for safeguarding at-risk adults can work better together to improve service delivery.

[17.2] Some jurisdictions provide for specific adult safeguarding reviews when a serious incident occurs involving an at-risk adult. Other jurisdictions carry out reviews of health and social care incidents more generally, which encompass incidents involving at-risk adults. Where adult safeguarding specific reviews take place in other jurisdictions, they may be required by statute, but they can also take place on a non-statutory basis arising out of local or national policies or guidance. Where provisions for adult safeguarding specific reviews are in place, some jurisdictions distinguish between older people and people with disabilities when it comes to reviewing incidents due to different regulatory frameworks.

[17.3] The purpose of this Chapter is to examine the review mechanisms that currently exist in Ireland where a serious incident involves an at-risk adult and to consider whether reform of the law is needed to introduce adult safeguarding specific reviews of serious incidents on a statutory basis for very serious incidents. This Chapter:

- discusses existing mechanisms for reviewing serious incidents involving at-risk adults in Ireland;

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1 Hegarty and others, "An International Perspective on Definitions and Terminology Used to Describe Serious Reportable Patient Safety Incidents: A Systematic Review" (2021) 17(8) Journal of Patient Safety 1247.

2 Mental Health Commission and Health Information and Quality Authority, *National Standards for the Conduct of Reviews of Patient Safety Incidents* (MHC and HIQA 2017) at page 13 < https://www.hiqa.ie/sites/default/files/2017-10/National-Standards-Patient-Safety-Incidents.pdf> accessed 6 April 2024; Health Service Executive, *Incident Management Framework* (HSE 2020) at page 27 https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf accessed 6 April 2024.

- explores review mechanisms for incidents involving at-risk adults in England, Scotland, Wales and Northern Ireland;
- analyses the need for reform in Ireland by considering how the system for reviewing very serious incidents involving at-risk adults could be improved; and
- makes proposals for reform by recommending the introduction of adult safeguarding reviews on a statutory basis to review very serious incidents, which are serious incidents that meet a high threshold for a mandatory review, as identified by the Commission in section 5 below.

2. Current system

[17.4] At present, there are a number of different review methods that can be used where a serious incident, which concerns an at-risk adult, occurs in a health or social care setting. The majority of these methods are not specific to at-risk adults and are of more general applicability. There is no prescribed avenue or set process for deriving learning from the most serious incidents involving at-risk adults. The existence of multiple review processes means that the approach can vary depending on the circumstances of each case, and the extent of the public scrutiny and reaction. In some cases, more than one review method is used,[3] which can result in:

- delay in disseminating learnings;
- distress for at-risk adults and their family members;
- duplication of process; and
- protracted investigations/ lack of finality.[4]

[17.5] Below, the Commission considers each of the review methods that may be used where a serious incident, which involves an at-risk adult, occurs.

(a) Health Service Executive (HSE) Internal Reviews

(i) HSE Incident Management Framework

[17.6] The HSE Incident Management Framework sets out the principles, governance requirements, roles and responsibilities and processes to be applied for the

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3 See for example, the 'Emily' case which resulted in three reviews; (1) a local Safeguarding and Protection Team review, (2) a National Independent Review Panel review, and (3) an independent review by Jackie McIlroy. See also the Leas Cross Nursing Home case which resulted in two reviews; (1) an independent review by Professor Desmond O'Neil and (2) a Commissions of Investigation review.

4 Although the different review processes may relate to the same incident, at-risk adult, or service setting, subsequent reviews after the first one may be considering aspects that stem from the initial incident, but do not cover the exact same ground.

management of incidents in all service areas.[5] While it applies across health and social care settings, to clinical and non-clinical incidents, it only applies to publicly funded health and social care services, including Community Health Organisations ("CHOs").[6] In 2022, 556 Serious Reportable Events ("SREs") were recorded on the HSE's National Incident Management System, with 106 occurring in social care settings and 66 in mental health services.[7]

[17.7] The Incident Management Framework identifies three categories of incidents:

- Category 1 Major/ Extreme
- Category 2 Moderate
- Category 3 Minor/ Negligible.[8]

[17.8] Category 2 and Category 3 events can be investigated by the HSE internally and are typically completed in the HSE Community Health Organisation where the incident occurs.[9] There are currently nine HSE Community Health Organisations but it should be noted that these structures will be replaced with six Health Regions that are geographically aligned to provide more integrated services between hospital and community care.[10] For further discussion, see the background section of this Report.

[17.9] Category 1 incidents are considered the most serious and therefore a review requires formal commissioning by the Senior Accountable Officer ("SAO").[11] The SAO is the person who is ultimately accountable and responsible for the services

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5 Health Service Executive, *Incident Management Framework* (HSE 2020).

6 Health Service Executive, *Incident Management Framework* (HSE 2020) at page 9.

7 McDermott, "Twelve patients reported to have been sexually assaulted in mental health facilities last year" *The Journal* (22 August 2023) <https://www.thejournal.ie/patients-sexually-assaulted-mental-health-ireland-serious-reportable-incidents-6147930-Aug2023/?utm_source=shortlink> accessed 3 April 2024. Serious reportable events are "a defined subset of incidents which are either serious or that should not occur if the available preventative measures have been effectively implemented by healthcare providers". See Health Service Executive, *Incident Management Framework* (HSE 2020) at page 5.

8 Health Service Executive, *Incident Management Framework* (HSE 2020) at page 3.

9 Category 3 incidents are generally reviewed by the team or department where the incident occurs. This should occur at the time the incident occurs or is identified, and steps should be taken to identify immediate actions required and any further discussions required. Category 2 incidents are generally reviewed by the team or department where the incidents occurs, although there is scope for an incident to be commissioned to the Local Accountable Officer in the service/ hospital. The Local Accountable Officer is defined in the framework as being "the local manager who is responsible for the service in which the incident occurred". This may be a clinical lead, assistant director of nursing, or business manager.

10 Government of Ireland, *Organisation Reform HSE Health Regions Implementation Plan* (July 2023) at page 10 <https://assets.gov.ie/266115/7b86800b-934d-4849-88ae-e8fc4b809465.pdf> accessed 6 April 2024.

11 Health Service Executive, *Incident Management Framework* (HSE 2020) at page 24.

within the area where the incident occurred.[12] When an incident is notified to the SAO, the notification will trigger the activation of the Serious Incident Management Team who will decide how to manage the incident, and monitor progress.[13] A multidisciplinary review team will be established.[14] The guidance notes that those managing the incident should ensure that the Review team is "sufficiently removed from the incident" to ensure there is no conflict of interest.[15] It should also consider whether it is necessary for members of the Review Team to be completely independent from the service where the incident occurred.[16]

[17.10] Incident reviews are used to "determine what happened, how it happened, why it happened, and whether there are any learning points for the service, wider organisation, or nationally".[17] The framework promotes a "just culture", which emphasises that individual practitioners cannot be blamed for system failings, however they should be encouraged to report errors to ensure quality improvement and safety.[18] While the investigations are aimed at managing incidents and identifying immediate actions required, the Incident Management Framework is also aimed at learning from incidents, which have occurred, and at preventing similar incidents from occurring in the future.

[17.11] The Incident Management Framework applies to HSE managed or funded organisations including services that provide services to at-risk adults. While many incidents of abuse or neglect related to at-risk adults would therefore fall to be reviewed under this framework, some fall outside the scope, for example incidents that occur in private nursing homes or care services, which do not receive public funding.[19] Moreover, in contrast to developments in other jurisdictions, discussed further below, this framework applies more generally across the HSE and is not specific to adult safeguarding incidents.

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[12] Health Service Executive, *Incident Management Framework* (HSE 2020) at page 5. In a hospital, this would be the person with delegated responsibility for the service reporting to the Hospital Group's CEO. In a Community Healthcare Organisation, it may be the Head of Service.

[13] Health Service Executive, *Incident Management Framework* (HSE 2020) at page 25.

[14] Health Service Executive, *Incident Management Framework* (HSE 2020) at page 28.

[15] Health Service Executive, *Incident Management Framework* (HSE 2020) at page 28.

[16] Health Service Executive, *Incident Management Framework* (HSE 2020) at page 24.

[17] Health Service Executive, *Incident Management Framework* (HSE 2020) at page 3.

[18] Health Service Executive, *Incident Management Framework – Guidance* (HSE 2020) at page 21.

[19] This may change in the future if the policy proposals in the Department of Health's Public Consultation – Policy Proposals on Adult Safeguarding in the Health and Social Care Sector document are implemented. Its policy proposals are intended to be applied across all health and social care services provided by the HSE including voluntary and private providers.

(ii) HSE Safeguarding and Protection Team Reviews

[17.12] The HSE's Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures document (the "HSE's National Policy and Procedures) sets out the procedures for responding to concerns or allegations of abuse arising in the community and in HSE managed or funded service settings.[20] The first step in this process is a preliminary screening procedure. The outcome of any preliminary screenings of safeguarding concerns that arise in HSE managed or funded services must be notified by the relevant service to the local HSE Safeguarding and Protection teams and actions after this point must be agreed with the HSE.[21]

[17.13] Where there are significant concerns in relation to a "vulnerable person" at any stage in the preliminary screening procedure, the Chief Officer ("CO") of the HSE Community Health Organisation in which the local Safeguarding and Protection Team is based must be notified immediately.[22] The CO must immediately notify the HSE Director of Social Care.[23] Where this arises, consideration should be given to notifying and obtaining advice from the National Incident Management team as the concern may need to be addressed under the Incident Management Framework (2020).[24]

[17.14] Where a preliminary screening establishes that there are reasonable grounds for concern, an internal or independent inquiry may be conducted, or an assessment or review may be undertaken by the relevant Safeguarding and Protection Team.[25] Relevant HSE policies must be considered in establishing an inquiry, and the following issues need to be considered:

- The nature of the concerns;
- If the matters relate to an identifiable person, or incident, or to system issues;
- The impact on confidence in the service; and

[20] Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures* (HSE 2014) at page 27 <https://assets.hse.ie/media/documents/ncr/personsatriskofabuse.pdf> accessed 6 April 2024.

[21] Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures* (HSE 2014) at page 30.

[22] Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures* (HSE 2014) at page 27.

[23] Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures* (HSE 2014) at page 27.

[24] Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures* (HSE 2014) at page 27.

[25] Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures* (HSE 2014) at pages 38 and 39.

- The views of the "vulnerable" person and/or his/her family.[26]

[17.15] Typically, the service manager where the incident occurs will commission the inquiry.[27] However, the HSE Head of Social Care in each Community Healthcare Organisation may decide that it would be more appropriate for an incident or concern to be reviewed by the relevant Safeguarding and Protection Team, as opposed to by the service manager.[28] This approach may be adopted where there are concerns that the involvement of the service manager may result in an unobjective assessment due to possible or perceived conflicts of interest.[29] The report of an inquiry will generally contain certain conclusions and recommendations. Whoever commissioned the report is responsible for receiving the report and determining what further actions are required.[30]

[17.16] A recent example of a Safeguarding and Protection Team review is the review carried out between 2020 and 2021 in the 'Emily' case.[31] A review by the National Independent Review Panel ("NIRP")[32] was also commissioned but the purpose of the Safeguarding and Protection Team review differed from that of the NIRP review– the purpose of the Safeguarding and Protection Team Review was to ascertain whether there were other reportable incidents under the HSE Safeguarding Vulnerable Person's at Risk of Abuse Policy which might need to be reported to the Gardai and investigated accordingly.[33] More recently, the HSE has appointed an independent safeguarding expert to review both reports, examine the issues arising in the 'Emily' case and HSE safeguarding policy, procedures and structures and consider the need for reform.[34]

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[26] Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures* (HSE 2014) at page 38.

[27] Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures* (HSE 2014) at page 38.

[28] Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures* (HSE 2014) at page 39.

[29] Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures* (HSE 2014) at page 39.

[30] Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures* (HSE 2014) at page 39.

[31] Health Service Executive, *Safeguarding Review Team Findings* (HSE 2023) <https://www.hse.ie/eng/services/publications/hse-safeguarding-review-team-findings.pdf> accessed 3 April 2024.

[32] This is a non-statutory review panel set up to investigate serious incidents occurring in health and social care settings.

[33] Health Service Executive, *Safeguarding Review Team Findings* (HSE 2023) at page 1.

[34] Health Service Executive, HSE CEO Announces External Expert to Consider Safeguarding Matters <https://www.hse.ie/eng/services/news/media/pressrel/hse-ceo-announces-external-expert-to-consider-safeguarding-matters.html#:~:text=Press%20Releases-,HSE%20CEO%20Announces%20External%20Expert

[17.17] Much like the HSE's Incident Management Framework, the HSE's National Policy & Procedures do not apply in private service settings such as in private nursing homes, privately provided and funded home care services and private hospitals. Incidents that involve at-risk adults in such settings therefore cannot be reviewed by Safeguarding and Protection Teams.[35]

(iii) Public Consultation on Policy Proposals on Adult Safeguarding in the Health and Social Care Sector

[17.18] As discussed in the background section of the Report, the Department of Health recently published its Public Consultation document on Policy Proposals on Adult Safeguarding in the Health and Social Care Sector.[36] One of the aims and objectives of the policy is to strengthen governance arrangements which includes putting processes in place to "share and apply system-wide learning from safeguarding incidents".[37] Its proposals suggest that the current HSE National Safeguarding Office would be given an expanded remit and be known as the "Sectoral Adult Safeguarding Office". It proposes that one of the functions of the Sectoral Adult Safeguarding Office would be the "dissemination of system learning from safeguarding incidents/investigations etc".[38]

[17.19] The policy suggests that the Sectoral Adult Safeguarding Office will be responsible for implementing processes to allow for standardised recording of safeguarding concerns across all regions and services. It will be the responsibility of services and Regional Safeguarding Teams to submit data to the Sectoral Adult Safeguarding Office on any reports they receiving that contain safeguarding concerns. The proposed policy provides that the Sectoral Adult Safeguarding Office will publish annual data on reported adult safeguarding concerns, analysed by different categories and classifications, as determined by the Office or the relevant Ministers.[39] If implemented, this policy will apply to public and private services within the health and social care sector.

%20to%20Consider%20Safeguarding%20Matters,at%20HSE%20safeguarding%20more%20broadly. > accessed 3 April 2024.

[35] This may change in the future. See Government of Ireland, *Public Consultation Policy Proposals on Adult Safeguarding in the Health and Social Care Sector* (Department of Health 2024) at page 9 <https://assets.gov.ie/282262/80e2ac40-eb19-482a-89e6-357de1c5928f.pdf > accessed 2 April 2024. These Policy Proposals were prepared by the Department of Health.

[36] Government of Ireland, *Public Consultation Policy Proposals on Adult Safeguarding in the Health and Social Care Sector* (Department of Health 2024).

[37] Government of Ireland, *Public Consultation Policy Proposals on Adult Safeguarding in the Health and Social Care Sector* (Department of Health 2024) at page 10.

[38] Government of Ireland, *Public Consultation Policy Proposals on Adult Safeguarding in the Health and Social Care Sector* (Department of Health 2024) at page 15.

[39] Government of Ireland, *Public Consultation Policy Proposals on Adult Safeguarding in the Health and Social Care Sector* (Department of Health 2024) at page 26.

(b) Independent Reviews Commissioned by the HSE

[17.20] The HSE may also commission external experts to undertake independent reviews of serious incidents. Examples of such independent reviews include the Leas Cross review,[40] the Áras Attracta review,[41] and the review in the case of 'Emily'.[42]

[17.21] In the Leas Cross case, Professor Des O'Neill, consultant geriatrician, was commissioned to carry out a review of the deaths of residents of Leas Cross Nursing Home between 2002 to 2005 through inspection and analysis of written documentation, including medical nursing and prescribing notes, hospital records, post-mortem summaries, death certificates, coroner notifications and inquests, correspondence and inspection reports.[43] The terms of reference also included:

1. relating the documents and findings to national and international data and guidelines and morbidity and mortality to institutional care for older people;
2. making recommendations as appropriate to the HSE and Department of Health and Children arising from the findings.[44]

[17.22] The review highlighted the need for a "robust and thorough system of inspections" to ensure standards of care in care settings are of the requisite standard.[45] Actions were taken following publication of the report including the enactment of the Health Act 2007, which put a social services inspectorate on an

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[40] Health Service Executive, *Leas Cross Review by Professor Des O'Neill* (HSE 2006) < https://www.hse.ie/eng/services/publications/olderpeople/leas-cross-report-.pdf> accessed 6 April 2024.

[41] Áras Attracta Swinford Review Group, *What matters most: Report of the Áras Attracta Swinford Review Group* (Áras Attracta Swinford Review Group 2016) < https://www.hse.ie/eng/services/publications/disability/aasrgwhatmattersmost.pdfv> accessed 6 April 2024.

[42] Health Service Executive, HSE CEO Announces External Expert to Consider Safeguarding Matters <https://www.hse.ie/eng/services/news/media/pressrel/hse-ceo-announces-external-expert-to-consider-safeguarding-matters.html#:~:text=Press%20Releases-,HSE%20CEO%20Announces%20External%20Expert%20to%20Consider%20Safeguarding%20Matters,at%20HSE%20safeguarding%20more%20broadly. > accessed 3 April 2024; McIlroy, *Adult Safeguarding Review – Professional Advice to the CEO of the Health Service Executive* < https://www.hse.ie/eng/services/news/newsfeatures/adult-safeguarding/adult-safeguarding-review-2023-ms-jackie-mcilroy.pdf> accessed 3 April 2024.

[43] Health Service Executive, *Leas Cross Review by Professor Des O'Neill* (HSE 2006) at page 2.

[44] Health Service Executive, *Leas Cross Review by Professor Des O'Neill* (HSE 2006) at page 2.

[45] Seanad Éireann Debates, 26 April 2007 vol 186 no 23 at pages 2028 and 2029.

independent statutory footing and contains provisions to underpin a more vigorous inspectorial system.[46]

[17.23] Having considered the report, the Government was of the view that a Commission of Investigation should be established under the Commissions of Investigation Act 2004 to investigate this matter, including a review of the systems in place and the roles and responses of all the main parties involved.[47] This was decided based on the gravity of the issues and the public interest in the outcome of the review.[48]

(c) Health Act 2007 and the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023

(i) HIQA's Review Mechanisms under section 9 of the Health Act 2007

[17.24] HIQA's review functions, at present, include:

- monitoring compliance with standards;
- undertaking investigations;
- reviewing and making recommendations regarding services (at the request of, or with the approval of the Minister for Health or the Minister for Children, Equality, Disability, Integration and Youth);
- providing advice and making recommendations to the Minister for Health, the Minister for Children, Equality, Disability, Integration and Youth, the HSE and the Child and Family Agency regarding deficiencies identified with services provided by the HSE or a service provider.[49]

[17.25] Section 9 of the Health Act 2007 ("the 2007 Act") provides that HIQA may investigate the safety, quality and standards of services. HIQA must believe on reasonable grounds that there is a serious risk to the health or welfare of a person receiving the service. It must also believe that the risk may be because of an act, omission or negligence by the HSE, the Child and Family Agency, a service provider, a registered provider of a residential centre or a person in charge of such a provider.[50]

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46 Health Act 2007.

47 Seanad Éireann Debates, 26 April 2007, vol 186 no 23 at page 2028.

48 Seanad Éireann Debates, 26 April 2007, vol 186 no 23 at page 2029.

49 Section 8(1)(c), (d), (e), (j) of the Health Act 2007.

50 Section 9(1) of the Health Act 2007.

[17.26] Services that may be investigated by HIQA include:[51]

- those provided by the HSE, the Child and Family Agency or a service provider under the relevant legislation,[52] and
- services provided by a nursing home as defined in the relevant legislation.[53]

[17.27] The Minster for Health has the power to require HIQA to undertake such an investigation.[54] Furthermore, when conducting such an investigation, HIQA is required to ensure that this inquiry does not interfere or conflict with the functions of any other statutory bodies.[55]

(ii) Amendment of Section 9 of the Health Act 2007 under section 64 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2013

[17.28] Section 9 of the Health Act 2007 will be amended by section 64 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023. Section 64 has not yet been commenced at the time of publication.

[17.29] Section 9 of the Health Act 2007 provides for the circumstances in which HIQA may undertake an investigation as to the safety, quality and standards of certain services, as discussed above. Currently, the provision provides that HIQA may undertake an investigation where it believes on reasonable grounds that "there **is** a serious risk" to the health or welfare of a person receiving those services.[56] When section 64(a)(ii) of the 2023 Act is commenced, section 9(1)(a) of the Health Act 2007 will allow HIQA to undertake an investigation where it believes, on reasonable grounds, that "there **may** be a serious risk" to the health or welfare of a person receiving those services "notwithstanding that such a risk may also exist elsewhere in those services".

[17.30] Once section 64(a)(iv) of the 2023 Act is commenced, section 9(1)(c) will be inserted and will provide that an investigation may be in the interests of:

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[51] Section 9(1)(b) of the Health Act 2007.

[52] Health Acts 1947 to 2007, except for services provided under the Mental Health Acts 1945 to 2001 that, under the Health Act 2004, are provided by the HSE; the Child Care Acts 1991 and 2001; the Children Act 2001.

[53] Section 2 of the Health (Nursing Homes) Act 1990.

[54] Section 9(2) of the Health Act 2007. The Minister for Children, Equality, Disability, Integration and Youth can also require HIQA to undertake an investigation under section 9(2A) of the Health Act 2007.

[55] Section 9(3) of the Health Act 2007.

[56] Section 9(1)(a) of the Health Act 2007. There is also provision for the investigation of failures to comply with the provisions of the Protection of Life During Pregnancy Act 2013.

(i) improving the safety, quality and standards of services which are the subject of the investigation, or

(ii) the provision of health and personal social services for the benefit of the health and welfare of the public.[57]

[17.31] Section 9(2)(c) will also provide that the Minister for Health may require HIQA to undertake an investigation.[58]

[17.32] Another change is that HIQA will be required to notify, in writing, the Minster for Health, before conducting an investigation under section 9.[59] Moreover, the insertion of 9(3A) into the Health Act 2007 will provide that, where such an investigation is undertaken, HIQA will be required to give written notice to the relevant person of the matters to which the investigation relates, and give this person copies of any documents that HIQA believes is relevant to the investigation.[60] A "relevant person" will be defined as a person or body referred to in section 9(1)(b), as amended by section 64(a)(iii) of the 2023 Act, and includes the HSE, service providers, and registered providers of residential centres as defined in the Health Act 2007.[61]

(iii) Insertion of Section 41A Review Process under section 68 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023

[17.33] Section 68 of the 2023 Act will insert section 41A into the 2007 Act. Section 41A will give the Chief Inspector powers to review a "specified incident".[62] This process will grant the Chief Inspector the power, where they consider it appropriate to do so, to review specified incidents to identify how the specified incident occurred and make general recommendations to reduce the risk and to

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[57] Section 9(1)(c) of the Health Act 2007 as inserted by section 64(a)(iv) of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced); also applies to investigations that the Minister for Health requires HIQA to undertake, under section 9(2) of the Health Act 2007 as substituted by Section 64(c) of the Patient Safety Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

[58] Section 9(2) of the Health Act 2007 as substituted by section 64(c) of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced). Section 9(2A) will introduce a similar power on the Minister for Children, Equality, Disability, Integration and Youth to require HIQA to undertake an investigation, see section 9(2A) of the Health Act 2007 as substituted by section 64(d) of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

[59] Section 9(1A) of the Health Act 2007 as inserted by section 64(b) of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

[60] Section 9(3A) of the Health Act 2007 as inserted by section 64(e) of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

[61] Section 9(6) of the Health Act 2007 as amended by section 64(f) Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

[62] Section 41A of the Health Act 2007 as inserted by section 68 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

improve the safety, quality and standards of services where the specified incident occurred.[63] A "specified incident" is defined as an incident:

(a) that may have resulted in the unintended or unanticipated death or serious injury of a patient, and

(b) that has occurred in the course of the provision of a health service to a patient by a relevant entity, where some or all of that health service was provided in a relevant designated centre.[64]

[17.34] The 2023 Act will also amend the existing interpretation section of the 2007 Act.[65] It will insert a definition for "health service" which will be defined as the "provision of clinical care or **any ancillary service**" to a person for:

(a) the screening (other than screening carried out by a cancer screening service), preservation or improvement of the health of the person,

(b) the prevention, diagnosis, treatment or care of an illness, injury or health condition of the person,

(c) the performance of surgery, or a surgical intervention, in respect of aesthetic purposes, or other non-medical purposes, that involves instruments or equipment being inserted into the body of a person, or

(d) without prejudice to paragraph (a), a cancer screening service.[66]

[17.35] While safeguarding at-risk adults could arguably be considered "ancillary services" where an at-risk adult is in receipt of a health service, and therefore come under the specified incidents that may be reviewed by the Chief Inspector, the Commission considers that specified incidents will largely be clinical in nature. Therefore, the fact that this Act will assign a role to the Chief Inspector to investigate specified incidents does not persuade the Commission that there is no need for adult safeguarding specific reviews. Of course, it is possible that the definition of a specified incident could be amended in the future to expressly expand the Chief Inspector's review powers to include incidents that are not linked to clinical services and services ancillary to clinical services. However, adult safeguarding incidents occur in settings outside the Chief Inspector's or HIQA's remit, and it may be necessary for a more broadly

[63] Section 41A(2) of the Health Act 2007 as inserted by section 68 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

[64] Section 41A(10) of the Health Act 2007 as inserted by section 68 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

[65] Section 2 of the Health Act 2007 as amended by section 62(a) of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

[66] Section 2 of the Health Act 2007 as amended by section 62(a) of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

applicable adult safeguarding review process to be introduced, in addition to the functions of the Chief Inspector to review specified incidents.

[17.36] The Chief Inspector may decide to undertake a review of a specified incident where they receive a complaint in relation to the specified incident, are notified that a specified incident occurred by a "relevant entity" (a service provider, relevant residential centre, person running a business of prescribed health service or the HSE)[67] or where the Chief Inspector becomes aware of the specified incident concerned.[68]

[17.37] Section 41A(7) of the Health Act 2007 will provide that a review by the Chief Inspector shall not:

(a) consider or determine fault, or assign civil or criminal liability,
(b) consider or determine whether any action should be taken in respect of an individual by any panel, committee, tribunal or professional regulatory body, or
(c) be admissible as evidence of fault or liability in a court in relation to the specified incident, or a clinical negligence action which arises (whether in whole or in part) from the consequences of that specified incident.[69]

[17.38] Section 41A(3) will provide circumstances in which the Chief Inspector may decide not to undertake a review, or decide to discontinue a review. Such circumstances include where:

(a) [a complaint was made] and the Chief Inspector believes on reasonable grounds that the complaint is frivolous or vexatious,
(b) the specified incident … has already been subject to a review under this section,
(c) the Chief Inspector believes on reasonable grounds that the incident the subject of the review concerned is not a specified incident,
(d) the Chief Inspector believes on reasonable grounds that, the subject matter of the review concerned has already been resolved or substantially resolved,
(e) the subject matter of the review concerned is the subject of criminal proceedings, or

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67 Section 41A(10) of the Health Act 2007 as inserted by section 68 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

68 Section 41A(1) of the Health Act 2007 as inserted by section 68 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

69 Section 41A(7) of the Health Act 2007 as inserted by section 68 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

(f) the review concerned is the subject of an investigation by An Garda Síochána.[70]

[17.39] Section 41A(4) will provide time limits regarding reviews under this section. The Chief Inspector shall not undertake a review where a year has passed since the specified incident occurred. For complaints, this date may be one year from when the complainant knew, or is reasonably expected to know, that the specified incident occurred.[71] Section 41A(8) will provide that "nothing in this section shall be construed as preventing a relevant entity from undertaking a review of a specified incident that may have occurred".[72] Section 41A(9) will provide that the Chief Inspector should ensure that reviews under this section should not "interfere, or conflict, with the functions of any statutory bodies".[73]

(iv) HIQA's Guidance on Reviews

[17.40] HIQA has published guidance in relation to the conduct of serious incident reviews. In 2010, it published Guidance for the Health Service Executive for the Review of Serious Incidents including Deaths of Children in Care.[74] The purpose of the guidance was to provide a "standard, unified, independent and transparent system for the review of serious incidents including deaths of children in care in Ireland".[75] It outlines the purpose of the national review into incidents, the role of the national review panel and the review process.[76] HIQA and the Mental Health Commission also jointly published the National Standards for the Conduct of Reviews of Patient Safety Incidents in 2017.[77] The

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70 Section 41A(3) of the Health Act 2007 as inserted by section 68 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

71 Section 41A(4) of the Health Act 2007 as inserted by section 68 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

72 Section 41A(8) of the Health Act 2007 as inserted by section 68 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

73 Section 41A(9) of the Health Act 2007 as inserted by section 68 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (not yet commenced).

74 Health Information and Quality Authority, *Guidance for the Health Service Executive for the Review of Serious Incidents including Deaths of Children in Care* (HIQA 2010) < https://www.lenus.ie/bitstream/handle/10147/104382/GuidanceHSEreviewincidentsofChildreninCare.pdf?sequence=1&isAllowed=y#:~:text=The%20timely%20nature%20of%20the,HSE%20and%20agreed%20with%20SSI.> accessed 6 April 2024. This followed on from a recommendation in the Report of the Commission to Inquire into Child Abuse (commonly known as the Ryan Report) that HIQA should develop such guidance.

75 Health Information and Quality Authority, *Guidance for the Health Service Executive for the Review of Serious Incidents including Deaths of Children in Care* (HIQA 2010) at page v. It also looked at other jurisdictions which have systemic review processes in place.

76 Health Information and Quality Authority, *Guidance for the Health Service Executive for the Review of Serious Incidents including Deaths of Children in Care* (HIQA 2010) at page v.

77 Health Information and Quality Authority and Mental Health Commission, *National Standards for the Conduct of Reviews of Patient Safety Incidents* (HIQA and MHC 2017).

National Standards were commissioned by the Department of Health following the Chief Medical Officer's 2014 Report on Perinatal Deaths in HSE Midland Regional Hospital Portlaoise, which recommended the development of national standards on the conduct of reviews of patient safety incidents.[78] The aim of the guidance is to "promote improvements in how services conduct reviews of patient safety incidents".[79]

(v) *Residential centres regulated by HIQA*

[17.41] General incident reviews are carried out at service level as a matter of practice, as explained above where the HSE Incident Management framework is discussed. It is important that services reflect on what has gone wrong, and update policies, procedures and processes to ensure similar incidents do not occur in the future. Services may also need to ascertain whether there is a continued risk to a particular individual or group of individuals and whether any immediate action is required to safeguard the person(s).

[17.42] For example, residential centres for older people are required to take all reasonable measures to protect residents from abuse.[80] The person in charge of a residential centre for older people must investigate any incident or allegation of abuse unless they are the subject of the concern. Where the person in charge is the subject of a concern, the registered provider of the residential centre should investigate the matter or nominate another person to investigate the matter.[81] In relation to residential centres for adults with disabilities, the registered provider is also under an obligation to protect residents from all forms of abuse.[82] The person in charge must initiate and put in place an investigation into "any incident, allegation or suspicion of abuse" and must take "appropriate action where a resident is harmed or suffers abuse".[83] Where the

[78] Department of Health, *HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date)* (Department of Health 2014) at page 44 <https://assets.gov.ie/11681/166af0f62cee4ec5a979d05519f5e5e3.pdf> accessed 6 April 2024.

[79] Health Information and Quality Authority and Mental Health Commission, *National Standards for the Conduct of Reviews of Patient Safety Incidents* (HIQA and MHC 2017) at page 13.

[80] Regulation 8(1) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013).

[81] Regulation 8(2) and (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013).

[82] Regulation 8(2) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013).

[83] Regulation 8(3) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013).

person in charge is the subject of the matter, the registered provider can either undertake the investigation or nominate a third party who is suitable to investigate the matter.[84]

[17.43] Regulation 31 of both the care and welfare regulations for residential centres for older people[85] and the care and welfare regulations for residential centres for adults with disabilities[86] specify requirements in relation to the notification of certain incidents to the Chief Inspector. In the case of residential centres for older people, the person in charge must notify the Chief Inspector of certain incidents[87] within 3 working days, whereas they should notify the Chief Inspector at quarterly intervals where less serious incidents occur.[88] Where an unexpected death occurs, the person in charge must notify the Chief Inspector as soon as the cause of the death has been established.[89]

[17.44] In relation to residential centres for adults with disabilities, the notification requirements are quite similar. The person in charge must notify the Chief Inspector within 3 working days where an "adverse incident" occurs in the residential centre. This includes the unexpected death of a resident, any serious injury to a resident that requires medical or hospital treatment, any allegation (suspected or confirmed) of abuse of a resident.[90] It also includes any allegation of misconduct by the registered provider or its staff, or any occasion where the registered provider becomes aware that a staff member is the subject of a review by a professional body.[91] Similarly to the provisions of the regulations for residential centres for older people, it is a requirement for residential centres for

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[84] Regulation 8(4) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013).

[85] Regulation 31 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013).

[86] Regulation 31 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013).

[87] See paragraphs 7(1)(a) to (j) of Schedule 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013).

[88] See paragraphs 7(2)(k) to (n) of Schedule 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013). Incidents not captured by these requirements in the regulations can be reported at the end of each 6 month period.

[89] Regulation 31(2) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013).

[90] Regulation 31(1)(a), (d), (f) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013).

[91] Regulation 31(1)(g) and (h) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013).

adults with disabilities to notify the Chief Inspector where an unexpected death occurs once the cause of death has been established. Certain incidents must be reported to the Chief Inspector quarterly such as recurring patterns of theft or burglary and any injury that does not require medical or hospital treatment.[92]

[17.45] There will be additional notification requirements to HIQA or the Chief Inspector where certain incidents occur when sections 27 and 28 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 are commenced.[93]

(d) Mental Health Act 2001

(i) Mental Health Commission Reports under section 42 of the Mental Health Act 2001

[17.46] Section 42 of the Mental Health Act 2001 outlines the reports to be prepared by the Mental Health Commission and any information the Minister for Health may request from the Mental Health Commission. Section 42(1) requires the Mental Health Commission, at the end of each year, to prepare and submit written reports to the Minister for Health of its activities during the year.[94] This report includes the report of the Inspector in accordance with section 51 of the Act.[95] Under section 42(3), the Minister for Health can request the Mental Health Commission to provide information on any matters the Minister may specify "concerning or relating to the scope of its activities" or in relation to any annual report or account regarding a report under section 42(1).[96] The Mental Health Commission may publish "other reports on matters related to its activities and functions" as it considers appropriate from time to time.[97]

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92 Regulation 31(3) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013). Other incidents not captured by the specific requirements in the regulations must be notified to the Chief Inspector on a six month basis.

93 For definition of notifiable incident see Schedule 1 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023. See also Health Information and Quality Authority, *Guidance on managing notifiable events in designated centres – Guidance for registered providers and persons in charge of designated centres* (HIQA 2022).

94 Section 42(1) of the Mental Health Act 2001.

95 Section 42(2) of the Mental Health Act 2001.

96 Section 42(3) of the Mental Health Act 2001.

97 Section 42(5) of the Mental Health Act 2001.

(ii) Functions of the Inspector of Mental Health Services under section 51 of the Mental Health Act 2001

[17.47] Section 51 of the Act outlines the primary functions of the Inspector. Their role involves conducting visits to and inspections of "approved centres" and other premises where mental health services are being provided at least once a year.[98]

[17.48] The Inspector is also responsible for carrying out reviews of mental health services in the State and providing a written report to the Mental Health Commission every year on:

- the quality of care and treatment given to people receiving mental health services,
- what the Inspector discovered as a result of any inspections carried out of approved centres or other premises where mental health services are being provided,
- the extent to which approved centres are complying with codes of practice prepared by the Mental Health Commission, and
- any other relevant matters that the Inspector considers appropriate to report on arising from their review.[99]

[17.49] One example of such a report is that concerning Child and Adolescent Mental Health Services ("CAMHS"). The final report was published in July 2023 by the Inspector at the time of publication, Dr Susan Finnerty, who detailed 49 recommendations on clinical and governance reforms necessary to ensure all children have access to safe services, regardless of their geographical location.[100]

(iii) Inquiries under section 55 of the Mental Act 2001

[17.50] Section 55 of the Act provides that the Mental Health Commission "may, and shall if so requested by the Minister" cause the Inspector or another specified person to inquire into:

(a) the carrying on of any approved centre or other premises in the State where mental health services are provided,

[98] Section 51(1)(a) of the Mental Health Act 2001.

[99] Section 51(1)(b) of the Mental Health Act 2001.

[100] Dr Susan Finnerty, *Independent Review of the Provision of Child and Adolescent Mental Health Services (CAMHS) in the State* (Mental Health Commission, July 2023) <https://www.mhcirl.ie/publications/independent-review-provision-child-and-adolescent-mental-health-services-camhs-state> accessed 3 April 2024.

(b) the care and treatment provided to a specified patient or a specified voluntary patient by the Commission,

(c) any other matter in respect of which an inquiry is appropriate having regard to the provisions of this Act or any regulations or rules made thereunder or any other enactment.101

Any inquiries carried out under this section must be followed by a written report of the findings and this report must be submitted to the Mental Health Commission.[102]

(iv) Approved centres regulated by the Mental Health Commission

[17.51] As stated above, it is important that service providers carry out incident reviews where an incident occurs at service-level. This ensures that immediate action can be taken to safeguard anyone availing of the service who is at risk of harm and minimise the likelihood of harm continuing or reoccurring. The regulations for approved centres under the Mental Health Act 2001 provide that registered proprietors of approved centres must have a risk management policy in place that sets out what precautions it has in place to control risks to residents and the arrangements in place to identify, record, investigate and learn from "serious or untoward incidents or adverse events involving residents".[103] The risk management policy should also specify how the approved centre will respond to emergencies and the arrangements that it has in place to protect "vulnerable adults" from abuse.[104]

[17.52] The regulations provide that the registered proprietor must keep a record of all incidents that occur within the approved centre and must notify the Mental Health Commission of any incidents in line with any codes of practices issued by the Mental Health Commission.[105] There will be new notification requirements for approved centres under the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023, once section 29 of the Act is commenced.[106]

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101 Section 55(1) of the Mental Health Act 2001.

102 At the time of writing, the Commission understands that there have been no section 55 inquiries in the last 10 years. This information was obtained from the Mental Health Commission.

103 Regulation 32(2)(b), (c) and (d) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 (SI No 551 of 2006).

104 Regulation 32(2)(e) and (f) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 (SI No 551 of 2006).

105 Regulation 32(3) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 (SI No 551 of 2006). See for example, Mental Health Commission, *Guidance on Quality and Safety Notifications* (MHC 2020).

106 See definition of notifiable incidents in Part 1 of Schedule 1 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023.

(e) National Independent Review Panel

[17.53] The National Independent Review Panel ("NIRP") was established on a non-statutory basis within the HSE in 2017 to promote learning and best practice by reviewing serious incidents across community health and social care settings.[107] While the NIRP is established within the HSE, it is independent of all HSE operations.[108] The HSE's National Clinical Director, Quality and Patient Safety may commission the NIRP to conduct a review when a high level of independence outside of the relevant Community Health Organisation is required.[109] These are typically category 1 incidents as defined in the HSE's Incident Management Framework (discussed above). Members of the NIRP are independent experts with qualifications and experience in social work.

[17.54] The NIRP conducts its work in line with the HSE's Incident Management Framework and its operational guidelines.[110] The purpose of a review is to "ensure that lessons can be learnt from the case and that those lessons can be applied to future cases to prevent similar situations from occurring again".[111] It will identify what went wrong and why and propose changes that can be made to improve the quality and safety of services and reduce the likelihood of recurrence.[112] The NIRP will review cases where:

- there are major concerns about how the care of an individual or group of individuals was managed by the services involved;
- it is suspected that there are serious failings by the HSE and/or its funded organisations that have led to significant harm and/or

[107] Health Service Executive, National Independent Review Panel < https://www2.healthservice.hse.ie/organisation/nirp/> accessed 3 April 2024.

[108] Health Service Executive and National Independent Review Panel, *National Independent Review Panel Operational Guidelines* (HSE and NIRP 2021) at page 4 < https://www.hse.ie/eng/about/who/nqpsd/nirp/nirp-operational-guidelines-2021.pdf> accessed 6 April 2024.

[109] Health Service Executive and National Independent Review Panel, *National Independent Review Panel Operational Guidelines* (HSE and NIRP 2021) at page 4. The Quality and Patient Safety division monitors and reports on the quality and safety of health and social care services. It focuses on building the capacity of organisations to learn from feedback and incidents.

[110] Health Service Executive and National Independent Review Panel, *National Independent Review Panel Operational Guidelines* (HSE and NIRP 2021) at page 4.

[111] Health Service Executive and National Independent Review Panel, *National Independent Review Panel Operational Guidelines* (HSE and NIRP 2021) at page 6.

[112] Health Service Executive and National Independent Review Panel, *National Independent Review Panel Operational Guidelines* (HSE and NIRP 2021) at page 11.

have compromised the quality of life of the person(s) concerned.[113]

[17.55] Following a review, the NIRP will produce a report on its findings, conclusions, and recommendations for the Chairperson of the HSE's Safety and Quality Committee.[114] The report will be disseminated to the relevant HSE service area involved and that HSE service area must indicate their acceptance or rejection of the recommendations.[115] It must also develop an action plan which identifies responsibilities and timelines for completion.[116] The NIRP may also commission an evaluation review to "determine if the recommendations made through NIRP reports are effecting systemic change, as intended".[117] The NIRP produces an annual report that contains an aggregated analysis of cases reviewed and which identifies learning that can be shared nationally.

[17.56] While the work of the NIRP includes incidents in the health and social care sectors more broadly, it has undertaken reviews in cases involving adult safeguarding incidents. An NIRP report was commissioned in the 'Brandon' case where there were concerns regarding the regular occurrence of sexual assaults by one resident on other residents in a HSE residential and day service for adults with intellectual disabilities.[118]

[17.57] An NIRP review was also commissioned in the 'Emily' case where a resident in a HSE community nursing home was raped by a male care assistant.[119] She disclosed this to staff but was not believed. The report's recommendations were directed towards the HSE and aimed at improving nursing homes' responses to sexual abuse of residents through awareness campaigns, safeguarding training,

[113] Health Service Executive and National Independent Review Panel, *National Independent Review Panel Operational Guidelines* (HSE and NIRP 2021) at page 5.

[114] Health Service Executive and National Independent Review Panel, *National Independent Review Panel Operational Guidelines* (HSE and NIRP 2021) at page 10.

[115] Health Service Executive and National Independent Review Panel, *National Independent Review Panel Operational Guidelines* (HSE and NIRP 2021) at page 10. Where the relevant HSE service area rejects the recommendations, it must provide rationale for this.

[116] Health Service Executive and National Independent Review Panel, *National Independent Review Panel Operational Guidelines* (HSE and NIRP 2021) at page 10.

[117] Health Service Executive and National Independent Review Panel, *National Independent Review Panel Operational Guidelines* (HSE and NIRP 2021) at page 10.

[118] National Independent Review Panel, *Independent Review of the Management of Brandon* (NIRP 2021) < https://www.hse.ie/eng/services/publications/the-national-independent-review-panel-brandon-report-for-publication.pdf> accessed 6 April 2024.

[119] National Independent Review Panel, *Independent Review of the Governance Arrangements in a HSE Nursing Home 'Emily'* (NIRP 2023) < https://www.hse.ie/eng/services/publications/independent-review-of-the-governance-arrangements-in-a-hse-nursing-home.pdf> accessed 6 April 2024.

communication and crisis response plans, improved file managements, and protocols between the HSE and the Garda Síochána.[120]

[17.58] Again, the NIRP can only review incidents that occur in HSE managed or funded organisations or services. Privately owned or privately funded services are not within the NIRP's remit. This gap means there is an incomplete picture of serious incidents regarding at-risk adults across the health and social care sector, and a reduced ability to drive improvement and share learnings in every setting where at-risk adults may be present.

[17.59] As of March 2024, the NIRP has completed five reviews since it was first commissioned in 2017, with one review ongoing.[121] The Commission understands that the Chief Executive Officer of the HSE has asked the new chair of the NIRP to review the panel's function, and that this work is ongoing.[122] This review was not complete at the time of writing.

(f) Commissions of Investigation

[17.60] The Commissions of Investigation Act 2004 provides for the establishment of Commissions of Investigations to investigate matters of significant public concern.[123] The Commission is set up by government order, which must be approved by the Dáil and the Seanad. The terms of reference need to be prepared alongside an accompanying statement that sets out the estimated costs (including legal costs) that will be incurred and a timeframe for submission of the report.[124] These can be amended with the consent or at the request of the Commission, for example, to extend the time period for submission of the report.[125]

[17.61] Commissions of investigation seek the voluntary cooperation of witnesses but have powers to compel people to given evidence if necessary.[126] Such Commissions also have powers of entry to search premises and inspect, secure,

[120] National Independent Review Panel, *Independent Review of the Governance Arrangements in a HSE Nursing Home 'Emily'* (NIRP 2023) at pages 11 to 12.

[121] Reilly, "HSE CEO asks Chair of serious incident panel to 'review function'" *The Medical Independent* (17 March 2024) https://www.medicalindependent.ie/in-the-news/hse-ceo-asks-chair-of-serious-incident-panel-to-review-function/ accessed 3 April 2024.

[122] Reilly, "HSE CEO asks Chair of serious incident panel to 'review function'" *The Medical Independent* (17 March 2024) https://www.medicalindependent.ie/in-the-news/hse-ceo-asks-chair-of-serious-incident-panel-to-review-function/ accessed 3 April 2024.

[123] Section 3(1) of the Commissions of Investigations Act 2004.

[124] Section 5 of the Commissions of Investigations Act 2004.

[125] Section 6 of the Commissions of Investigations Act 2004.

[126] Sections 10 and 16 of the Commissions of Investigations Act 2004.

or take documents.[127] Generally, witnesses give evidence in private, meaning Commissions of Investigation should be less adversarial than tribunals.[128]

[17.62] Commissions of Investigation were introduced as they were considered less expensive and quicker than a tribunal of inquiry.[129] However, they have been criticised in recent years for lengthy delays in delivering reports with Commissions seeking repeated extensions, and spiralling costs.[130] Mr Justice Cregan, the sole member of the Commission of Investigation (Irish Bank Resolution Corporation) recently called for reform of the Commission of Investigation process in his final report. He remarked that where the Oireachtas has determined that an issue is a matter of urgent public importance, it should not take many years to complete the investigation.[131] He suggests that a permanent Commission of Investigation body should be established, as this

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[127] Section 28 of the Commissions of Investigations Act 2004.

[128] Section 11 of the Commissions of Investigation Act 2004.

[129] Law Reform Commission, *Report on Public Inquiries Including Tribunals of Inquiry* (LRC 73-2005) at page 8 < https://publications.lawreform.ie/Portal/External/en-GB/RecordView/Index/35399#:~:text=The%20Report%20recommended%20the%20replacement,rather%20than%20on%20individual%20wrongdoing.> accessed 6 April 2024.

[130] Ó Cionnaith, "Grace inquiry must finish work by September – minister" *RTÉ* (13 March 2024) < https://www.rte.ie/news/ireland/2024/0313/1437730-grace-commission/> accessed 3 April 2024; Commission of Investigation (Irish Bank Resolution Corporation), *Final Report* (COI 2023); Irish Examiner, "Final report on Leas Cross delayed a third time" *The Irish Examiner* (15 April 2009) <https://www.irishexaminer.com/news/arid-20089317.html > Accessed 3 April 2024; McDonnell, "Have we learned anything from tribunals fiasco?" *The Irish Examiner* (6 March 2019) <https://www.irishexaminer.com/opinion/commentanalysis/arid-30908967.html> accessed 3 April 2024; Oonan, "Ireland must reconsider its use of commissions of investigations" *The Irish Times* (23 June 2019) <https://www.irishtimes.com/opinion/ireland-must-reconsider-its-use-of-commissions-of-investigation-1.3963941> accessed 3 April 2024; McDonnell, "Anger over delays in 'Grace' inquiry" *The Irish Examiner* (5 June 2022) <https://www.irishexaminer.com/news/politics/arid-40888571.html#:~:text=Anne%20Rabbitte%20TD%2C%20Minister%20of,%2C%20Disability%2C%20Integration%20and%20Youth.&text=There%20is%20mounting%20anger%20in,extension%20to%20conclude%20its%20work.> accessed 3 April 2024; McGee, "Tribunals and commissions of investigations have cost taxpayers over €500m" *The Irish Times* (12 January 2023) < https://www.irishtimes.com/politics/2023/01/11/tribunals-and-commissions-of-investigation-have-cost-the-taxpayer-over-500-million/> accessed 3 April 2024; McDonnell, "Anger at yet another delay in 'Grace' foster abuse inquiry" *The Irish Examiner* (9 March 2023) <https://www.irishexaminer.com/news/arid-41089483.html> accessed 3 April 2024; Murphy, "Govt faces tough choice on inquiries" *RTÉ* (4 June 2023) < https://www.rte.ie/news/analysis-and-comment/2023/0604/1387304-siteserv-probe-raises-questions-about-inquiries/> accessed 3 April 2024.

[131] Commission of Investigation (Irish Bank Resolution Corporation), *Final Report* (IBRC Commission of Investigation 2023) at pages 2 to 3 < https://www.gov.ie/en/publication/9f83c-final-report-of-the-ibrc-commission-of-investigation/#:~:text=The%20Commission's%20substantive%20work%20was,commissions%20of%20investigation%20process%20generally.> accessed 6 April 2023.

would retain expertise and experience (which is presently lost after each Commission winds up) and result in cost savings in terms of infrastructure.[132]

[17.63] Commissions of Investigation are used in the adult safeguarding context in response to serious incidents. These include the O'Donovan Commission to investigate matters in relation to the management, operation, and supervision of Leas Cross Nursing Home,[133] and the Farrelly Commission to investigate matters arising from the 'Grace' case, which was ongoing at the time of publication of this Report.[134] To date, the Farrelly Commission has found repeated and systemic failures in managing the care of 'Grace' from 1989 to 2007 and a lack of intervention by public authorities.[135]

[17.64] In terms of membership of Commissions of Investigation, the relevant Minister or the government must be satisfied "having regard to the subject matter of the investigation, that the person has the appropriate experience, qualifications, training or expertise".[136] While it is possible for there to be more than one member of the Commission,[137] the Farrelly Commission and O'Donovan Commission have consisted of one sole member, a senior barrister. It can be said that Commissions of Investigation when it comes to adult safeguarding lack a multi-disciplinary approach or social work expertise in terms of the membership of the review team. On the other hand, HSE Safeguarding and Protection Team reviews, and independent reviews commissioned by the HSE are largely carried out by social workers or social work experts.

[132] Commission of Investigation (Irish Bank Resolution Corporation), *Final Report* (IBRC Commission of Investigation 2023) at pages 12 to 13.

[133] Commission of Investigation (Leas Cross Nursing Home), *Final Report* (Leas Cross Nursing Home Commission of Investigation 2009) < https://www.lenus.ie/handle/10147/76516> accessed 6 April 2024.

[134] This Commission has published 8 interim reports to date but has not submitted a final report. An extension was granted in March 2023 until March 2024, and a subsequent extension was granted in March 2024 until September 2024. The initial timeframe for submission of the report was March 2018. See Ó Cionnaith, "Grace inquiry must finish work by September – minister" *RTÉ* (13 March 2024) < https://www.rte.ie/news/ireland/2024/0313/1437730-grace-commission/> accessed 5 April 2024.

[135] Commission of Investigation (Certain matters relative to a disability service in the South East and related matters, *First Substantive Interim Report* (Farrelly Commission of Investigation 2021) < https://www.gov.ie/en/collection/8bbdc7-the-farrelly-commission-of-investigation-certain-matters-relative-to/#:~:text=The%20Commission%20of%20Investigation%20(Certain,Reference%20can%20be%20viewed%20here.> accessed 6 April 2024.

[136] Section 7 of the Commissions of Investigation Act 2004.

[137] Section 7(1) of the Commissions of Investigation Act 2004.

(g) Tribunals of inquiry

[17.65] Another option for investigating matters of public importance is to establish a tribunal of inquiry. The Tribunals of Inquiry (Evidence) Act 1921 provides that tribunals of inquiry may be established to inquire into urgent matters of public importance.[138] To date, there have been no tribunals of inquiry related to adult safeguarding serious incidents. Commissions of Investigations appear to be the preferred route for investigation of issues of public concern in more recent years.

(h) Coroner's Inquest

[17.66] Deaths in certain circumstances are required to be reported to the coroner in the relevant locality. The Coroners Act 1962 sets out a list of reportable deaths, and also prescribes certain persons who are obligated to report deaths to the coroner.[139] For example, a person in charge of a public or private institution or premises where a deceased person was residing or receiving treatment or care at the time of their death is required to report deaths to a coroner.[140]

[17.67] The coroner has the power to hold an inquest if they believe that the death may have occurred "in a violent or unnatural manner, or unexpectedly and from unknown causes or in a place or in circumstances which … require that an inquest should be held".[141] The purpose of an inquest includes to establish how, when and where the death occurred and the circumstances of the death, where necessary.[142] The coroner may make general recommendations with the view to preventing similar deaths in the future.[143] Section 31 of the Coroners Act 1962 provides that:

> recommendations of a general character that are designed to prevent further fatalities or are considered necessary or desirable in the interests of public health or safety may be appended to the verdict at any inquest.[144]

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[138] Section 1(1) of the Tribunals of Inquiry (Evidence) Act 1921.

[139] Sections 16A and 16B of the Coroner's Act 1962.

[140] Section 16B(3)(g) of the Coroner's Act 1962. See also parts 13(f) and 23 of Schedule 2 of the Coroner's Act 1962 in particular.

[141] Section 17(1) of the Coroner's Act 1962.

[142] Section 18A(1) of the Coroner's Act 1962.

[143] Section 31 of the Coroner's Act 1962.

[144] Section 31 of the Coroner's Act 1962.

[17.68] However, these recommendations have been criticised for not being enforceable, resulting in implementation being optional.[145] This can be contrasted with the position in England and Wales, where the coroner can make "Prevention of Future Deaths" reports to a person, organisation, local authority or government department or agency, if the coroner believes that action should be taken to prevent future deaths.[146] The person or organisation the coroner makes the report to must provide a written response to the coroner detailing actions that will be taken, or an explanation as to why no action is proposed.[147]

(i) The Office of the Ombudsman

[17.69] The Office of the Ombudsman has the power to investigate complaints in relation to a wide range of bodies, including actions taken by government departments.[148] These complaints may relate to adult social care and other issues if they fall within the remit of the Ombudsman. The Ombudsman has powers to investigate public, publicly funded, voluntary and private bodies. These bodies include the HSE and agencies delivering health and personal services on behalf of the HSE including charitable organisations, voluntary bodies and nursing homes. Complaints in relation to private healthcare are excluded from the remit of the Ombudsman. However, since August 2015, the Ombudsman can deal with complaints in relation to administrative actions of private nursing homes that are in receipt of public funding.[149] The Ombudsman may carry out an investigation on their own motion or on receipt of a complaint.[150]

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[145] Murphy, "Anything that causes some good and prevents deaths should be taken more seriously" *The Irish Examiner* (26 February 2022) https://www.irishexaminer.com/news/spotlight/arid-40817025.html#:~:text=In%20relation%20to%20recommendations%20made,ground%20to%20be%20more%20persuasive%3F%E2%80%9D accessed 4 April 2024; Irish Council for Civil Liberties, *Death Investigations, Coroners' Inquests and the Rights of the Bereaved* (ICCL 2021) at pages 7 and 10 < https://www.iccl.ie/wp-content/uploads/2021/04/ICCL-Death-Investigations-Coroners-Inquests-the-Rights-of-the-Bereaved.pdf> accessed 6 April 2024.

[146] Paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 (England and Wales); regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 (England and Wales). These reports are published and available online. See Courts and Tribunals Judiciary, Prevention of Future Death Reports < https://www.judiciary.uk/?s=&pfd_report_type=&post_type=pfd&order=relevance> accessed 4 April 2024.

[147] Paragraph 7(3) of Schedule 5 of the Coroners and Justice Act 2009. (England and Wales) See also regulation 29(3) of the Coroners (Investigations) Regulations 2013 (England and Wales).

[148] Ombudsman Act 1980.

[149] The Ombudsman Act 1980 (Section 1A) (No. 2) Order 2015 (SI No 300 of 2015).

[150] The Ombudsman's "own initiative" investigations tend to focus on more systemic issues, where a series of complaints are made, or the Ombudsman identifies a recurring issue. See part 7 of Ombudsman, Ombudsman Procedures for conducting an investigation < https://www.ombudsman.ie/about-us/foi-publication-scheme/procedures-for-

[17.70] Section 4(2) of the Ombudsman Act 1980 sets out the grounds for which the Ombudsman may investigate any action taken by a relevant body or organisation where an action has or may have adversely affected someone. The majority of which concern maladministration such as actions being taken without proper authority, or as a result of negligence or carelessness.[151] Before making a complaint to the Ombudsman, the complainant must exhaust all other complaint mechanisms.[152] If the Ombudsman upholds or partially upholds a complaint, they can make recommendations to the relevant body or organisation that the matter be further considered, that measures be taken to remedy, mitigate, or alter the adverse effect of the action, or that reasons for taking the action be given.[153] The Ombudsman may also request that the relevant body or organisation notify the Ombudsman within a specified time of its response to the recommendation(s).[154] While the Ombudsman's recommendations are not binding, they are followed in the majority of cases.[155] Typically, reports from the Ombudsman following investigations are more geared towards righting wrongs stemming from individual complaints, rather than identifying learnings to drive quality improvement on a more systemic level.

3. Serious incident reviews in other jurisdictions

(a) England

[17.71] The Care Act 2014 provides that each local authority must establish a Safeguarding Adults Board ("SAB") for its area.[156] These are inter-agency local boards that are responsible for helping and protecting adults in its area that have care and support needs, are experiencing, or are at risk of experiencing, abuse or neglect, and as a result of their care and support needs they are unable to protect themselves from harm.[157] The members of SABs in each local area

conducting/#:~:text=The%20Ombudsman%20may%20investigate%20an,as%20'own%20initiative%20investigations> accessed 4 April 2024.

[151] Section 4(2) of the Ombudsman Act 1980.

[152] Section 4(5)(b)(iii) of the Ombudsman Act 1980.

[153] Section 6(3) of the Ombudsman Act 1980.

[154] Section 6(3)(b) of the Ombudsman Act 1980.

[155] The Ombudsman, Developing and Optimising the Role of the Ombudsman <https://www.ombudsman.ie/publications/submissions-and-proposals/developing-and-optimising/> accessed 4 April 2024. If a recommendation is not accepted by the relevant body or organisation, the Ombudsman can report non-acceptance to the Oireachtas, which can bring the matter to the attention of the relevant Oireachtas Committee.

[156] Section 43(1) of the Care Act 2014 (England).

[157] Section 42(1) and 43(2) of the Care Act 2014 (England). Sometimes local SABs are combined with Safeguarding Children Partnerships and Community Safety Partnerships, with single governance arrangements and the one independent chair. See National Network of

must include representatives from: the local authority, the integrated care board, the chief officer of the police, and any person specified in regulations.[158] The local authority may also include other people in the SAB if it considers it appropriate to do so, once it has consulted with the other members.[159] While the legislation does not require the chair of the SAB to be independent, in most cases SABs are independently chaired.[160]

[17.72] SABs must arrange what are known as safeguarding adult reviews ("SARs") where an adult in its area has care and support needs and has died,[161] or it is known or suspected that they have experienced serious abuse or neglect.[162] In order to meet the criteria for a review, there needs to be "reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult".[163] The objective of these reviews is to identify lessons to be learned from the adult's care and to apply those lessons to future cases.[164] The SAB must arrange a review irrespective of whether the local authority has been meeting the adult's care and support needs.[165] At the SAB's discretion, it may also carry out reviews into other cases involving adults with needs for care and support in its area that do not meet the above criteria.[166] This enables SABs to carry out reviews in less serious cases if it believes there are insights to be gained.

Safeguarding Adult Board Chairs, Annual Report 2021 to 2022 (NNSABC 2022) at page 3 <https://www.local.gov.uk/national-network-safeguarding-adults-board-chairs-annual-report-2020-2021> accessed 6 April 2024.

[158] Schedule 2 of the Care Act 2014 (England). Where there is more than one police area or integrated care board area within the local authority area, more than one representative for the police or the integrated care board must be represented on the SAB.

[159] Paragraph 1(2) of Schedule 2 of the Care Act 2014 (England).

[160] Copper and Bruin, "Adult Safeguarding and the Care Act (2014) – the impacts on partnership and practice" (2017) 19(4) Journal of Adult Protection 209 at pages 214 to 215. The statutory guidance on the Care Act 2014 provides that "although it is not a requirement, the local authority should consider appointing an independent chair to the SAB who is not an employee or a member of an agency that is a member of the SAB". See Department of Health and Social Care (England), *Care and support statutory guidance* (DHSC 2016) at para 14.150 (last updated 28 March 2024) < https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance> accessed 6 April 2024.

[161] The SAB must know or suspect that the death resulted from abuse or neglect.

[162] Section 44(1), (2), (3) of the Care Act 2014 (England).

[163] Section 44(1)(a) of the Care Act 2014 (England).

[164] Section 44(5) of the Care Act 2014 (England).

[165] Section 44(1) of the Care Act 2014 (England).

[166] Section 44(4) of the Care Act 2014 (England).

[17.73] There is no standardised procedure for safeguarding adult reviews; each SAB may determine its own procedures.[167] However, there is statutory guidance about how safeguarding adult reviews should be carried out.[168] For example, it provides that SABs should aim to complete safeguarding adult reviews "within a reasonable period of time, and in any event within 6 months of initiating it, unless there are good reasons for a long period being required".[169] The guidance also provides that SABs should consider publishing safeguarding adult review reports within the boundaries imposed by confidentiality.[170]

[17.74] The Care Act 2014 does not provide for an overarching national structure to oversee the work of local SABs or centralise safeguarding adult review reports. SABs existed before they were made a statutory requirement, and a peer support network for chairs was established informally in 2009.[171] This is known as the National Network of Safeguarding Adults Board Chairs. The network aims to promote best practice and collaborative working across regions, collate learnings, and influence change at a national level.[172] For many years, there was no central repository containing all safeguarding adult review reports, which was repeatedly raised as a limitation in disseminating learnings by experts in the area.[173] A database was established within the Social Institute for Excellence, but it did not contain all reports and its functionality was restricted by not having an effective search engine.[174] More recently, the Network of Chairs has established

[167] Paragraph 1(8) of Schedule 2 of the Care Act 2014 (England).

[168] Department of Health and Social Care (England), *Care and support statutory guidance* (DHSC 2016).

[169] Department of Health and Social Care (England), *Care and support statutory guidance* (DHSC 2016) at para 14.173. For example, good reasons may include the possibility that the review may potentially prejudice court proceedings.

[170] Department of Health and Social Care (England), *Care and support statutory guidance* (DHSC 2016) at para 14.179.

[171] National Network for Chairs of Adult Safeguarding Boards, About the National Network of Safeguarding Adult Boards <https://nationalnetwork.org.uk/about_us.html> accessed 4 April 2024.

[172] National Safeguarding Adults Board Chairs Network, *Terms of reference* (NSABC 2021) at page 1 < https://nationalnetwork.org.uk/Final%20NSCN%20ToR%20Sep%2021.pdf> accessed 6 April 2024.

[173] For example, see Copper and Bruin, "Adult Safeguarding and the Care Act (2014) – the impacts on partnership and practice" (2017) 19(4) Journal of Adult Protection 209 at page 216; Preston-Shoot, "On self-neglect and safeguarding adult reviews: diminishing returns of adding value? (2017) 19(2) Journal of Adult Protection 53 at page 53; Smith and others, "The scope of safety in English older adult care homes: a qualitative analysis of Safeguarding Adult Reviews" (2023) 25(1) Journal of Adult Protection 3 at page 4.

[174] Preston-Shoot, "Safeguarding adult reviews: informing and enriching policy and practice on self-neglect" (2020) 22(4) Journal of Adult Protection 199 at page 200. NHS Digital also published data on safeguarding adult reviews.

a searchable SARs library which contains local safeguarding adult review reports published from 2015 up until 2023.[175]

[17.75] There is no organisation responsible for conducting thematic analysis of local safeguarding adult reviews, although a recent national analysis from April 2017 to March 2019 was commissioned by national organisations.[176] Other more regionally focused thematic reviews have previously been carried out.[177] Preston-Shoot maintains that thematic reviews can scale up the impact of SARs as they:

> unify learning that otherwise remains localised and disparate … [and] … contribute to developing patterns of understanding and knowledge through the synthesis and generalisations, contrasts and comparisons that can be drawn.[178]

[17.76] Until recently, there was no clear pathway for local SABs to escalate recommendations or issues of national relevance to government departments or national organisations.[179] Following calls for improved processes for sharing learning with central government and national regulatory bodies,[180] a National Escalation Protocol was established. This formalised the role of the chairs in regional networks and the National Network of Safeguarding Adults Board Chairs in escalating issues of national importance.[181]

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[175] National Network for Chairs of Adult Safeguarding Boards, SARs Library < https://nationalnetwork.org.uk/search.html> accessed 4 April 2024. It does not appear that local SABs are required to submit reports to the SARs library.

[176] Local Government Association, *Analysis of Safeguarding Adult Reviews April 2017 – March 2019 Findings for sector-led improvement* (LGA 2020). Partners in Care and Health are currently commissioning a second national analysis of safeguarding adult reviews for the period April 2019 to March 2023. Preston-Shoot has criticised the fact that the Department of Health and Social Care does not sponsor or commission thematic analysis at a national level, which can be contrasted with the biennial or periodic reviews of serious case reviews commissioned by the Department of Education. See Preston-Shoot, "Making any difference? Conceptualising the impact of safeguarding adult boards" (2020) 22(1) Journal of Adult Protection 21 at page 25.

[177] For example, see Braye and Preston-Shoot, *Learning from SARS: A report for the London Safeguarding Adults Boards* (2017); East Midlands Safeguarding Adult Network*, Report from a thematic review of Safeguarding Adult Reviews within the East Midlands* (2017).

[178] Preston-Shoot, "Learning from safeguarding adult reviews on self-neglect: addressing the challenge of change" (2018) 20(2) Journal of Adult Protection 78 at page 90.

[179] See Preston-Shoot, "Making any difference? Conceptualising the impact of safeguarding adult boards" (2020) 22(1) Journal of Adult Protection 21 at page 25.

[180] Local Government Association, *Analysis of Safeguarding Adult Reviews April 2017 – March 2019 Findings for sector-led improvement* (LGA 2020) at page 211.

[181] Local Government Association, *National Escalation Protocol for Issues from Safeguarding Adults Reviews from Safeguarding Adult Boards* (LGA 2021).

(b) Wales

[17.77] In Wales, the Social Services and Well-being (Wales) Act 2014 provides for the establishment of local Safeguarding Adults Boards ("SABs").[182] Membership must include the local authority, the chief officer of the police, the local Health Board, the relevant NHS Trust and certain people carrying out probation services in the local area.[183] There is also a power to specify further members in regulations if they carry out functions in relation to children or adults under another enactment. The SAB may also include people or bodies who carry out functions or are engaged in activities involving adults in the area.[184] The SAB's objectives are to (1) protect adults in its area who have care and support needs and are experiencing, or are at risk of experiencing abuse or neglect, and (2) prevent those adults from becoming at risk of abuse or neglect.[185] The legislation provides that regulations must set out the functions and procedures of the SAB.[186]

[17.78] One of the functions of the SAB is to carry out practice reviews.[187] The aim of practice reviews is to "identify any steps that can be taken by Safeguarding Board partners or other bodies to achieve improvements in multi-agency … adult protection practice".[188] There are two types of reviews in Wales: concise reviews and extended reviews. The type of review that is carried out will depend on whether the at-risk adult was a person who the local authority took action to protect from abuse or neglect in the 6 months preceding the incident. Reviews must be undertaken where it is known or suspected that the adult has died, sustained potentially life-threatening injury, or sustained serious and permanent impairment of health or development.[189]

[17.79] The regulation details the steps that must be followed by a Safeguarding Adult Board while conducting a practice review.[190] This includes holding a multi-

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[182] These exist within Safeguarding Boards which include Safeguarding Children Boards in areas designated by regulations. See section 134 of the Social Services and Well-being (Wales) Act 2014.

[183] Section 134(2) of the Social Services and Well-being (Wales) Act 2014.

[184] Section 134(9), (10) of the Social Services and Well-being (Wales) Act 2014.

[185] Section 135(2) of the Social Services and Well-being (Wales) Act 2014.

[186] Section 135(4) of the Social Services and Well-being (Wales) Act 2014.

[187] Regulation 3(2)(l) of The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015.

[188] Regulation 4(2) of The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015.

[189] Regulation 4(3)(a) and (4)(a) of The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015.

[190] Regulation 4(5) of The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015.

agency learning event before finalising a report which gives practitioners an opportunity to reflect on what happened and identify systems improvements and any organisational barriers to change.[191] The regulation provides that Boards should produce action plans detailing actions that must be taken by bodies represented on the Board to implement the recommendations, and that it should undertake periodic progress reviews to monitor progress. It also states that practice reviews must be made publicly available for a specified period.[192] Statutory guidance further details the process involved in practice reviews and provides that the review process should be finished as soon as possible but should not generally take longer than six months from the date of referral.[193]

[17.80] In contrast to England, the Social Services and Well-being (Wales) Act 2014 provides for the establishment of an overarching structure on a statutory basis known as the National Independent Safeguarding Board.[194] The objectives of the National Board are to (1) provide support and guidance to SAB, (2) report on the suitability and efficacy of arrangements to safeguard children and adults, and (3) propose reforms to the Welsh Ministers on how to improve these arrangements.[195] The Board must produce an annual report for the Welsh Ministers and any other report that the Welsh Ministers may request. The Board may also submit a report on any other issue that it wishes to raise with the Ministers.[196] This ensures that the National Board has an effective mechanism to escalate issues of national relevance to the Welsh Ministers who can implement system improvements in the form of policy or legislative change.

[17.81] At present, the Welsh government is considering introducing a Single Unified Safeguarding Review ("SUSR") process.[197] This process will combine adult

[191] Regulation 4(5)(d) of the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015; Welsh Government, *Social Services and Well-being (Wales) Act 2014 – Working Together to Safeguard People – Volume 3 – Adult Practice Review* (2016) at para 6.36.

[192] The statutory guidance provides that the report should be published on the Board's website for a minimum of 12 weeks. After that, a reference on the website should provide that it should be available on request. See Welsh Government, *Social Services and Well-being (Wales) Act 2014 – Working Together to Safeguard People – Volume 3 – Adult Practice Review* (2016) at para 6.49.

[193] Welsh Government, *Social Services and Well-being (Wales) Act 2014 – Working Together to Safeguard People – Volume 3 – Adult Practice Review* (2016) at para 6.50.

[194] Section 132 of the Social Services and Well-being (Wales) Act 2014.

[195] Section 132(2) of the Social Services and Well-being (Wales) Act 2014.

[196] Section 132(3) of the Social Services and Well-being (Wales) Act 2014.

[197] Welsh Government, Open Consultation – Single Unified Safeguarding Review (SUSR): consultation information (2023) < https://www.gov.wales/single-unified-safeguarding-review-susr-consultation-information-html> accessed 4 April 2024. Calls for a single review process arose out of two reports which called for a more coordinated review process. Robinson, Rees, Dehaghani, *Findings from a thematic analysis of reviews into adult deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide*

practice reviews, child practice reviews, mental health homicide reviews, domestic homicide reviews and offensive weapon homicide reviews under a single review process.[198] An SUSR will be carried out by the regional Safeguarding Boards (as currently exist), and depending on the circumstances, they will sometimes conduct SUSRs in collaboration with Community Safety Partnerships and other similar community structures. The Welsh government considers that this will simplify the review process, reduce duplication of effort, break down silos, and promote a multi-agency approach.[199] Where the criteria for one or more of the review processes listed above are met, the regional Safeguarding Board must undertake a SUSR.[200] The draft guidance proposes the creation of multiple structures, which will have different roles in the SUSR process.[201]

[17.82] The draft statutory guidance details how the SUSR process will operate. Its main objective is to streamline the review process and avoid the need to undertake multiple reviews in relation to the same incident. The guidance notes that:

> Multiple reviews have caused significant duplication of effort and resources, while also putting the family and principal individuals through numerous reviews, causing delays in the identification of the identified learning.[202]

Reviews (Cardiff University 2018); James, *Domestic Homicide Reviews in Wales: Illuminate the Past to Make the Future Safer* (2018) unpublished.

[198] Welsh Government, *Draft Statutory Guidance - Single Unified Safeguarding Review – Learning from the Past to make the Future Safer* (2023) < https://www.gov.wales/single-unified-safeguarding-review-statutory-guidance> accessed 6 April 2024.

[199] Welsh Government, *Draft Statutory Guidance - Single Unified Safeguarding Review – Learning from the Past to make the Future Safer* (2023) at page 8.

[200] Welsh Government, *Draft Statutory Guidance - Single Unified Safeguarding Review – Learning from the Past to make the Future Safer* (2023) at pages 17 to 19.

[201] This will include a Ministerial Board (which will provide political and strategic oversight of the SUSR process), and a Strategy Group (which will provide leadership and oversight to the Ministerial Board and Operational Management Group, and advise, inform and influence the Welsh and UK Governments and national organisations). The Operational Management Group will contribute to the delivery of the SUSR programme and have ownership over the Co-Ordination Hub (that will identify and disseminate key learnings, themes and issues, collate outcomes of Learning Events and organise themed Dissemination Events) and the Wales Safeguarding Repository (which will hold all completed SUSR reviews). It will also include a Victim and Family Reference Group, which is a forum to ensure the voices of victims and families are a central input in the SUSR process. See Welsh Government, *Draft Statutory Guidance - Single Unified Safeguarding Review – Learning from the Past to make the Future Safer* (2023) at pages 6 and 12.

[202] Welsh Government, *Draft Statutory Guidance - Single Unified Safeguarding Review – Learning from the Past to make the Future Safer* (2023) at page 12.

(c) Scotland

[17.83] The Adult Support and Protection (Scotland) Act 2007 provides for the establishment of Adult Protection Committees ("APCs").[203] These are local, multi-agency, strategic forums that seek to improve co-operation and communication between public bodies and office-holders concerned with safeguarding adults in a particular region.[204] Each public body and office-holder must nominate a representative who has the relevant skills and knowledge to sit on the APC.[205]

[17.84] Learning reviews are conducted by APCs to carry out their statutory function to keep procedures and practices related to adult safeguarding under review and improve multi-agency cooperation and communication.[206] The purpose of learning reviews is to learn from incidents in which an at-risk adult has died or been seriously harmed in order to share and apply that learning locally and nationally to improve the quality of services.[207]

[17.85] Prior to learning reviews, APCs carried out significant case reviews.[208] The National Guidance for Adult Protection Committees – Undertaking Learning Reviews, published in 2022, sets out how learning reviews should be carried out.[209] The aim of the guidance is to provide a consistent approach to learning

[203] Section 42 of the Adult Support and Protection (Scotland) Act 2007.

[204] These include: the local council, the Care Inspectorate (Scotland), Healthcare Improvement Scotland, the local Health Board, the chief constable of the Police Service of Scotland and any other public body or office-holder specified in regulations. See section 42(3) of the Adult Support and Protection (Scotland) Act 2007.

[205] Section 43 of the Adult Support and Protection (Scotland) Act 2007.

[206] Section 42(1) of the Adult Support and Protection (Scotland) Act 2007. Learning reviews can be requested by any agency with an interest in an at-risk adult's wellbeing and safety, where they consider the criteria for a review is met. Learning reviews may also be triggered by complaints made by families through normal complaints procedures, where an agency considers the criteria for a learning review is met.

[207] Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 4 <https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2022/05/adult-support-protection-learning-review-guidance/documents/national-guidance-adult-protection-committees-undertaking-learning-reviews/national-guidance-adult-protection-committees-undertaking-learning-reviews/govscot%3Adocument/national-guidance-adult-protection-committees-undertaking-learning-reviews.pdf> accessed 6 April 2024.

[208] Scottish Government, *Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review* (Scottish Government 2019) <https://www.careinspectorate.com/images/Interim_SCR_Guidance.pdf> accessed 6 April 2024.

[209] Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022).

reviews.[210] It provides that learning reviews should seek to establish what happened, examine the role of all relevant services connected with the incident, identify any systemic issues, and establish whether there are areas for improvement in how agencies work individually or collectively to safeguard at-risk adults.[211] The guidance notes that learning reviews are not investigations, and the focus is not individual culpability. Instead, learning reviews provide an opportunity for "in-depth analysis and critical reflection in order to gain understanding of inevitably complex situations and to develop strategies to support practice and improve systems across agencies".[212]

[17.86] Learning reviews are conducted by a Review Team,[213] appointed by APCs where the at-risk adult "is, or was, subject to adult support and protection processes and the incident or accumulation of incidents gives rise for reasonable cause for concern about how professionals and services worked together to protect the adult from harm".[214] This applies where the at-risk adult dies,[215] or is believed to have experienced serious abuse or neglect.[216] Learning reviews can also be conducted where an at-risk adult is not subject to adult support and protection processes and has died or been seriously harmed where:

- the findings of an inquiry or review by another organisation or court proceedings, or a referral from another organisation gives rise to reasonable cause for concern about the lack of involvement in relation to the Adult Support and Protection (Scotland) Act 2007; or

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210 Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 4.

211 Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 4.

212 Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 6.

213 Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at pages 11 to 13. The Review Team will comprise of a Chair, team members, a Reviewer and an Administrator.

214 Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 7.

215 For a death to meet the criteria for a learning review, it must meet the following conditions: (1) harm or neglect is a factor in the death, or is suspected to be a factor, (2) the death is by suicide or accidental, (3) the death is by alleged murder, culpable homicide, reckless conduct or an act of violence.

216 Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 7.

- the Adult Protection Committee determines that there may be learning to be gained through conducting a learning review.[217]

[17.87] The guidance sets out how APCs should proceed with learning reviews where there are inter-related investigations, reviews and other processes being undertaken in relation to the same incident, such as criminal investigations, disciplinary processes and NHS Significant Adverse Event reviews.[218] It emphasises the need to avoid duplication "through the integration and coordination of these processes wherever possible" and encourages ongoing dialogue to ascertain whether or when a learning review can be initiated, progressed or concluded in light of other reviews and investigations.[219] The timescale for conducting learning reviews is six to nine months, although the guidance acknowledges that parallel processes may result in unavoidable delay.[220]

[17.88] In terms of the learning review report, the guidance prescribes what should be included in a report,[221] and includes a model report. The report of the Review Team will be presented to the APC and Chief Officer Group ("COG") to agree on the recommendations and sign off the report.[222] A report may specify desired outcomes for change and assign responsibility for their implementation within a set time period. The implementation of recommendations may be subject to review.[223]

[17.89] Learning reviews are not automatically published; it is a decision for the COG.[224] Publications must be appropriately anonymised while also ensuring that learning is capable of being derived from the report. If a decision is made not to

[217] Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 7.

[218] Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 8. See also Annex 7.

[219] Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 8.

[220] Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 17.

[221] Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 16.

[222] Chief Officer Groups comprise of the council Chief Executive, the NHS Chief Executive and a representative from the Police. It also includes the Chief Social Work Officer. They are responsible for improving the experience of at-risk adults in their local areas. They oversee the work of Adult Protection Committees and ratify the initiation of learning review processes and recommendations in reports.

[223] Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 16.

[224] Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 16.

publish a report, the learning should be extracted and published separately, and the "exceptional circumstances underpinning" the decision not to publish should be noted in the minutes of the COG meeting.[225] In deciding whether to publish the report, the COG will consider:

- the view of the APC;
- the views of the at-risk adult and their family;
- issues of confidentiality; and
- data protection principles.[226]

[17.90] Once the report is ratified, the APC will agree a local dissemination approach. It will also submit the report online to the Care Inspectorate (Scotland), which maintains a central repository for all learning reviews conducted in Scotland.[227] The Care Inspectorate also inspects care services in Scotland and investigates complaints about care services. The role of the Care Inspectorate (Scotland) is to support "practical improvement as a result of national learning identified by Learning Reviews by holding learning events and by exploring the development of mechanisms to support better sharing of learning from Learning Reviews across the country".[228] The Care Inspectorate also regularly reviews Learning Reviews submitted to it by local APCs and reports nationally on salient learning themes to improve services across Scotland and inform the Scottish government on safeguarding issues.[229]

(d) Northern Ireland

[17.91] At present, Northern Ireland does not have adult safeguarding legislation. The Adult Protection Bill is in development and if enacted, will establish an

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[225] Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 16.

[226] Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 16.

[227] Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 17.

[228] Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 17.

[229] Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 17. See for example, Care Inspectorate, *Triennial review of initial case reviews and significant case reviews for adults (2019-2022): Learning from reviews* (Care Inspectorate 2022) <https://www.careinspectorate.com/images/documents/6965/Triennial%20review%20adult%20initial%20case%20reviews%20and%20significant%20case%20reviews%202019-22.pdf> accessed 6 April 2024. From 2023, initial case reviews and significant case reviews that were ongoing at the time the guidance changed will be complete and the Care Inspectorate will move to considering learning reviews only.

Independent Adult Protection Board ("IAPB").[230] As part of its remit, the IAPB will have responsibility for "Serious Case Reviews" ("SCRs"). SCRs are defined as "multi-agency reviews that look into the circumstances surrounding the death of, or serious harm to, an adult at risk and in need of protection".[231] It is stated that the purpose of SCRs will be "to establish whether there are lessons to be learned from a case about the way in which agencies and professionals work together and to action change as a result".[232]

[17.92] SCRs will be new to Northern Ireland, and do not currently take place in practice.[233] Very little information is available on how SCRs would work if the legislation were enacted. The consultation document, which sought views on the Adult Protection Bill, states that "statutory guidance supporting the legislation will be required to provide further details on eligibility criteria and to consider the interface with other review mechanisms…".[234]

[17.93] Northern Ireland currently conducts Serious Adverse Incident ("SAI") reviews across health and social care settings.[235] The current SAI procedure provides that SAIs must be reported to the Health and Social Care Board (now Strategic

[230] Department of Health (Northern Ireland), *Legislative options to inform the development of an Adult Protection Bill for Northern Ireland* (2020) < https://www.health-ni.gov.uk/consultations/legislative-options-inform-development-adult-protection-bill-northern-ireland> accessed 6 April 2024. Proposals for the Bill suggest that it will include a regulatory making power to set out "further operational details in relation to the membership and procedures of the IAPB". See Department of Health (Northern Ireland), *Adult Protection Bill – Draft Final Policy Proposals for Ministerial Consideration* (2021) at para 8 < https://www.health-ni.gov.uk/sites/default/files/consultations/health/adult%20protection%20bill-final%20policy%20proposals.pdf> accessed 6 April 2024.

[231] Department of Health (Northern Ireland), *Adult Protection Bill – Draft Final Policy Proposals for Ministerial Consideration* (2021) at para 9.

[232] Department of Health (Northern Ireland), *Adult Protection Bill – Draft Final Policy Proposals for Ministerial Consideration* (2021) at para 9.

[233] The Serious Adverse Incidents Procedure (2016) mentions that the procedure for serious case reviews is set by the Northern Ireland Adult Safeguarding Partnership ("NIASP"). However, the Commission understands that NIASP as a regional body no longer exists, and that while it had started to look at the SCR process, work on this was never completed.

[234] Department of Health (Northern Ireland), *Legislative options to inform the development of an Adult Protection Bill for Northern Ireland* (2020) at para 2.69. The responses to the consultation were hugely in favour of SCRs, only two respondents were critical of the introduction of SCRs, they felt that findings under the current procedure Serious Adverse Incidents reviews rarely translated into practice, and that the focus should be on fixing the existing system as opposed to introducing a new review process. See Department of Health (Northern Ireland), *Adult Protection Bill – Consultation Analysis Report* (2021) at page 30 < https://www.health-ni.gov.uk/sites/default/files/consultations/health/consultation%20documant-adult%20protection%20bill.pdf> accessed 6 April 2024.

[235] These were first introduced in regional guidance in 2004, which has been updated intermittently since then, with the latest update taking place in 2016.

Planning and Performance Group ("SPPG") within the Department of Health in Northern Ireland),[236] who works jointly with the Public Health Agency ("PHA") and where required, the Regulation and Quality Improvement Authority ("RQIA").[237]

[17.94] In terms of the distinction between SAIs and SCRs, SCRs will be carried out by the IAPB and therefore can be said to be specific to adult safeguarding, in contrast to SAI reviews which can be carried out in relation to serious incidents arising.[238] The Commission understands that SAIs are generally undertaken by the relevant Trust where the incident occurs, whereas SCRs, if introduced, will operate at a higher level, involving multiple agencies overseen by the IAPB. The interface between the two procedures is unclear at this stage, but it may be the case that one of the review processes will be paused, while the other is ongoing.

[17.95] SAI reviews, as set out in the 2016 guidance, aim to:

(a) provide a mechanism to effectively share learning in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for service users;
(b) provide a coherent approach to what constitutes a SAI; to ensure consistency in reporting;
(c) clarify the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning arising from SAIs;
(d) ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident or be involved in the review;
(e) ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence.[239]

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[236] As of 31 March 2022, the HSCB's functions and responsibilities were transferred to the Department of Health. Its former staff now work in the SPPG within the Department which was set up to host the former HSCB's functions. The 2016 policy has not yet been updated to reflect this change.

[237] RQIA are statutorily obliged to investigate certain incidents that are also reported under the SAI procedure. Where this arises, RQIA will work in conjunction with the SPPG/PHA with regard to the review of certain categories of SAI. See Health and Social Care Board, *Procedure for the Reporting and Follow up of Serious Adverse Incidents* (HSCB 2016) at para 7.3 < https://www.ihrdni.org/401-002p.pdf> accessed 6 April 2024 and Appendix 15; article 35 of the Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003.

[238] Health and Social Care Board, *Procedure for the Reporting and Follow up of Serious Adverse Incidents* (HSCB 2016) at para 9.

[239] Health and Social Care Board, *Procedure for the Reporting and Follow up of Serious Adverse Incidents* (HSCB 2016) at para 2.

[17.96] The 2016 guidance acknowledges that there may be overlapping reporting, review and investigation processes, and provides that these will operate "in tandem" with the procedure for reporting SAIs.[240] The guidance contains a protocol for responding to SAIs in the event of homicide where the person had a mental illness or disorder and/or was known to or referred to mental health services or learning disability services in the 12 months prior to the incident.[241] The guidance also explicitly mentions that an incident resulting in an SAI might also require a safeguarding investigation and provides that these should "run in parallel as separate to the SAI process with the relevant findings from these investigations/ reviews informing the SAI review".[242] Appendix 17 of the guidance sets out how SAI reviews should be conducted in the context of child and adult safeguarding, which outlines various protocols and memorandums of understanding governing the area.[243]

[17.97] HSC organisations report SAIs to the SPPG. The role of the SPPG, in conjunction with the PHA is to disseminate learnings from SAI reviews. This may be done by learning letters, reminder of best practice letters, newsletters, or thematic reviews. The SPPG/PHA will also:

- provide an assurance mechanism that learning from SAIs has been disseminated and appropriate action taken by all relevant organisations;
- review and consider learning from external/independent reports relating to quality/ safety.[244]

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[240] Health and Social Care Board, *Procedure for the Reporting and Follow up of Serious Adverse Incidents* (HSCB 2016) at para 3.5. A memorandum of understanding was agreed between the Department of Health, on behalf of the HSCS, the PSNI, the Coroners Service for NI and the Health and Safety Executive for NI in 2013. It sets out how the organisations should communicate with one another where "unexpected death or serious untoward harm" occurred which requires investigation by the PSNI, Coroners Service for NI or HSENI separately or jointly. It does not preclude simultaneous investigations or reviews by the HSC.

[241] Appendix 14 of the Health and Social Care Board, *Procedure for the Reporting and Follow up of Serious Adverse Incidents* (HSCB 2016).

[242] Appendix 17 of the Health and Social Care Board, *Procedure for the Reporting and Follow up of Serious Adverse Incidents* (HSCB 2016).

[243] For example, see DHSSPS, PSNI, HSENI, Courts and Tribunal Service (NI), *Memorandum of Understanding: Investigating patient or client safety incidents (Unexpected death or serious untoward harm): Promoting liaison and effective communications between the Health and Social Care, Police Service of Northern Ireland, and the Health and Safety Executive for Northern Ireland* (2013) < https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/mou-patient-client-safety-incidents.pdf> accessed 6 April 2024.

[244] Health and Social Care Board, *Procedure for the Reporting and Follow up of Serious Adverse Incidents* (HSCB 2016) at para 8. This is in addition to any local learning from SAIs that may be disseminated within a particular area.

[17.98] There have been a number of reports and reviews in recent years related to SAI reviews that are critical of the SAI process, highlight deficiencies in the system and make recommendations for reform.[245] In particular, a RQIA review concluded that the SAI procedure consistently fails to "achieve a systemic understanding" of serious incidents and "design recommendations and action plans" that will reduce the likelihood of recurrence.[246] In July 2022, the Minister for Health, in response to the RQIA review, announced plans to improve the SAI process in Northern Ireland by re-designing a new regional SAI procedure.[247] It is unclear when this will take place. The 2016 procedure remains in operation.

[17.99] In response to the report of the Office of the Commissioner for Older Peoples outlining significant failures in care of residents in a Dunmurry Manor nursing home,[248] the Department of Health commissioned an independent review by CPEA Ltd.[249] Its Adult Safeguarding and Complaints papers are particularly relevant as Ireland also has overlapping processes and a disjointed approach to adult safeguarding. In its Adult Safeguarding paper, CPEA made comments about the divergence in procedures across the region and the lack of coherent approach to adult safeguarding. It stated that there has been:

> no evaluation or impact assessment of the quality and effectiveness of adult safeguarding in Northern Ireland, taking

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[245] Donaldson, Rutter, Henderson, *The Right Time, The Right Place – An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland* (2014); O'Hara, The Inquiry into Hyponatraemia-related Deaths (2018); the Regulation and Quality Improvement Authority, *RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland* (RQIA 2022); Commissioner for Older People in Northern Ireland, *Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home* (COPNI 2018); CPEA, *Independent Whole Systems Review into Safeguarding and Care at Dunmurry Manor Care Home - Evidence Paper 1: Adult Safeguarding within a Human Rights Based Framework in Northern Ireland* (CPEA 2022).

[246] Regulation and Quality Improvement Authority, *RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland* (RQIA 2022) at page 43 < https://www.rqia.org.uk/RQIA/files/24/24765aab-014c-42bb-ba0b-9aa85e739704.pdf#:~:text=RQIA%20endorse%20the%20point%20made,whole%20system%20to%20apply%20learning.> accessed 6 April 2024.

[247] Northern Ireland Executive, *Reform planned for SAI Process- Swann* (NIE, July 2022) < https://www.northernireland.gov.uk/news/reforms-planned-sai-process-swann> accessed 4 April 2024. See also BBC, "NI Health: Serious adverse incidents 'likely to be repeated'" BBC News (7 July 2022) <https://www.bbc.com/news/uk-northern-ireland-62083787> 4 April 2024.

[248] Commissioner for Older People in Northern Ireland, *Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home* (COPNI 2018) < https://setrust.hscni.net/wpfd_file/set3918-commissioner-for-older-people-northern-ireland-copni-report-home-truths-a-report-on-the-commissioners-investigation-into-dunmurry-manor-care-home/> accessed 6 April 2024.

[249] CPEA Ltd is a Liverpool-based independent social services consultancy and social care network.

account of the contrasting priorities and arrangements of RQIA inspections, professional regulation, law enforcement, complaints, clinical governance, serious adverse incidents and internal disciplinary processes.[250]

[17.100] Its Complaints paper noted that the interface between “complaints, serious adverse incidents, whistleblowing, safeguarding and RQIA notifications has become complex and widely misunderstood”.251 The paper stated that the intersection between the various mechanisms “is susceptible to professional disagreement, misunderstanding and delayed responses”.[252]

[17.101] It is notable that Northern Ireland proposes to introduce SCRs carried out by the IAPB, despite already having an SAI system in place for reviewing incidents in health and social care settings, which also includes incidents involving at-risk adults. While it is unclear how SCRs will operate in practice, it is evident that they are considered to be a necessary component in an Adult Protection Bill in Northern Ireland.

4. The need for reform in Ireland

[17.102] Ireland is somewhat of an outlier among its neighbouring jurisdictions in that it does not have adult safeguarding specific reviews of serious incidents.[253] There have been recent calls to introduce such adult safeguarding reviews. The Irish Association of Social Workers (“IASW”) called for legislation that includes the introduction and publication of “mandatory, transparent, Safeguarding Adult Reviews” where it is known or suspected that an at-risk adult suffered serious injury or loss of life due to abuse or neglect, and there is “concern that agencies could have worked together more effectively to protect the person”.[254] The IASW states that these reviews should take place “across the entire spectrum of

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[250] CPEA Ltd, *Independent Whole Systems Review into Safeguarding and Care at Dunmurry Manor Care Home – Evidence Paper 1: Adult Safeguarding within a Human Rights Based Framework in Northern Ireland* (CPEA 2022) at page 20. For all the CPEA Ltd reports on the issue see < https://www.health-ni.gov.uk/publications/independent-review-safeguarding-and-care-dunmurry-manor-care-home> accessed 6 April 2024.

[251] CPEA Ltd, I*ndependent Whole Systems Review into Safeguarding and Care at Dunmurry Manor Care Home – Evidence Paper 2: Complaints* (CPEA 2022) at page 34.

[252] CPEA Ltd, I*ndependent Whole Systems Review into Safeguarding and Care at Dunmurry Manor Care Home – Evidence Paper 2: Complaints* (CPEA 2022) at page 51.

[253] Safeguarding Ireland, *Identifying RISKS Sharing RESPONSIBILITIES: The Case for a Comprehensive Approach to Safeguarding Vulnerable Adults – Discussion Paper* (SA 2022) at pages 22 and 201. England, Scotland and Wales all have adult safeguarding specific reviews. Northern Ireland is planning on introducing serious case reviews for incidents involving at-risk adults through its Adult Protection Bill.

[254] Irish Association of Social Workers, *Position Paper on Adult Safeguarding: Legislation, Policy and Practice (IASW 2022)* at page 21.

adult social care" in a broad range of settings".[255] A recent report on deaths of homeless people also called for the introduction of adult safeguarding reviews or critical incident reviews to identify learning for homeless and health services to improve their response to homelessness.[256]

[17.103] While the Commission's Issues Paper on a Regulatory Framework for Adult Safeguarding did not directly ask for views on whether adult safeguarding reviews of serious incidents should be introduced, some respondents suggested in their responses that reviews akin to those that exist in England, Scotland and Wales should be carried out in Ireland. They did not express a definitive collective view on what body or structure should carry out these reviews; suggestions included HIQA, an independent "Adult Safeguarding Authority" and inter-sectoral Safeguarding Boards on which key partners in the safeguarding sphere would be represented. The IASW is of the view that "SARs are an integral part of open learning, transparency, and culture change". The IASW said that it is "imperative" that the role of safeguarding adult reviews in bringing about improvements to organisational and learning culture, practice and positive outcomes for at-risk adults is recognised in this jurisdiction.[257]

(a) No fault

[17.104] Where reviews are too focused on attributing blame to individuals, organisations, agencies or service providers instead of learning from what has happened in the past, this can have a negative impact on the ability to learn from past incidents. Where reviews are overly focused on identifying wrongdoings and shortcomings in professional practice, this can result in defensiveness on behalf of those involved in the reviews, reluctance to reflect on what could have been done differently and resistance to change.

[17.105] The focus of serious incident reviews should be to unearth systemic issues and identify contributing factors that offer insight into how to improve adult safeguarding practices. The success of this exercise can be severely impacted where there is a focus on blaming individuals for mistakes as opposed to

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[255] Irish Association of Social Workers, *Position Paper on Adult Safeguarding: Legislation, Policy and Practice (IASW 2022)* at page 21. These include residential services, hospitals, nursing homes, direct provision, prisons, homeless services, mental health settings and any service providing care or support to a vulnerable adult.

[256] Dr Austin O'Carroll, *Interim Report on Mortality in Single Homeless Population 2020* (Dublin Region Homeless Executive and HSE 2021) at pages 51, 53; Joint Committee on Housing, Local Government and Heritage Debates 24 June 2021 at pages 7 to 8; Holland, "Calls for every death of a homeless person to have an 'adult safeguarding review'" *The Irish Times* (12 July 2021).

[257] Irish Association of Social Workers, *IASW Response to Public Consultation on Policy Proposals on Adult Safeguarding in the Health and Social Care Sector* (IASW 2024) at page 2 <https://iasw.ie/download/1238/IASW%20Submission%20to%20DOH%20re.%20Adult%20Safeguarding_02.04.24.pdf> accessed 4 April 2024.

identifying how systems, procedures and processes should be improved to reduce the likelihood of recurrence.

[17.106] Serious incidents involving at-risk adults frequently occur in circumstances where there are systemic organisational issues that can make it more challenging for individuals or service providers to respond appropriately to warning signs or concerns. For example, inadequate staffing levels may impact how individuals or service providers react to situations. It is important that contextual and systemic factors are taken into consideration when conducting a review to identify how the system as a whole can be improved.

[17.107] It is equally important that staff believe that they can contribute to serious incident reviews without fear of retribution or liability. This maximises the effectiveness of the review by ensuring that there is open communication by all those effected by a serious incident, and that lessons can be identified and learned. For that reason, the Commission takes the view that it is important that serious incident reviews are conducted in a culture that promotes learning, minimises risk and improves safety practices to prevent incident recurrence.

[17.108] The Commission believes that serious incident reviews should be focused on learning, not on individual culpability. Their purpose should not be to hold any individual or organisation to account. Depending on the serious incident at issue, there may be other processes that exist for that purpose, such as criminal investigations and proceedings, disciplinary proceedings, and professional and service regulation. Reviews are distinct from these processes, and it is important that they are carried out in a way that does not undermine the primary objective of learning.

(b) Consistency

[17.109] At present, serious incidents concerning at-risk adults in Ireland can be examined through a variety of different mechanisms, as identified earlier. Sometimes serious incidents will go through more than one review process, particularly if the case faces intense scrutiny from the public and the media. For example, an incident may be reviewed initially by the local Safeguarding and Protection Team and later be subject to a review by the NIRP or an independent expert commissioned by the HSE. Alternatively, an NIRP report may be followed by a Commission of Investigation, depending on the seriousness or prevalence of the type of incident in the particular setting and whether it raises significant issues of public concern.

[17.110] There is no consistent approach to addressing very serious incidents concerning at-risk adults. The approach taken can vary even where the serious incident involves the same or very similar circumstances or care settings. This gives rise to a concern that serious incidents that do not receive the same media attention or public scrutiny as those that spur multiple reviews are not being adequately addressed. The setting up of multiple ad-hoc reviews in response to serious

incidents can appear to be reactive and haphazard. It creates the impression that there is no set pathway to be followed, and there is a lack of transparency about:

- why some serious incidents prompt more than one review process and other equivalent serious incidents do not; and
- why different review processes are chosen for identical or similar situations.

[17.111] If the purpose of these types of reviews is to identify lessons to be learned to improve the safety and quality of services, and prevent recurrences, it would be preferrable to have a more systematic and structured approach to addressing the most serious incidents involving at-risk adults. Introducing adult safeguarding reviews for very serious incidents in this jurisdiction, similar to those that exist in England, Scotland and Wales, would provide more certainty and consistency for at-risk adults, their families, service providers and relevant agencies, by providing a primary method of reviewing serious incidents involving at-risk adults and identifying learning.[258] If adult safeguarding reviews of very serious incidents were routinely carried out and operated efficiently to generate safety and quality improvements, the need for more elaborate, costly, and lengthy review processes such as independent expert reviews and Commissions of Investigation would lessen.

[17.112] The Commission is not suggesting that all the review mechanisms outlined in section 2 of this Chapter should be replaced with adult safeguarding reviews. If adult safeguarding reviews of very serious incidents were introduced in this jurisdiction, there would still be a place for localised reviews of safeguarding incidents by the HSE, other service providers, or Safeguarding and Protection Teams whether situated in the HSE or a new Safeguarding Body; and reviews, investigations and inquiries by regulators. However, the Commission sees the case for a consistent approach when it comes to very serious incidents, and for reviews of that nature to be mandatory, and standardised to ensure that learning is derived from every serious incident where it meets the threshold and there are no disparities in how they are addressed.

(c) Applicability

[17.113] Most of the review mechanisms in Ireland, discussed earlier in this Chapter, require a decision to set up or commission a review. These procedures do not

[258] Of course, many of the current review mechanisms would continue to exist even if adult safeguarding specific reviews are introduced on a statutory basis. To avoid duplication, and the carrying out of multiple reviews into the same incident, guidance could be introduced to clarify the status of the various review processes where a serious incident concerns an at-risk adult or at-risk adults. It could clarify the circumstances where more than one review is required, and instances where adult safeguarding specific reviews suffice.

automatically happen as a matter of course. For example, for a Safeguarding and Protection Team in a CHO to carry out a review, a decision must first be made by the HSE Head of Social Care in the relevant CHO that it would be more appropriate for the Safeguarding and Protection Team to undertake the review instead of the service provider.[259] Similarly, the HSE's National Clinical Director, Quality and Patient Safety, needs to commission the NIRP to carry out a review.[260] This can be contrasted with safeguarding adult reviews in England, Scotland and Wales where there are set criteria that automatically trigger a mandatory review by a local Safeguarding Adult Board or Adult Protection Committee. This ensures that all serious incidents involving at-risk adults, which meet set criteria, are dealt with in a comparable manner.

[17.114] Adult safeguarding reviews of serious incidents would only be concerned with very serious incidents specific to adult safeguarding involving at-risk adults, as opposed to (1) more general health and social care incidents, as is the case with the HSE Incident Management Framework and NIRP reports, or (2) general issues of public importance, as is the case with Commissions of Investigation and Tribunals of Inquiry. At present, many of the frequently used review mechanisms, such as the HSE Incident Management Framework, Safeguarding and Protection Team Reviews, NIRP reviews and independent reviews commissioned by the HSE, only take place in relation to incidents occurring in HSE managed or funded services or organisations. Commissions of Investigation can be established to address issues of significant public concern, and conceivably could cover incidents occurring in services or organisations not funded or managed by the HSE. However, given the cost, time and resources inherent in this review mechanism, it is often reserved for situations where it appears that abuse is widespread or endemic in a particular setting. Legislation introducing adult safeguarding reviews for very serious incidents could extend their remit beyond the range covered by current mechanisms, to cover all serious incidents involving at-risk adults regardless of whether the service or organisation where the incident occurred is managed or funded by the HSE. For example, they could cover serious incidents that occur in the home or community, where the at-risk adult was not in receipt of services, or in private nursing homes not funded by the HSE.

[17.115] Again, the Commission considers that many of the existing review mechanisms could operate in tandem with adult safeguarding reviews of very serious incidents, and that statutory guidance could outline how the interface between the various review mechanisms should be approached. There is a lot to be said for a review mechanism specific to adult safeguarding where reviews would

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[259] Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures* (HSE 2014) at pages 38 to 39.

[260] National Independent Review Panel and Health Service Executive, *National Independent Review Panel Operational Guidelines 2021* (NIRP and HSE 2021) at page 1.

automatically be conducted where a high threshold is met. The Commission believes that adult safeguarding reviews should be conducted in respect of incidents occurring in all care or refuge settings and services, and that they should not just be restricted to health and social care settings. This will ensure that learnings are identified and shared across all sectors, and it will facilitate the reviewing body in carrying out thematic analysis of multiple reviews spanning incidents across different settings and services.

(d) Statutory powers to require information

[17.116] There is also a disparity between the multiple review processes in terms of powers to require information. For example, Commissions of Investigation have robust powers to require information as they can direct any person to produce documents that are in that person's possession or power.[261] It can seek a court order to enforce its direction if a person does not comply.[262] In contrast, the NIRP panel has much weaker powers to require information. Reviews are based on documentation procured by the Senior Liaison Person in the service where the incident occurred, who acts as a point of contact between the NIRP review team and the service.[263] Where a HSE managed or funded organisation refuses to comply with the NIRP's requests for information, participation or engagement, the National Clinical Director of Quality and Patient Safety will be informed, and they will direct the issue to the appropriate National Director for a resolution.[264]

[17.117] In order for reviews into serious incidents involving at-risk adults to be conducted effectively, the reviewing body needs to be able to access information related to the serious incident, or the at-risk adult, or service provider more generally. They also need to be empowered to interview relevant persons to find out what occurred. Without this, it is difficult to determine what went wrong and what systems needs to be improved to reduce the likelihood of the serious incident recurring. Where there are issues of non-compliance, it would be helpful to have an effective enforcement mechanism, which is independent of the service being reviewed, to ensure that documentation is not being suppressed on a systemic level.

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[261] Section 16 of the Commissions of Investigation Act 2004.

[262] Section 16(6) of the Commissions of Investigation Act 2004.

[263] National Independent Review Panel, Health Service Executive, *National Independent Review Operational Guidelines 2021* (NIRP, HSE 2021) at page 23.

[264] National Independent Review Panel, Health Service Executive, *National Independent Review Operational Guidelines 2021* (NIRP, HSE 2021) at page 33.

(e) Timeliness

[17.118] Some processes in Ireland set timelines for the review and submission of final reports in the form of guidelines. For example, the NIRP's operational guidelines stipulate that the timeline for a review should not exceed nine months, however, extensions can be granted.[265] Others, such as the work of Commissions of Investigation, reviews by local Safeguarding and Protection Teams, and independent expert reviews, rely on terms of reference which will set out the timeline for the review.[266]

[17.119] Unfortunately, as discussed earlier, timelines are frequently not met, and multiple extensions are often sought, making these reviews costly and time-consuming.[267] For example, the Farrelly Commission that is undertaking a review into the 'Grace' case commenced its work in 2017 and was due to complete its work on phase 1 in 2018.[268] It has been granted a number of extensions, most recently until March 2024, six years after it was due to conclude.[269] The IASW express the view that "our costly reviews, as seen in the 'Grace' case, fail to deliver essential lessons in a timely way".[270]

[17.120] In England, Scotland and Wales, statutory guidance provides that Safeguarding Adult Boards and Adult Protection Committees should aim to complete reviews within a reasonable period of time. However, the statutory guidance sets an outer limit for completion that should be adhered to unless there are legitimate reasons for a longer period. This outer limit ranges from six months to nine months.[271] For adult safeguarding reviews to achieve their objectives of

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[265] Health Service Executive and National Independent Review Panel, *National Independent Review Panel Operational Guidelines* (NIRP, HSE 2021) at page 24. Agreement to an extension must be sought from the NIRP Chairperson.

[266] Section 5(2)(a)(ii) of the Commissions of Investigation Act 2004; Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures* (HSE 2014) at page 38.

[267] There are numerous factors that contribute to delays including; lengthy time periods to be considered, difficulties obtaining records, expansion of scope, new lines of inquiry, the need to adhere to fair procedures and ongoing parallel processes such as criminal, coronial or disciplinary investigations or proceedings.

[268] It is also expected to undergo a subsequent review into 46 individuals who were looked after by the same foster care family as 'Grace'. McConnell, "'Grace' commission to be widened to examine cases of 46 others in same foster home" *The Irish Examiner* (17 May 2021) < https://www.irishexaminer.com/news/arid-40290719.html> accessed 6 April 2024.

[269] See articles referenced earlier in this Chapter.

[270] Irish Association of Social Workers, *Position Paper on Adult Safeguarding: Legislation, Policy and Practice* (IASW 2022) at page 14 < https://www.iasw.ie/download/1076/IASW%20Adult%20Safeguarding%20Position%20Paper%202022%20%282%29.pdf> accessed 6 April 2024.

[271] Department of Health and Social Care, *Care and support statutory guidance* (DHSC 2016) at para 14.173; Scottish Government, *National Guidance for Adult Protection Committees Undertaking Learning Reviews* (Scottish Government 2022) at page 17; Welsh Government,

improving the quality and safety of services, and reducing incident recurrence, it is important that reviews are concluded in a timely manner so that learnings can be shared promptly that are still relevant to current practice.

(f) Publication

[17.121] Where a serious incident or series of incidents occur in relation to at-risk adults and a review, investigation or inquiry is conducted, there are often repeated calls for publication of the report. The decision on whether to publish a report on serious incidents affecting at-risk adults has historically proven to be a controversial one in Ireland. For example, the HSE faced severe criticism for not publishing the full NIRP 'Brandon' report and instead opting to publish only an executive summary containing general findings and recommendations, which is a position it continues to adopt.[272] The IASW has criticised the fact that reviews concerning at-risk adults in Ireland are rarely published in full. They note that reports are:

> 'owned' by the HSE/Service Provider who is then the gatekeeper of information about failures in their own services. Residents and families remain uninformed about the true extent of failings within their 'home',

Social Services and Well-being (Wales) Act 2014 – Working Together to Safeguard People – Volume 3 – Adult Practice Reviews (2016) at page 5. These timeframes are not always achievable, even where there are statutory objectives. Analysis of information available in SARs in England from April 2017 to March 2019 found that only 10% of SARs were completed within six months, with more SARs being completed between 6-12 months, or taking longer than 12 months to complete. See Local Government Association, *Analysis of Safeguarding Adult Reviews April 2017 – March 2019 - Findings for sector-led improvement - Final Report* (LGA 2020) at pages 35 to 36.

[272] Minister of State for Disability at the time, Anne Rabbitte, wanted to publish the report in full against the HSE's wishes and sought the advice of the Attorney General on the issue, who ultimately concluded that there was no basis for publishing the report in full, as Ministers are not legally permitted to publish a report where the HSE (which is responsible for publication under the NIRP operational guidelines) determines it should not be published in full. Other reasons put forward by the Attorney General were that undertakings of confidentiality and non-publication were made, and that publication of the full report may adversely affect disciplinary proceedings. See: Holland, "Details of 'Brandon' report makes for devastating reading" *The Irish Times* (16 December 2021) <https://www.irishtimes.com/news/social-affairs/details-of-brandon-report-make-for-devastating-reading-1.4757416> accessed 6 April 2024; McGarry, "HSE in damage control mode to block full publication of Brandon report" *Irish Examiner* (13 January 2022) <https://www.irishexaminer.com/opinion/commentanalysis/arid-40783659.html> accessed 6 April 2024; Burns, "Not possible to publish full Brandon report, AG advises Minister" *The Irish Times* (17 January 2022) <https://www.irishtimes.com/news/social-affairs/not-possible-to-publish-full-brandon-report-ag-advises-minister-1.4778917> accessed 6 April 2024; Conneely, "No basis to publish Brandon report in full – Attorney General" *RTE* (18 January 2022) <https://www.rte.ie/news/ireland/2022/0117/1274212-brandon-report-attorneygeneral/> accessed 6 April 2024; Dáil Eireann Debates, 20 January 2022, vol 1016 no 5 at pages 676 to 677; Dáil Eireann Debates, 20 January 2022, vol 1016 no 5 at pages 676 to 677.

> while Irish social workers are forced to rely on international safeguarding reports to learn what can go wrong and seek to improve practice accordingly here.[273]

[17.122] Publishing full anonymised reports makes the learning therein easily accessible, and provides a nuanced picture of what occurred, which promotes transparency, accountability and a learning culture.[274] However, there may be valid reasons for not publishing a report in full or for deciding to delay publication, such as confidentiality, data protection, the impact on parallel proceedings and the views of affected at-risk adults or family members. If adult safeguarding reviews were to be introduced in this jurisdiction on a statutory basis, this would enable the Oireachtas to determine how it wishes to address the publication of review reports.

(g) Dissemination of learnings and implementation

[17.123] There are many benefits to having an adult safeguarding review mechanism in terms of dissemination of learnings and information gathering. Introducing a designated review process for very serious incidents involving at-risk adults would facilitate the development of a comprehensive, subject-specific database of review reports. Review reports could be hosted in a central repository of reviews that would be easily accessible online, promoting the dissemination of learnings beyond the service or local area where the incident occurred.[275] This would allow reviewers to build upon and make connections with past reviews, resulting in richer analysis and better outcomes for adult safeguarding practice and service improvement. At present, reviews are disparate given the variety of review mechanisms, and full reports are often not freely available. Conducting adult safeguarding reviews would make it easier to gather data on the number and type of very serious incidents involving at-risk adults. It would also be possible to carry out national thematic analysis of review reports (as the reports will be comparable) which would enable the identification of common trends and patterns as well as obstacles to the implementation of recommendations.

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[273] Irish Association of Social Workers, *Position Paper on Adult Safeguarding: Legislation, Policy and Practice* (IASW 2022) at page 14.

[274] In England and Scotland, there are minimal statutory requirements regarding publication of full reports, however it is advised in statutory guidance that full reports should be published except in exceptional circumstances or where there are concerns about confidentiality. In Wales, a regulation provides that practice review reports should be made publicly available. A national thematic review in England concluded that 82% of SAR reports were published in full between April 2017 and March 2019, however, they are typically archived after a certain period has passed. See Local Government Association, *Analysis of Safeguarding Adult Reviews – April 2017 – March 2019 – Findings for sector-led improvement* (LGA 2020) at pages 49 to 50.

[275] This is now the case in England, Scotland and Wales.

[17.124] The objective of adult safeguarding reviews is not to attribute blame to individuals, but to learn from serious incidents and generate improvements in systems and practices.[276] To achieve this aim, recommendations in reviews must be implemented and bring about systemic change. Dissemination of learning from reviews has a major role to play in implementation and can go further than just publishing findings and recommendations. Briefing meetings, conferences and training materials tailored to specific audiences like members of the Gardaí or nursing home staff, can be highly effective in actively disseminating learning from reviews and ensuring that they are implemented promptly in practice.[277]

[17.125] Another way to encourage implementation is to mandate the production of action plans and responses to recommendations where they are directed towards service providers, organisations, agencies, or departments. At present, the ability of the reviewer to follow-up on recommendations made depends on the nature of the review. For example, the NIRP's reports are disseminated to the relevant HSE service area, which must indicate whether it accepts or rejects the recommendations contained therein.[278] Where the HSE service area rejects the recommendations, it must provide a rationale for this. Where it accepts the recommendations, it will develop an action plan that designates responsibilities and indicates timeframes for completion.[279] The NIRP's operational guidelines provide that it will "from time to time, commission an evaluation review to determine if the recommendations made through NIRP reports are effecting systemic change, as intended".[280] The HSE Incident Management Framework also provides for the development and monitoring of action plans in response to recommendations.[281] This approach can be contrasted with Commissions of Investigation, which are dissolved once they submit their final report to the

[276] Copper and Bruin, "Adult safeguarding and the Care Act (2014) – the impacts on partnership and practice" (2017) 19(4) Journal of Adult Protection 209 at page 216.

[277] Preston-Shoot, "Learning from safeguarding adult reviews on self-neglect: addressing the challenge of change" (2018) 20(2) Journal of Adult Protection 78 at page 89. For example, in Wales, practitioner-focused learning events are a key element of the practice review process.

[278] National Independent Review Panel, Health Service Executive, *National Independent Review Panel Operational Guidelines 2021* (NIRP, HSE 2021) at page 10.

[279] National Independent Review Panel, Health Service Executive, *National Independent Review Panel Operational Guidelines 2021* (NIRP, HSE 2021) at page 10.

[280] National Independent Review Panel, Health Service Executive, *National Independent Review Panel Operational Guidelines 2021* (NIRP, HSE 2021) at page 10.

[281] Health Service Executive, *Incident Management Framework* (HSE 2020) at page 35. The framework notes that instead of monitoring action plans for individual reviews, it is important that action plans developed "…are interfaced with the relevant service improvement plan with implementation monitored via these", particularly where reviews have made similar recommendations.

relevant Minister, and reviews conducted by independent experts, as neither have a role in monitoring implementation.[282]

[17.126] Legislation (either primary or secondary) could provide that action plans should be generated and that the relevant service providers, organisations, regulators, agencies or departments must respond and indicate how they have implemented or will implement the actions specified in the action plan. The reviewing body should be responsible for monitoring fulfilment of action plans.

5. Conclusions and recommendations

(a) Overall recommendations

[17.127] Having considered the existing review mechanisms in Ireland, the systems in other jurisdictions and the need for reform, the Commission believes that Ireland should introduce adult safeguarding reviews on a statutory basis to review very serious incidents that meet a certain threshold. The Commission does not define what a "very serious incident" is, the phrase is used to refer to adult safeguarding incidents that meet the criteria for a mandatory adult safeguarding review outlined in section 5(c) of this Chapter. The Commission also considers that it may be worthwhile for the reviewing body to be empowered to conduct discretionary reviews even where the high threshold for a mandatory review is not met. The Commission believes that adult safeguarding reviews would bring about consistency and transparency as all serious incidents involving at-risk adults that meet the high threshold for a mandatory review would be dealt with in the same way.

[17.128] The purpose of adult safeguarding reviews would be to learn from past failures and bring about improvements to systems and practices to reduce the likelihood of incidents reoccurring. The Commission believes that adult safeguarding reviews can exist alongside standard incident reviews that are carried out at service level or investigations or inquiries by service providers or regulators as these review mechanisms are more focused on identifying immediate actions that need to take place to safeguard a particular at-risk adult, or at-risk adults, or to bring a service provider into compliance. The Commission hopes that adult safeguarding reviews will remove the need for higher levels of review that are focused on learning such as independent expert reviews commissioned by the HSE, reviews by Commissions of Investigation and NIRP reviews. Not every incident that occurs in relation to an at-risk adult should be the subject of an adult safeguarding review. The Commission was mindful of this when considering the criteria for mandatory adult safeguarding reviews. It believes that adult safeguarding reviews should be required only where a serious incident meets the very high threshold for a mandatory review, which is

[282] Section 43(1) of the Commissions of Investigation Act 2004.

set out in section 5(c) below. This is to ensure that the time and resources of the reviewing body are only directed at very serious incidents. As discussed in section 5(c), the Commission considers that there are circumstances where a reviewing body may wish to carry out a discretionary adult safeguarding review in circumstances where the high bar required for a mandatory review is not met.

[17.129] Given the importance of adult safeguarding reviews, the Commission considers that they should be introduced on a statutory basis. Placing them on a statutory footing would give adult safeguarding reviews an enhanced status and it would ensure that adult safeguarding reviews are carried out in all cases where set criteria are met. It also provides an opportunity to standardise and formalise the review process for very serious adult safeguarding incidents, and to introduce statutory powers to require information to ensure the effectiveness of reviews.

[17.130] The Commission believes that it would make little sense to introduce adult safeguarding reviews on a non-statutory basis, in circumstances where adult safeguarding legislation is being proposed by the Commission. Including provisions for adult safeguarding reviews in the Commission's proposed Adult Safeguarding Bill 2024 demonstrates that adult safeguarding reviews focused on learning are a central part of a statutory framework for adult safeguarding. Statutory adult safeguarding reviews would be an integral part of the adult safeguarding legislative framework being proposed by the Commission, which aims to be preventative as well as reactive. Adult safeguarding reviews are reactive as they will be carried out in response to particularly serious incidents, but the objective of these reviews will be to identify the lessons that need to be learned to reduce the likelihood of reoccurrence and in that sense, they are preventative.

[17.131] The Commission believes that adult safeguarding reviews should apply to all serious incidents involving at-risk adults that meet a high threshold, irrespective of care settings. This will ensure that no at-risk adult will fall through the gaps, which can happen with many of the current review mechanisms that only cover HSE managed or funded services or organisations. This means that very serious incidents involving at-risk adults at home, in community settings, or private nursing homes will be capable of being reviewed.

R. 17.1 **The Commission recommends that** adult safeguarding reviews should be introduced on a statutory basis to review serious incidents that reach a high threshold.

(b) Principles underpinning adult safeguarding reviews

[17.132] To assist policymakers, the Commission considers that it is worthwhile to set out the principles that should underpin adult safeguarding reviews of very serious incidents. The importance of these principles is highlighted in the preceding section where the Commission discussed the need for reform in Ireland. The

Commission believes that the following principles should be followed when an adult safeguarding review is carried out:

1. Adult safeguarding reviews should be learning focused, the objective is not to attribute blame. The aim should be to identify changes that can be made to improve the quality and safety of services and reduce the likelihood of reoccurrence;
2. There should be a consistent, standardised and transparent adult safeguarding review process for very serious incidents, and adult safeguarding review reports should be made publicly available where possible;
3. Adult safeguarding reviews should apply to all serious incidents involving at-risk adults that meet set criteria, irrespective of the care settings;
4. Adult safeguarding reviews should be completed in a timely manner in order to disseminate learnings without delay;
5. There should be a shared learning culture, where at-risk adults, their families, advocates, staff and service providers are all given the opportunity to engage meaningfully in the review process;
6. The implementation of recommendations should be audited and evaluated by the reviewing body to ensure that reviews are achieving their objective and are effectively bringing about systems improvement;
7. A response should be required from agencies and organisations identified in the report, outlining their acceptance or rejection of the recommendations contained therein, and the actions they have taken, or will take to implement the recommendations. These responses should be made publicly available by the reviewing body.

[17.133] The Commission takes the view that a key feature of adult safeguarding reviews should be that they are learning-focused. The purpose should not be to assign blame or liability. There are other processes that may take that approach including disciplinary and criminal processes which may also be engaged in relation to a very serious incident or series of serious incidents that occur.

[17.134] To ensure that reviews are conducted in a non-punitive manner, the Commission considers that a model similar to the approach taken in the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 should be followed.[283] It provides that a review of a specified incident should not—

(a) consider or determine fault, or assign civil or criminal liability,

[283] When commenced section 68 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 will insert section 41A into the Health Act 2007 to enable the Chief Inspector to carry out reviews of specified incidents.

(b) consider or determine whether any action should be taken in respect of an individual by any panel, committee, tribunal or professional regulatory body, or

(c) be admissible as evidence of fault or liability in a court in relation to the specified incident, or a clinical negligence action which arises (whether in whole or in part) from the consequences of that specified incident.[284]

[17.135] A similar approach is taken in the Air Navigation (Notification and Investigation of Accidents, Serious Incidents and Incidents) Regulations 2009. The regulations provide that the purpose of the Air Aviation Investigation Unit should be to gather and analyse air safety data for “accident or incident prevent purposes”.[285] They state that “an investigation shall be separate from any other proceedings whose function is to apportion blame or liability”.[286] Notably, the regulations also provide that:

> [t]he sole objective of an investigation conducted under these Regulations shall be the prevention of future accidents and incidents. It is not the purpose of an investigation to apportion blame or liability.[287]

[17.136] The Commission recommends that provisions emphasising that the purpose of adult safeguarding reviews is not to attribute blame or liability should be included in its proposed Adult Safeguarding Bill 2024.

R. 17.2 **The Commission recommends that** the following principles should be followed when an adult safeguarding review is carried out:

(1) Adult safeguarding reviews should be learning focused. The objective is not to attribute blame. The aim should be to identify changes that can be made to improve the quality and safety of services and reduce the likelihood of reoccurrence;

(2) There should be a consistent, standardised and transparent adult safeguarding review process for very serious incidents, and adult safeguarding review reports should be made publicly available where possible;

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[284] See section 68 of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 which will insert section 41A(7) into the Health Act 2007.

[285] Regulation 4(3) of the Air Navigation (Notification and Investigation of Accidents, Serious Incidents and Incidents) Regulations 2009 (SI No 460 of 2009). It does not have responsibility for “regulatory, administrative or standards matters”.

[286] Regulation 4(8) of the Air Navigation (Notification and Investigation of Accidents, Serious Incidents and Incidents) Regulations 2009 (SI No 460 of 2009).

[287] Regulation 8(3) of the Air Navigation (Notification and Investigation of Accidents, Serious Incidents and Incidents) Regulations 2009 (SI No 460 of 2009).

(3) Adult safeguarding reviews should apply to all serious incidents involving at-risk adults that meet set criteria, irrespective of the care setting;

(4) Adult safeguarding reviews should be completed in a timely manner in order to disseminate learnings without delay;

(5) There should be a shared learning culture, in which at-risk adults, their families, advocates, staff and service providers are all given the opportunity to engage meaningfully in the review process;

(6) The implementation of recommendations should be audited and evaluated by the reviewing body to ensure that reviews are achieving their objective and are effectively bringing about systems improvement;

(7) A response should be required from agencies and organisations identified in the review, outlining their acceptance or rejection of the recommendations contained therein, and the actions they have taken, or will take, to implement the recommendations. These responses should be made publicly available by the reviewing body.

R. 17.3 **The Commission recommends that** provisions emphasising that the purpose of adult safeguarding reviews is not to attribute blame or liability should be included in its proposed Adult Safeguarding Bill 2024.

(c) Criteria for adult safeguarding reviews

[17.137] The Commission takes the view that adult safeguarding reviews should take place as a matter of course, where a serious incident meets a high threshold. If a decision was required by an authority to initiate a review, this would run the risk that not all serious incidents involving at-risk adults that meet the threshold would be treated equally and the Commission is concerned with the transparency of overly discretionary review mechanisms. On the other hand, it is also important to ensure that there is not an overload of adult safeguarding reviews because they are mandatory and the threshold for carrying out reviews is too low. This would dilute the learnings and impact of these reviews and be overly administratively burdensome for the reviewing body.

[17.138] As noted earlier in this Chapter, the Commission does not consider that adult safeguarding reviews should replace all existing review mechanisms. There is still a need for localised reviews of safeguarding incidents including serious incidents, as often these are focused on identifying immediate actions that need to be taken to safeguard an at-risk adult, or other at-risk adults who have been or may be exposed to harm.[288] Equally, there will also be a need for reviews,

[288] See for example, regulation 8(3) and (4) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013); regulation 8(3), (4), and (5) of the Health Act 2007 (Care and Support of Residents in

investigations and enquiries by the relevant regulators in the area including HIQA, the Chief Inspector of Social Services, the Mental Health Commission and the Inspector of Mental Health Services.[289] Identifying immediate actions to safeguard an at-risk adult will not be the purpose of the adult safeguarding reviews being proposed by the Commission, which are instead focused on taking a step back and assessing what occurred with the view to learning from the incident and improving the quality and safety of services.

[17.139] The Commission proposes that there should be two types of adult safeguarding reviews (1) mandatory adult safeguarding reviews and (2) discretionary adult safeguarding reviews. Both would follow the same process. The Commission considers that the reviewing body should be able to choose to carry out an adult safeguarding review where an incident occurs involving an at-risk adult that does not meet the high threshold necessary for a mandatory review to be initiated. There may be incidents that do not meet the higher threshold that present opportunities for learnings to be derived to improve the quality and safety of services providing care and support to at-risk adults. The Commission considers that it should be up to the reviewing body to determine whether the mandatory criteria are met, or whether it wishes to exercise its discretion to carry out a review where the mandatory criteria are not met.

[17.140] Accordingly, the Commission recommends that an adult safeguarding review **must** be carried out when:

(a) (i) an at-risk adult dies and abuse or neglect is known or suspected to be a factor in the death; or
(ii) an at-risk adult does not die, but it is known or suspected that they experienced or are experiencing serious abuse or neglect; and

(b) where an incident or series of incidents suggests that there have been serious and significant failings on behalf of one or more agencies, organisations or individuals responsible for the care and protection of at-risk adults.

[17.141] The Commission also recommends that an adult safeguarding review may be carried out where the criteria for a mandatory review are not met, and the reviewing body has reasonable grounds for believing that valuable insights could be gained from an adult safeguarding review regarding the safety, quality

Designated Centres for Persons (Children and Adults) with Disabilities) Regulation 2013 (SI No 367 of 2013); section 32(2)(d) and (3) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 (SI No 551 of 2006). See also Health Service Executive, *Incident Management Framework* (HSE 2018) and Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures* (HSE 2014).

[289] See discussion in section 2(c) and (d) of this Chapter.

and standards of adult safeguarding services provided by one or more agencies, organisations or individuals can be improved to:

(a) protect and promote the health, safety and welfare of adults at risk of harm, and
(b) minimise the risk of harm to adults at risk of harm

[17.142] There may be circumstances where an adult safeguarding review should not be undertaken, even where the criteria for a mandatory review are met. For example, there may be ongoing criminal investigations or proceedings, or other statutory bodies may be conducting a review into the incident. Too much time may have elapsed from the date the serious incident occurred meaning very little learning can be found as processes and policies have changed so much in the interim. For this reason, the Commission recommends that the reviewing body may decide to pause, discontinue, or not undertake a mandatory or discretionary adult safeguarding review if:

(a) the incident concerned is the subject of criminal proceedings;
(b) the incident concerned is the subject of investigation by the Garda Síochána;
(c) the incident concerned is or will be the subject of a review or investigation under any other enactment by another statutory body or officeholder under a statutory duty;
(d) the incident concerned has already been resolved or substantially resolved; or
(e) the reviewing body believes, based on reasonable grounds, that, due to the considerable length of time between the incident concerned occurring, and deciding whether to undertake an adult safeguarding review, it is not necessary or appropriate to undertake a review.

R. 17.4 **The Commission recommends that** an adult safeguarding review must be carried out when:

(a) (i) an at-risk adult dies, and abuse or neglect is known or suspected to be a factor in the death; or

(ii) an at-risk adult does not die, but it is known or suspected that they experienced or are experiencing serious abuse or neglect; and

(b) where an incident or series of incidents suggests that there have been serious and significant failings on behalf of one or more agencies, organisations or individuals responsible for the care and protection of at-risk adults.

R. 17.5 **The Commission recommends that** an adult safeguarding review may be carried out where the criteria for a mandatory review are not met and the reviewing body has reasonable grounds for believing that valuable insights could be gained from an adult safeguarding review regarding how the safety, quality and standards of adult safeguarding services provided by one or more agencies, organisations or individuals can be improved to—

(a) protect and promote the health, safety and welfare of adults at risk of harm, and

(b) minimise the risk of harm to adults at risk of harm.

R. 17.6 **The Commission recommends that** the reviewing body may decide to pause, discontinue, or not undertake a mandatory or discretionary adult safeguarding review if:

(a) the incident concerned is the subject of criminal proceedings;

(b) the incident concerned is the subject of investigation by the Garda Síochána;

(c) the incident concerned is or will be the subject of a review or investigation under any other enactment by another statutory body or officeholder under a statutory duty;

(d) the incident concerned has already been resolved or substantially resolved, or

(e) the reviewing body believes, based on reasonable grounds, that, due to the considerable length of time between the incident concerned occurring, and deciding whether to undertake an adult safeguarding review, it is not necessary or appropriate to undertake a review.

R. 17.7 **The Commission recommends that** the reviewing body shall ensure that any mandatory or discretionary adult safeguarding review undertaken does not interfere, or conflict, with the functions of any statutory bodies or office holders under a statutory duty.

(d) Statutory powers to require information

[17.143] If adult safeguarding reviews are to be conducted effectively, it is crucial that the reviewing body has sufficient powers to require information and documents that are relevant to the review and to interview relevant persons. Commissions of Investigations have similar statutory powers to compel people to produce information and documents and answer questions.[290]

[290] Section 16 of the Commissions of Investigation Act 2004.

[17.144] When something goes wrong, the services or organisations involved may be reluctant to share documents and information central to the review or participate in interviews in case doing so would draw attention to their own actions. Producing the relevant documents can be administratively burdensome which may also result in a disinclination to comply with requests. Without the relevant documents and information, or the power to interview relevant persons, it would be impossible for the reviewing body to determine what took place, and what can be done differently in the future to improve the quality and safety of services and reduce the likelihood of recurrence.

[17.145] For these reasons, the Commission recommends that the reviewing body carrying out adult safeguarding reviews should be given statutory powers to require the production of information and documents, and interview relevant persons. If these powers are bestowed on a statutory basis, people will be more likely to comply with requests which will facilitate reviews being carried out efficiently.

[17.146] The Commission also considers that where a person does not comply with a request to produce information or documents, or to participate in an interview, the reviewing body should be able to apply for a court order directing the person to comply with the request.

R. 17.8 **The Commission recommends that:** the reviewing body should have powers to:

(a) require the production of information or documents;

(b) inspect and take copies of, or extracts from, information or documents;

(c) inspect the operation of any computer and any associated apparatus or material which is, or has been, in use in connection with the information or documents; and

(d) interview in private relevant persons to enable it to carry out adult safeguarding reviews effectively.

R. 17.9 **The Commission recommends that** where a person does not produce information or documents upon request or does not consent to participate in an interview in private, the reviewing body should be able to apply for a court order directing the person to produce information or documents or to participate in an interview in private.

(e) The reviewing body

[17.147] The Commission carefully considered whether it should make recommendations about the appropriate structure to carry out adult safeguarding reviews. There are a number of options. Adult safeguarding reviews could be conducted on a national basis by an existing body with relevant expertise (for example, HIQA, the Chief Inspector of Social Services, the Mental Health Commission or the Inspector of Mental Health Services), by an independent body set up specifically

to handle these reviews, or the NIRP, if it were placed on a statutory footing and given a broader remit. Adult safeguarding reviews could also be conducted on a local or regional basis by multi-agency committees, comprised of key safeguarding partners in the area, as is the case in England, Scotland and Wales.[291]

[17.148] The Commission is not in a position to evaluate these options as the question of which body would be the appropriate reviewing body involves policy considerations and significant resource implications that are outside of the scope of this project. The government and policymakers are better positioned to weigh up competing considerations and determine the most appropriate model. The comparative material on the approaches in England, Scotland and Wales and the principles that the Commission believes should govern adult safeguarding reviews, which are identified below, will aid the government and policymakers in evaluating the options. The Commission takes the view that whichever structure is preferred, the reviewing body should have the requisite knowledge, skills and experience to carry out an adult safeguarding review and should be sufficiently independent and objective in the carrying out of its functions.[292]

[17.149] In a similar vein, the Commission believes that is not best placed to recommend how adult safeguarding reviews should be carried out as the substantive details of procedure would depend on which body will ultimately be designated as the reviewing body. The government may prefer to opt for a local approach with local multi-agency type structures or a national approach, whether it establishes an independent review body or assigns the function to an existing regulator. If adult safeguarding reviews are introduced on a statutory basis and a determination is made on which body should carry out these reviews, the government may wish to give the relevant Minister the power to specify in regulations or statutory guidance the procedure to be followed when conducting adult safeguarding reviews. This could set out how cases will be referred for review and how reviews are initiated. It could also address key issues such as timelines for submission of final reports; sharing of reports with those involved in a review; publication of reports; monitoring and evaluating actions

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[291] Similar structures to those that exist in England, Scotland and Wales already exist in Ireland on a non-statutory basis within each CHO. These are multi-agency structures known as Safeguarding and Protection Committees (Vulnerable Persons). See Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures* (HSE 2014) at pages 52 to 53.

[292] For example, if a multi-agency body approach is preferred, it would be important that those whose actions may be examined in a review are not responsible for overseeing or carrying out a review. Independence could be ensured by making an independent chair a requirement. It is more likely that the actual review would be carried out by a team or health or social care professional commissioned by the body. The multi-agency body would be responsible for overseeing the review process, analysing earlier drafts of review reports and ratifying recommendations.

and outcomes; and procedural safeguards. It could also explain how adult safeguarding reviews interface with parallel procedures such as criminal, coronial or disciplinary proceedings or investigations and other review mechanisms.

[17.150] In Chapter 6, the Commission discusses the possibility of regulators conducting adult safeguarding reviews, and why the Safeguarding Body would be an inappropriate reviewing body.

CHAPTER 18
REGULATION OF PROFESSIONALS AND OCCUPATIONAL GROUPS

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1. Introduction

[18.1] Many people providing care and support for at-risk adults on a paid basis do so in a highly regulated environment. Medical and nursing professionals, for example, have professional governing bodies that set and apply professional standards, with clear qualifications for admission to the professions. In addition, those professions have an elaborate array of disciplinary sanctions, which can operate to restrict or prohibit practise if professional conduct falls short of the required standards. Such regulation serves to protect the public.

[18.2] However, a significant adult safeguarding challenge is presented by workers in unregulated occupational groups ("unregulated workers"), such as health care assistants ("HCAs") and health care support assistants ("HCSAs"), who often have considerable levels of engagement with, and access to, at-risk adults in Ireland.[293] For example, home care is provided by HCSAs in Ireland without minimum training requirements, without the oversight of a professional regulator, and without the supervision that would be provided if they were working in a congregated or healthcare setting. HCSAs provide personal care services to clients in their homes, which includes bathing, showering, dressing and mobilising, as well as the preparation of food and domestic cleaning on the basis of assessed need.[294] In contrast to HCSAs, HCAs carry out delegated nursing tasks which are planned, supervised and reviewed by registered nurses.[295]

[18.3] This Chapter explores the distinctions between regulated professionals and unregulated workers involved in caring and support work, examines the adequacy of pre-employment vetting as a protective measure, and assesses the approaches of the neighbouring jurisdictions of England and Wales, Scotland and Northern Ireland to the regulation and oversight of unregulated work.

[18.4] To consider whether reform is required in respect of unregulated workers in Ireland, it is worth examining regulated professions in the health and social care sector. While regulated professionals in other sectors may provide other types of support such as legal or financial support to at-risk adults, regulated professions in the health and social care sector have more similarities with unregulated professions such as HCAs and HCSAs. A regulated profession is one

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[293] HCSAs were formerly known as home help or homecare assistants.

[294] HSE and Cork Kerry Community Healthcare, *Home Support Service Department Best Practice Guidance for Health Care Support Assistants* (April 2021) at page 12 <https://www.hse.ie/eng/services/publications/olderpeople/best-practice-guidance-for-health-care-support-assistants.pdf> accessed on 5 April 2024.

[295] HSE, *Review of Role and Function of Health Care Assistants* (December 2018) at para 5.5 <https://www.hse.ie/eng/staff/resources/hrstrategiesreports/health-care-assistant-review-final-report-2018.pdf> accessed on 5 April 2024.

where access to, or the practise of, the profession is restricted to those who have professional qualifications required by law.[296] Professional regulation protects professional boundaries and titles, establishes professional standards and registers which list those entitled to practise, and controls admission and removal from the registers.[297]

[18.5] Currently in Ireland, there is little to prevent an unregulated worker in any sector, in respect of whom abuse or neglect concerns have been raised, from moving to another job and continuing to perpetuate abuse or harm. Vetting provides protection by reducing the likelihood that people with relevant criminal convictions, or who have had specific allegations made against them, will work or come into contact with children or at-risk adults. Vetting involves the making of enquiries to establish whether there is a criminal record or specified information about a person which should prevent them from engaging in work or activity wherein they have access to, or contact with, children or at-risk adults, in circumstances where the work or activity that a person proposes to undertake consists of having regular access to, or contact with, children or at-risk adults. "Specified information" is defined in section 2 of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 ("2012 Act") as:

> information concerning a finding or allegation of harm to another person that is received by the [National Vetting] Bureau from (a) the Garda Síochána pursuant to an investigation of an offence or pursuant to any other function conferred on the Garda Síochána by or under any enactment or the common law, or (b) a scheduled organisation pursuant to subsection (1) or (2) of section 19 [of the 2012 Act], in respect of the person and which is of such a nature as to reasonably give rise to a [real] concern that the person may (i) harm any child or vulnerable person, (ii) cause any child or vulnerable person to be harmed, (iii) put any child or vulnerable person at risk of harm, (iv) attempt to harm any child or vulnerable person, or (v) incite another person to harm any child or vulnerable person.

[296] Irish Point of Single Contact, *Regulated Professions in Ireland* <http://www.pointofsinglecontact.ie/regulated%20professions%20in%20ireland/#:~:text=A%20regulated%20profession%20is%20one,regulations%20required%20across%20the%20EU.> accessed on 5 April 2024.

[297] Royal College of Nursing, *The Regulation of Healthcare Support Workers Policy Briefing 11/2007* (RCN Policy Unit September 2007) at page 7 <https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/policies-and-briefings/uk-wide/policies/2007/1107.pdf> accessed on 5 April 2024.

[18.6] In the UK, barred lists have been established, which contain the details of individuals who are prevented from working with children or at-risk adults due to past behaviours (which may fall below the criminal threshold) or offences.

[18.7] This Chapter examines the case for reform in Ireland in relation to unregulated occupational groups in the health and social care sector who have access to or come into contact with adults, including at-risk adults. It also examines the case for reform of vetting legislation and the introduction of post-conviction prohibition orders, which would temporarily prohibit a person from working with children and at-risk adults. Reform of vetting legislation and the introduction of post-conviction prohibition orders would apply to regulated and unregulated professionals working with at-risk adults across all sectors. This Chapter outlines the regulation of relevant professional and occupational groups in Ireland and the UK; current vetting legislation in Ireland and vetting and barring legislation in the UK; the gaps in the existing Irish framework; and recommendations to address such gaps.

2. Regulation of relevant professionals and occupational groups in Ireland

[18.8] In the health and social care sector in Ireland, a range of professionals and occupational groups have access to, or come into contact with, at-risk adults. While some of these, such as doctors and nurses, are regulated, others such as HCAs and HCSAs are not regulated. This section examines the existing regulatory or oversight frameworks for these professionals and occupational groups in Ireland, as well as the minimum educational requirements for the roles. This section also briefly looks at complaints or fitness to practise procedures that exist to address issues and concerns when they arise. It is important to note at the outset of this Chapter that the Commission does not propose any changes to the regulatory framework for currently regulated professionals and occupational groups in Ireland.

(a) Regulated professionals and occupational groups

[18.9] Medical practitioners are regulated under the Medical Practitioners Act 2007. Nurses are regulated under the Nurses and Midwives Act 2011. A range of health and social care professionals, including social workers, are regulated under the Health and Social Care Professionals Act 2005 ("2005 Act").[298] Social care work is a designated profession under the 2005 Act,[299] and has very

[298] At the time of writing, the professions regulated under the Health and Social Care Professionals Act 2005 are dietitians, dispensing opticians, medical scientists, occupational therapists, optometrists, physical therapists, physiotherapists, podiatrists/chiropodists, radiographers, radiation therapists, social workers and speech and language therapists.

[299] Section 4(1)(j) of the Health and Social Care Professionals Act 2005.

recently become subject to regulation by CORU, which comprises of the Health and Social Care Professionals Council and the registration boards for each of the professions designated in the 2005 Act.[300] Each registration board establishes and maintains a register of members of its profession, one for each profession designated in the 2005 Act. On 30 November 2023, the Social Care Workers Register opened.[301] A transitional period has now commenced, during which those who seek to use the title of social care worker can apply to register with CORU. Social care workers work directly with clients to meet their physical, social and emotional needs.[302]

(i) Existing registration/regulatory framework

[18.10] The Medical Council regulates medical doctors in Ireland. Its key responsibilities include maintaining the register of medical practitioners, ensuring the highest standards of medical training and education, and investigating complaints against medical doctors.[303] Nurses and midwives must be registered on the register of nurses and midwives.[304] The register is established and maintained by the Nursing and Midwifery Board of Ireland ("NMBI").[305] The NMBI also establishes procedures and criteria for assessment and registration, and investigates and considers complaints against nurses and midwives.[306] CORU is Ireland's regulator responsible for regulating health and social care professionals, and includes the Health and Social Care Professionals Council and the registration boards for each of the professions.[307] Each registration board establishes and maintains a register of members of its profession.[308]

(ii) Minimum education and training requirements

[18.11] It is the responsibility of the Medical Council to set and publish the standards of medical education and training for medical qualifications and to monitor

[300] CORU, *Frequently Asked Questions – General* <https://coru.ie/public-protection/frequently-asked-questions/> accessed on 5 April 2024.

[301] 'Social Care Workers to be regulated as new statutory register opens' *CORU* (30 November 2023) <https://www.coru.ie/news/news-for-the-public/social-care-workers-to-be-regulated-as-new-statutory-register-opens.html> accessed on 5 April 2024.

[302] Social Care Ireland, *What is Social Care Work?* <https://socialcareireland.ie/what-is-social-care-work/> accessed on 5 April 2024.

[303] Medical Council, *About Us* <https://www.medicalcouncil.ie/about-us/> accessed on 5 April 2024.

[304] Section 46(1) of the Nurses and Midwives Act 2011.

[305] Section 46(1) of the Nurses and Midwives Act 2011.

[306] NMBI, *What we do* <https://www.nmbi.ie/What-We-Do> accessed on 5 April 2024.

[307] CORU, *Frequently Asked Questions – General* <https://coru.ie/public-protection/frequently-asked-questions/>accessed on 5 April 2024.

[308] Section 36(1) of the Health and Social Care Professionals Act 2005.

adherence to these standards.[309] It is the responsibility of the Health Service Executive ("HSE") to facilitate the education and training of nurses and midwives.[310] The NMBI sets and publishes the standards of nursing and midwifery education and training and monitors adherence to these standards.[311] The registration board of each health and social care profession approves education and training programmes and monitors the continuing suitability of each programme.[312]

(iii) Pathways for addressing complaints regarding relevant occupational groups

[18.12] Complaints concerning registered medical practitioners can be made to the Preliminary Proceedings Committee ("PPC") of the Medical Council.[313] Complaints about nurses and midwives can be made to the Chief Executive Officer of the NMBI.[314] The Health and Social Care Professionals Council has the

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[309] Section 88(1) of the Medical Practitioners Act 2007, section 88(1). Medical Council Rules in Respect of the Duties of Council in Relation to Medical Education and Training (Section 88 of the Medical Practitioners Act 2007) (SI No 685 of 2016) sets out the rules with which an education provider must comply to provide medical education. Section 2 of the Medical Practitioners Act 2007 defines a "basic medical qualification" as: "(a) a qualification arising from the completion of a basic medical education and training programme approved [by the Medical Council], or (b) a qualification in basic medical training specified in point 5.1.1 of Annex V to Directive 2005/36/EC, or (c) a degree, diploma or other qualification recognised to be at least the equivalent of a qualification [approved by the Medical Council]".

[310] Section 84(1) of the Nurses and Midwives Act 2011.

[311] NMBI, *Nurse Registration Programmes Standards and Requirements* 5th edn (2023) <https://www.nmbi.ie/NMBI/media/NMBI/NMBI-Nurse-Registration-Programmes-Standards-and-Requirements-Fifth-Edition_1.pdf?ext=.pdf> accessed on 5 April 2024.

[312] Sections 48 and 49 of the Health and Social Care Professionals Act 2005.

[313] Section 20(2)(a) of the Medical Practitioners Act 2007 establishes the Preliminary Proceedings Committee to give initial consideration to complaints. Under section 57(1) of the Medical Practitioners Act 2007, complaints can be made on the following grounds: professional misconduct, poor professional performance, a relevant medical disability, a failure to comply with a relevant condition, a failure to comply with an undertaking or to take any action specified in a consent given in response to a request under section 67(1) of the Medical Practitioners Act 2007, a contravention of a provision under the Medical Practitioners Act 2007, failure to comply with regulations made under section 13(2) of the Health (Pricing and Supply of Medical Goods) Act 2013 and a conviction in the State for an offence triable on indictment or a conviction outside the State for an offence consisting of acts or omissions that, if done or made in the State, would constitute an offence triable on indictment.

[314] Section 55(1) of the Nurses and Midwives Act 2011. Section 55 also sets out the following grounds on which complaints can be made: professional misconduct, poor professional performance, non-compliance with a code of professional conduct, a relevant medical disability, a failure to comply with a relevant condition, the imposition on the nurse or midwife of: (i) a prohibition against him or her providing one or more than one kind of health or social care in the State or another jurisdiction; or (ii) a restriction on his or her ability to provide one or more than one kind of health or social care in the State or another jurisdiction, a failure to comply with an undertaking or to take any action specified in a consent given in response to a request under section 57A(1) or 65(1), a contravention of a

power to establish committees, including a PPC and a professional conduct committee.[315]

(iv) Fitness to practise concerns and the handling of disciplinary matters

[18.13] Medical practitioners and nurses and midwives can be called before Fitness to Practise Committees. The sanctions that can be imposed on medical practitioners and nurses and midwives are almost identical, namely: (a) an advice or admonishment (firm reprimand) or a censure, in writing; (b) a censure in writing and a fine not exceeding €2,000 for nurses and midwives,[316] or €5,000 for medical practitioners;[317] (c) the attachment of conditions to the relevant professional's registration; (d) the transfer of the relevant professional's registration to another division of the register; (e) the suspension of the relevant professional's registration for a specified period; (f) the cancellation of the relevant professional's registration; and (g) a prohibition from applying for a specified period for the restoration of the relevant professional's registration.[318]

[18.14] Sanctions (c)-(g) do not take effect until the decision is confirmed by the High Court.[319] A relevant professional against whom a sanction is imposed can appeal

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provision of this Act (including a provision of any regulations or rules made under this Act), a failure to comply with regulations made under section 13(2) of the Health (Pricing and Supply of Medical Goods) Act 2013, an irregularity in relation to the custody, prescription or supply of a controlled drug under the Misuse of Drugs Act 1977 and 1984 or another drug that is likely to be abused, or a conviction in the State for an offence triable on indictment or a conviction outside the State for an offence consisting of acts or omissions that, if done or made in the State, would constitute an offence triable on indictment.

[315] Section 51(1) of the Health and Social Care Professionals Act 2005. Section 52(1) of the Health and Social Care Professionals Act 2005 sets out the grounds on which complaints can be made: professional misconduct, poor professional performance, a relevant medical disability, failure to comply with a term or condition of registration imposed under the 2005 Act, failure to comply with an undertaking or to take any action specified in a consent given in response to a request under section 61 of the 2005 Act, the imposition on the registrant of: (i) a prohibition against them providing one or more kind of health or social care in the State or another jurisdiction; or (ii) a restriction on their ability to provide one or more than one kind of health or social care in the State or another jurisdiction, or a contravention of the 2005 Act, its rules or bye-laws, or a conviction in the State for an offence triable on indictment or a conviction outside the State for an offence consisting of acts or omissions that, if done or made in the State, would constitute an offence triable on indictment.

[316] Section 69(1)(b) of the Nurses and Midwives Act 2011.

[317] Section 71(1)(b) of the Medical Practitioners Act 2007.

[318] Section 71(1) of the Medical Practitioners Act 2007 and section 69(1) of the Nurses and Midwives Act 2011.

[319] Section 74(1) of the Medical Practitioners Act 2007 and section 72(1) of the Nurses and Midwives Act 2011.

that decision, either as to a finding or as to the appropriateness of the sanction, or both, to the High Court.[320]

[18.15] For health and social care professionals, if there is sufficient cause to warrant further action being taken in relation to a complaint made against them, the Health and Social Care Professionals Council shall refer the complaint to the PPC.[321] Where the PPC considers that there is sufficient cause to warrant further action, it may refer the complaint to a committee of inquiry (either a professional conduct committee or a health committee).[322] If an allegation is substantiated,[323] the Health and Social Care Professionals Council can impose one or more of the following sanctions on the health or social care professional: (a) an admonishment or censure; (b) the attachment of conditions to the professional's registration, including restrictions on the practice of the designated profession by the registrant; (c) the suspension of their registration for a specified period; (d) the cancellation of their registration; and (e) a prohibition from applying for a specified period for restoration to the register.[324]

(b) Unregulated professionals and occupational groups

[18.16] While a range of professions are regulated under the 2005 Act, a number of designated professions have yet to be regulated.[325] HCAs and HCSAs are currently unregulated in Ireland and regularly have access to, or come into contact with, adults, including at-risk adults.

(i) Health Care Assistants (HCAs) and Health Care Support Assistants (HCSAs)

[18.17] HCAs and HCSAs have access to, or come into contact with, adults, including at-risk adults. HCAs assist and support nurses and midwives.[326] In respect of HCAs, the International Standard Classification of Occupations ("ISCO") states:

> [HCAs] provide direct personal care and assistance with activities of daily living to patients and residents in a variety of health care settings such as hospitals, clinics and residential nursing care facilities. [HCAs] generally work in implementation of established care plans and practices, and under the direct supervision of

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320 *Andrea Hermann v Medical Council* [2010] IEHC 414.

321 Section 53(1) of the Health and Social Care Professionals Act 2005.

322 Section 56(1)(b) of the Health and Social Care Professionals Act 2005.

323 Section 64 of the Health and Social Care Professionals Act 2005.

324 Section 66(1) of the Health and Social Care Professionals Act 2005.

325 Professions not currently regulated under the Health and Social Care Professionals Act 2005 are clinical biochemists, counsellors, orthoptists, psychologists and psychotherapists.

326 HSE, *Review of Role and Function of Health Care Assistants* (December 2018) at page 3.

> medical, nursing or other health professionals or associate professionals.[327]

[18.18] In contrast to HCAs, HCSAs deliver support care services to clients in their homes on the basis of assessed need, for example bathing, showering, dressing, mobilising, preparing food and domestic cleaning. The Health (Amendment) (Professional Home Care) Bill 2020, a Private Members Bill, defines “professional home care” as:

> services which are required to ensure that an adult person, that is, a person aged 18 years or over, can continue to live independently in their own home, and includes, but is not limited to, the services of nurses, home care attendants, home helps, various therapies and personal care, and palliative care.[328]

[18.19] There are a range of home care services available in Ireland. The HSE’s Home Support Service[329] supports older people to remain in their homes for as long as possible by supporting them in their everyday tasks, including getting in and out of bed, dressing, undressing and personal care.[330] The Home Support Service is only available to those aged 65 and over, and may be provided by, or through an arrangement with, the HSE or private home care providers contracted directly by service users or their families.[331]

(ii) Existing post-employment oversight mechanisms

[18.20] As outlined above, the Social Care Workers Registration Board opened the Social Care Workers Register on 30 November 2023. As registrants, social care workers are expected to comply with a Code of Professional Conduct and Ethics.[332] The Code outlines the standards of ethical behaviour and conduct

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[327] Open Risk Manual, *ISCO Unit Group 5321 Health Care Assistants* (C5321.1) <https://www.openriskmanual.org/wiki/ISCO_Unit_Group_5321_Health_Care_Assistants> accessed on 5 April 2024.

[328] Section 2(2) of the Health (Amendment) (Professional Home Care) Bill 2020.

[329] Formerly known as the Home Help Service or the Home Care Package Scheme. See HSE, *Home Support Service for Older People Information Booklet & Application Form 2023* (2023) <https://www.hse.ie/eng/home-support-services/home-support-services-information-booklet.pdf> accessed on 5 April 2024.

[330] HSE, *Home Support Service for Older People Information Booklet & Application Form 2023* (2023) at page 2.

[331] HSE, *Home Support Service for Older People Information Booklet & Application Form 2023* (2023) at page 2. Exceptions to this age limit can sometimes be made for younger people suffering from early onset dementia or a disability.

[332] CORU, *Social Care Workers Registration Board Code of Professional Conduct and Ethics* (Social Care Workers Registration Board 2019) <https://coru.ie/files-codes-of-conduct/scwrb-code-of-professional-conduct-and-ethics-for-social-care-workers.pdf> accessed on 5 April 2024.

expected from registered social care workers, and registrants are asked annually to pledge their compliance with the Code.[333] The Code states that a breach of the Code may constitute professional misconduct or poor professional performance which may, following a fitness to practise inquiry, result in the imposition of a disciplinary sanction on a registrant.[334]

[18.21] In Ireland, the relationship between HCAs and nurses and midwives is governed by the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives, which provides that nurses and midwives: (a) recognise their role in delegating care appropriately and in providing supervision;[335] (b) are accountable if they decide to delegate a nursing or midwifery task to someone who is not a registered nurse or midwife;[336] and (c) provide comprehensive and effective assessment, planning, communication, monitoring, supervision, evaluation and feedback.[337]

[18.22] Nurses and midwives are professionally responsible and accountable for the practice, attitudes and actions (including inactions and omissions) of HCAs to whom they delegate tasks.[338] HCAs carry out delegated nursing tasks, which are planned, supervised and reviewed by registered nurses.[339] There is neither a register of HCAs currently operating in Ireland nor is a licence required to carry out the duties of a HCA. Accordingly, there is nothing to prevent a HCA, who has been discharged from duty due to poor practice, to subsequently obtain new employment and continue malpractice.[340]

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[333] CORU, *Social Care Workers Registration Board Code of Professional Conduct and Ethics* (Social Care Workers Registration Board 2019) at page 1.

[334] CORU, *Social Care Workers Registration Board Code of Professional Conduct and Ethics* (Social Care Workers Registration Board 2019) at page 4.

[335] NMBI, *Conduct of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* (11 May 2021) Principle 5, Value 4 <https://www.nmbi.ie/NMBI/media/NMBI/Code-of-Professional-Conduct-and-Ethics.pdf?ext=.pdf> accessed on 5 April 2024.

[336] NMBI, *Conduct of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* (11 May 2021) Principle 5, Standard of Conduct 8.

[337] NMBI, *Conduct of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* (11 May 2021) Principle 5, Standard of Conduct 9.

[338] HSE, *Review of Role and Function of Health Care Assistants* (December 2018) at para 5.6.

[339] HSE, *Review of Role and Function of Health Care Assistants* (December 2018) at para 5.5.

[340] Conyard, Metcalfe, Corish, Flannery, Hannon, Rusk, Yeates, Codd, *Healthcare Assistants and Qualified Carers, A Trained but Untapped Underutilised Resource: A Population-Based Study in Ireland of Skillset, Career Satisfaction, Wellbeing and Change Across All Sectors and Care Settings: Full Report* (2020 University College Dublin) at page 116 <https://www.lenus.ie/bitstream/handle/10147/627406/hca%26cstar_%20final%20report.pdf?sequence=1&isAllowed=y> accessed on 5 April 2024.

[18.23] In respect of HCSAs, HIQA currently has no remit to regulate the home care sector and therefore there is currently no regulation of the services provided by HCSAs and their employing agencies.[341] Like HCAs, there is neither a register of HCSAs currently operating in Ireland nor is a licence required to carry out the duties of a HCSA. The Commission understands that HIQA has long advocated for the regulation of home care service providers and that the current government policy is to introduce legislation that will extend the remit of HIQA's Chief Inspector of Social Services to regulate home support service providers. At the time of writing, a statutory home support scheme is being developed.[342] In the debate in Dáil Éireann on 8 November 2023, the Minister of State at the Department of Health stated that progress continues on the introduction of a statutory home support scheme.[343]

(iii) Minimum education and training requirements

[18.24] The 2005 Act specifies that existing social care workers must possess the following qualifications in order to register with CORU: (a) a National Diploma in Child Care awarded by the Higher Education and Training Awards Council ("HETAC")/Dublin Institute of Technology ("DIT");[344] (b) a National Diploma in Applied Social Care Studies awarded by HETAC/DIT; (c) a Diploma in Social Care awarded by HETAC/DIT; (d) a Diploma in Applied Social Studies/Social Care from DIT; or (e) an Open Training College National Diploma in Applied Social Studies (Disability).[345]

[18.25] There is no legal requirement for HCAs in Ireland to undertake a recognised training programme. But it is recommended that they complete a relevant Quality and Qualifications Ireland ("QQI") Level 5 award.[346] Accordingly, HCAs

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[341] HIQA, *Exploring the regulation of health and social care services – Older People's services* (2017) at page 11 <https://www.hiqa.ie/sites/default/files/2017-05/exploring-the-regulation-of-health-and-social-care-services-op.pdf> accessed on 5 April 2024.

[342] Department of Health, *Report of the Strategic Workforce Advisory Group on Home Carers and Nursing Home Healthcare Assistants* (September 2022) at page 6 <https://www.gov.ie/pdf/?file=https://assets.gov.ie/237210/448892b3-36b4-4b7a-a41e-90368ff2345c.pdf#page=null> accessed on 5 April 2024.

[343] Dáil Éireann Debates 8 November 2023 vol 1045 no 2 <https://www.oireachtas.ie/en/debates/debate/dail/2023-11-08/6/?highlight%5B0%5D=home&highlight%5B1%5D=home&highlight%5B2%5D=support&highlight%5B3%5D=scheme> accessed on 5 April 2024.

[344] Technological University Dublin ("TUD") was established under the terms of the Technological Universities Act 2018 and the Technology Universities Act 2018 (Section 36) (Appointed Day) Order 2018 (SI No 437 of 2018). Dublin Institute of Technology was dissolved with effect from 1 January 2019. At that date all assets, rights, obligations and staff were transferred to TUD in accordance with the Technological Universities Act 2018.

[345] Schedule 3 to the Health and Social Care Professionals Act 2005.

[346] Conyard, Metcalfe, Corish, Flannery, Hannon, Rusk, Yeates, Codd, *Healthcare Assistants and Qualified Carers, A Trained but Untapped Underutilised Resource: A Population-Based Study*

who are both qualified and unqualified work in the Irish health system.[347] Currently, there are no consistent standards for the training of HCAs in Ireland. There is also very little continuing education and training, and there is role confusion between HCAs and nurses.[348]

[18.26] The HSE requires HCSAs to have completed, at a minimum, any two of the following modules: (1) Care Support, (2) Safety and Health at Work or (3) Care Skills. HCSAs must also be willing to complete a QQI Level 5 Certificate in Healthcare Support. Different private home care providers require different levels of qualification. For example, one private home care provider requires completion of some QQI Level 5 modules, such as Care of the Older Person and Care Skills, but does not appear to require completion of the QQI Level 5 certificate as a precondition to employment.[349]

3. Regulation of relevant professionals and occupational groups in England and Wales, Scotland and Northern Ireland

[18.27] Although the safeguarding systems operating in the UK's various jurisdictions have unique local features, comparative analysis of these neighbouring jurisdictions is useful and instructive in assessing how best to address deficiencies in the levels of training and oversight in Ireland. In the UK, HCAs work under the guidance of a healthcare professional, namely a doctor, nurse, midwife or other healthcare professional.[350] There are no set entry requirements

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in Ireland of Skillset, Career Satisfaction, Wellbeing and Change Across All Sectors and Care Settings: Full Report (2020 University College Dublin) at page 27. Relevant QQI Level 5 qualifications include: Community Care, Community Health Services, Health Service Skills and Healthcare Support.

[347] Drennan, Hegarty, Savage, Brady, Prendergast, Howson, Murphy, Spilsbury, *Provision of the Evidence to Inform the Future Education, Role and Function of Health Care Assistants in Ireland* (University College Cork and University of Leeds September 2018) at page 20 <https://www.hse.ie/eng/staff/resources/hrstrategiesreports/health-care-assistant-literature-review-2018.pdf> accessed on 5 April 2024.

[348] HSE, *Review of Role and Function of Health Care Assistants* (December 2018) at para 11.6.

[349] Private HomeCare, *New to Caring?* <https://privatehomecare.ie/wp-content/uploads/2023/06/new-to-caring-application-v2.2-web-version-1.pdf> accessed on 5 April 2024.

[350] NHS, *Healthcare assistant* <https://www.healthcareers.nhs.uk/explore-roles/healthcare-support-worker/roles-healthcare-support-worker/healthcare-assistant> accessed on 5 April 2024.

to become a HCA in the UK.[351] HCAs undergo on-the-job training, including basic nursing skills, but there is little guidance on their training needs.[352]

[18.28] The Cavendish Review was commissioned in the wake of a number of scandals in the UK to assess what could be done to ensure that unregulated staff treat all patients and clients with care and compassion.[353] The Cavendish Review found that the system did not guarantee the safety of the public, and highlighted that there were no minimum educational requirements to commence work as a HCA or a support worker in either the National Health Service ("NHS") or social care.[354] While recommendations on formal registration of HCAs were outside the scope of the Cavendish Review, it highlighted that a major obstacle to the improvement of care throughout the NHS was the difficulty in removing staff who were neither caring nor competent.[355] It was noted that confusion was exacerbated by the use of different job titles and the variance of job descriptions from employer to employer.[356] After the Cavendish Review, separate arrangements for the regulation of social workers and other social care staff were introduced in England and Wales, Scotland and Northern Ireland.[357]

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[351] NHS, *Healthcare assistant*. See also, Cavendish, *The Cavendish Review – An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings* (Department of Health and Social Care 2013) at para 6.3.1 <https://assets.publishing.service.gov.uk/media/5a7b9df6e5274a7202e18537/Cavendish_Review.pdf> accessed on 5 April 2024.

[352] NHS, *Healthcare assistant* <https://www.healthcareers.nhs.uk/explore-roles/healthcare-support-worker/roles-healthcare-support-worker/healthcare-assistant> accessed on 5 April 2024. See also, Cavendish, *The Cavendish Review – An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings* (Department of Health and Social Care 2013) at para 6.3.3.

[353] Cavendish, *The Cavendish Review – An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings* (Department of Health and Social Care 2013) at page 5.

[354] Cavendish, *The Cavendish Review – An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings* (Department of Health and Social Care 2013) at para 6.3.1. The Royal College of Nursing shares the view that health care assistants should be regulated in the interests of public protection and patient safety, in Royal College of Nursing, *The Regulation of Healthcare Support Workers Policy Briefing 11/2007* (RCN Policy Unit September 2007) at page 13.

[355] Cavendish, *The Cavendish Review – An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings* (Department of Health and Social Care, July 2013) at page 6.

[356] Cavendish, *The Cavendish Review – An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings* (Department of Health and Social Care 2013) at para 3.2.2.

[357] Law Commission, Scottish Law Commission and Northern Ireland Law Commission, *Regulation of Health Care Professionals and Regulation of Social Care Professionals in England* (Law Com No 345 / Scot Law Com No 237 / NILC 18 2014) at para 2.28 https://s3-<eu-west-2.amazonaws.com/cloud-platform-

(a) England

(i) Home care/domiciliary care

[18.29] Home care, or domiciliary care, is defined in England and Wales as the provision of personal care in the homes of persons who by reason of illness, infirmity or disability are unable to provide such care for themselves without assistance.[358] Health and social care services in England are regulated by the Care Quality Commission, and any person carrying on or managing a domiciliary care agency must be registered under the Care Standards Act 2000.[359] However individual domiciliary care workers are not regulated in England.

(ii) Social care work

[18.30] "Social care worker" is defined in England as a person who: (a) is employed at, or manages, a children's home in England, a care home in England or a residential family centre in England; (b) is employed at, or manages, a domiciliary care agency, a fostering agency, a voluntary adoption agency or an adoption support agency, insofar as the agency provides services to persons in England; or (c) is supplied by a domiciliary care agency to provide personal care in their own homes for persons in England who by reason of illness, infirmity or disability are unable to provide such care for themselves without assistance.[360]

[18.31] In England, the Health and Social Care Act 2012 granted a power to regulatory bodies to establish and maintain voluntary registers of unregulated health professionals, unregulated health care workers or unregulated social care workers.[361] Concerns have been raised about the utility of voluntary registers, and the potential for confusion if registers of those not subject to statutory regulation are kept by regulators.[362]

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e218f50a4812967ba1215eaecede923f/uploads/sites/30/2015/03/lc345_regulation_of_health care_professionals.pdf> accessed on 5 April 2024.

[358] Section 4(3) of the Care Standards Act 2000.

[359] Section 2(2) of the Health and Social Care Act 2008. See also, Care Quality Commission, *About Us* <https://www.cqc.org.uk/about-us> accessed on 5 April 2024.

[360] Section 55(2) of the Care Standards Act 2000.

[361] Section 228 of the Health and Social Care Act 2012. A "voluntary register" is defined as a register of persons in which a person is not required by an enactment to be registered in order to be entitled to use a title, practise as a member of a profession or engage in work that involves the provision of health care.

[362] Law Commission, Scottish Law Commission and Northern Ireland Law Commission, *Regulation of Health Care Professionals and Regulation of Social Care Professionals in England* (Law Com No 345 / Scot Law Com No 237 / NILC 18 2014) at para 5.30. In this Report, at Recommendation 28, the Law Commissions recommended that the regulators' powers to keep voluntary registers should be removed.

[18.32] England operates a voluntary register for social care workers called the Voluntary Care Professional Register ("VCPR").[363] The National Association of Carers and Support Workers has emphasised that the VCPR has been developed independently without any official mandate from the government. Accordingly, it is not obligatory for anyone to register on the VCPR.[364] The VCPR launched on 1 September 2023 and ran as a pilot until 1 March 2024.[365] Its operation was extended beyond 1 March 2024 due to interest and demand. At the time of writing, the VCPR remains active.

(b) Wales

[18.33] In Wales, social care workers are regulated under the Regulation and Inspection of Social Care (Wales) Act 2016 by Social Care Wales.[366] Social Care Wales has published a Code of Professional Practice for Social Care which sets out standards by which social care workers must abide.[367] In Wales, "social care workers" are defined as persons who: (a) engage in relevant social work; (b) manage a place at or from which a regulated service is provided; (c) in the course of their employment with a service provider, provide care and support to any person in Wales in connection with a regulated service provided by that provider; and (d) under a contract for services, provide care and support to any person in Wales in connection with a regulated service provided by a service provider.[368]

[18.34] Domiciliary care workers are included in the definition of "social care workers".[369] To join the register, applicants must be appropriately qualified, fit to practise and intend to practise in the area of work of persons on the register.[370] Appropriate qualifications include a Level 2 or 3 in health and social care.[371]

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[363] The Voluntary Care Professional Register, *Welcome to the Voluntary Care Professional Register* <https://www.vcpr.co.uk/>accessed on 5 April 2024.

[364] The Voluntary Care Professional Register, *Frequently Asked Questions* <*https://www.vcpr.co.uk/faq-s*> accessed on 5 April 2024.

[365] The Voluntary Care Professional Register <https://www.vcpr.co.uk/>accessed on 5 April 2024.

[366] Section 68(1) of the Regulation and Inspection of Social Care (Wales) Act 2016. See also, Section 80(1) of the Regulation and Inspection of Social Care (Wales) Act 2016.

[367] Social Care Wales, *Code of Professional Practice for Social Care* (2017) at page 8.

[368] Section 79(1) of the Regulation and Inspection of Social Care (Wales) Act 2016.

[369] Social Care Wales, *Who must register and why?* <https://socialcare.wales/registration/why-we-register> accessed on 5 April 2024. See also, rule 2(1)(b) of the Social Care Wales (Registration) Rules 2022.

[370] Section 83(2) of the Regulation and Inspection of Social Care (Wales) Act 2016. Details on appropriate qualifications can be found in section 84 of the Regulation and Inspection of Social Care (Wales) Act 2016.

[371] Social Care Wales, *Qualifications and other ways to register* <https://socialcare.wales/registration/qualifications-needed> accessed on 5 April 2024.

Alternatively, employers can confirm a worker's application to register after assessing their understanding in the relevant areas.[372] Workers who use the employer assessment route to register must complete one of the relevant qualifications within three years of registering.[373] As social care workers are regulated in Wales, they can be subject to fitness to practise proceedings.[374]

(c) Scotland

[18.35] The Scottish Social Services Council ("SSSC") regulates the social care workforce in Scotland.[375] The Care Inspectorate regulates organisations which employ workers and provide registered care services.[376] The SSSC maintains a register of social workers and social service workers.[377] It registers, among others, those working in adult day services and residential care, and home care services.[378] For those working in a home care service, the SSSC requires one of a number of specified qualifications, including a Higher National Certificate in Social Services (Scottish Credit and Qualifications Framework ("SCQF") Level 7) or a Scottish Vocational Qualification in Social Services and Healthcare (SCQF Level 6).[379]

Levels 2 and 3 are equivalent to an NFQ (Ireland) Level 4 and 5 or an EQF Level 3 and 4: Quality and Qualifications Ireland, *Qualifications can cross boundaries* <https://qhelp.qqi.ie/learners/qualifications-recognition-advice/comparing-qualifications-in-the-uk-and-ireland/Qualifications_Can_Cross_Boundaries.pdf>accessed on 5 April 2024.

[372] Social Care Wales, *Qualifications and other ways to register* <https://socialcare.wales/registration/qualifications-needed>accessed on 5 April 2024.

[373] Social Care Wales, *Qualifications and other ways to register*.

[374] Section 117(1) of the Regulation and Inspection of Social Care (Wales) Act 2016. A finding of impaired fitness to practice can be made on any of the following grounds: deficient performance as a social care worker, serious misconduct, the inclusion of the person in a barred list, a determination by a relevant body to the effect that the person's fitness to practise is impaired, adverse physical or mental health, or a conviction of caution in the UK for a criminal offence, or a conviction or caution elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence. The fitness to practise matter may be disposed of according to section 138 of the Regulation and Inspection of Social Care (Wales) Act 2016.

[375] Scottish Social Services Council, *Codes of Practice for Social Service Workers and Employers* (2016) at page 3 <https://www.sssc.uk.com/_entity/annotation/4025a3ca-db14-ee11-9cbe-0022481b5c93> accessed on 5 April 2024.

[376] Scottish Social Services Council, *Codes of Practice for Social Service Workers and Employers* (2016) at page 3.

[377] Section 44(1) of the Regulation of Care (Scotland) Act 2001.

[378] Section 44(1) of the Regulation of Care (Scotland) Act 2001. See also, Scottish Social Services Council, *Who can register?* <https://www.sssc.uk.com/registration/who-can-register/> accessed on 5 April 2024.

[379] Scottish Social Services Council, *Support worker in a care at home service* <https://www.sssc.uk.com/knowledgebase/article/KA-02529/en-us>accessed on 5 April 2024. SCQF Level 6 and 7 are equivalent to NFQ (Ireland) Level 5 and 6 and EQF Level 4 and 5: Quality and Qualifications Ireland, *Qualifications can cross boundaries*

SSSC Codes of Practice, along with the Health and Social Care Standards, are an important part of regulating and improving the quality of care experienced by people using social services.[380] The SSSC can take action against workers through the fitness to practise process, and the Care Inspectorate can advise care service providers and, if necessary, take action against them.[381]

(d) Northern Ireland

(i) Social care

[18.36] The Northern Ireland Social Care Council ("NISCC") is the regulatory body for the social care workforce in Northern Ireland.[382] Fitness to practise of workers is judged against the NISCC's Standards of Conduct and Practice for Social Care Workers.[383] Social care workers must register with the NISCC[384] and include social workers, those working in residential homes, nursing homes and day service settings, and those supplied by home care agencies to provide personal care in the homes of persons who by reason of illness, infirmity or disability are unable to provide such care for themselves without assistance.[385] While social care workers and domiciliary care workers are regulated in Wales, Scotland and Northern Ireland, they are not subject to mandatory regulation in England.

4. Vetting, disclosure and barring

[18.37] Vetting refers to enquiries undertaken by employers or bodies recruiting voluntary workers to establish if the applicant for the vetting certificate has any criminal record or there exists any specified information relating to them. Disclosures involve the disclosure of the above information to potential

<https://qhelp.qqi.ie/learners/qualifications-recognition-advice/comparing-qualifications-in-the-uk-and-ireland/Qualifications_Can_Cross_Boundaries.pdf>accessed on 5 April 2024.

[380] Scottish Social Services Council, *Codes of Practice for Social Service Workers and Employers* (2016) at page 3.

[381] Scottish Social Services Council, *Codes of Practice for Social Service Workers and Employers* (2016) at page 3. See also, Rule 2(2) of the Scottish Social Services Council (Fitness to Practise) Rules 2016.

[382] Section 1(2) of the Health and Personal Social Services Act (Northern Ireland) 2001.

[383] Northern Ireland Social Care Council, *Standards of Conduct and Practice for Social Care Workers* (2019) at page 3 <https://niscc.info/app/uploads/2020/09/standards-of-conduct-and-practice-for-social-workers-2019.pdf> accessed on 5 April 2024. See also, Northern Ireland Social Care Council, *Fitness to Practise (Amendment) Rules 2019* (May 2019), Rule 4(1) <https://niscc.info/app/uploads/2020/07/20190522_fitness-to-practise-rules-2019.pdf> accessed on 5 April 2024.

[384] HIQA, *Regulation of Homecare: Research Report* (2021) at page 119. See also, Northern Ireland Social Care Council, *Registering as a Social Care Worker* <https://niscc.info/who-can-register/social-care-workers/> accessed on 5 April 2024.

[385] Section 2(2) of the Health and Personal Social Services Act (Northern Ireland) 2001.

employers. Barring is a process in the UK whereby "barred lists" are established, which are databases containing details of individuals prohibited from working in regulated activities with children or at-risk adults. With no formal system of regulation of HCAs and HCSAs in Ireland, the current system of vetting only provides a minimal level of protection.[386] This section considers existing vetting legislation in Ireland and examines vetting, disclosure and barring legislation and procedures in the UK.

(a) Existing vetting legislation in Ireland

[18.38] The National Vetting Bureau of the Garda Síochána maintains the National Vetting Bureau (Children and Vulnerable Persons) Database System which contains the register of relevant organisations, the register of specified information and the register of vetted persons.[387] The National Vetting Bureau provides vetting services to relevant organisations in respect of work or activities, which may include work of employees or volunteers.[388] Under the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016 ("National Vetting Bureau Acts"), organisations that receive vetting disclosures must consider and take into account the information contained therein when deciding to employ a person concerned.[389] The Database System does not contain lists that prohibit or bar individuals from working with children or at-risk adults. The National Vetting Bureau undertakes a number of steps in the vetting process. It first establishes the identity of the person who is the subject of the application for vetting disclosure and determines if any criminal records or specified information exist in respect of that person.[390] If any specified

[386] Currently, all HCAs are required to undergo Garda vetting before commencing employment, in accordance with para 1(b) of Part 2 of Schedule 1 to the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. Para 3 of Part 2 of Schedule 1 to the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 states that Garda vetting is also required of anyone undertaking any "work or activity which consists of the care (including the provision of health and personal social services and essential domestic services) of vulnerable persons unless the care is merely incidental to the care of persons who are not vulnerable persons".

[387] Sections 6(1) and 6(2) of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. For the register of relevant organisations, see section 8 of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. For the register of specified information, see section 10 of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. For the register of vetted persons, see section 11 of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

[388] Section 7(2) of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

[389] Section 16(2)(a) of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

[390] Sections 7(2)(b) and 7(2)(c) of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. Schedule 1 to the 2012 Act sets out the relevant work or activities relating to "vulnerable" persons for which a vetting disclosure is required.

information is discovered, it makes enquiries to assess that information.[391] The National Vetting Bureau then decides whether the information should be disclosed to the relevant organisation.[392]

[18.39] The Chief Bureau Officer of the National Vetting Bureau must ensure that a register of specified information is established and maintained.[393] When completing a vetting disclosure, if specified information is discovered, the staff member of the National Vetting Bureau must refer the matter to the Chief Bureau Officer for assessment.[394] The Chief Bureau Officer notifies the person subject to the application for vetting disclosure and provides a summary of the specified information.[395] After assessing the specified information, the Chief Bureau Officer makes a determination to disclose the information only if they reasonably believe that the specified information gives rises to a concern that the person may: (a) harm a child or "vulnerable person"; (b) cause any child or "vulnerable person" to be harmed; (c) put any child or "vulnerable person" at risk of harm; (d) attempt to harm any child or "vulnerable person"; or (e) incite another person to harm any children or "vulnerable person".[396]

[18.40] When deciding to disclose the information, the Chief Bureau Officer will have regard to: (a) its relevance to the type of work or activity to which the application for vetting disclosure relates; (b) the extent to which the proposed relevant work or activity is likely to require contact with children or at-risk adults; (c) the source and reliability of the information; (d) any submissions made by or on behalf of the person; and (e) whether the rights of the person have been considered and taken into account.[397]

[18.41] The person shall be notified of a specified information disclosure and be supplied with a copy of the information.[398] The person has the right to appeal the decision to disclose the information within 14 days.[399]

[18.42] Although not yet commenced at the time of writing, section 20 of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 provides for

[391] Section 7(2)(f) of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

[392] Section 7(2)(e) of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

[393] Section 10(1) of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. Certain scheduled organisations are required to notify specified information to the National Vetting Bureau, and are found in Schedule 2 to the 2012 Act.

[394] Section 14(3) of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

[395] Section 15(1) of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

[396] Section 15(3) of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

[397] Section 15(4) of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

[398] Section 15(6) of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

[399] Section 15(6) of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

mandatory re-vetting even if the person has not changed roles.[400] In April 2021, the Minister for Justice established the Garda Vetting Review Group to examine issues in relation to Garda vetting, including the introduction of a mandatory system of re-vetting every three years.[401] The Garda Vetting Review Group includes members of the National Vetting Bureau, officials from the Department of Justice, the Child and Family Agency and other relevant stakeholders. In response to a parliamentary question on 20 March 2024, the Minister for Justice stated that she expects to receive the report of the Garda Vetting Review Group in the context of the introduction of a statutory re-vetting regime by the end of the second quarter of 2024.[402] At the time of writing, the report of the Garda Vetting Review Group has not yet been published.

[18.43] The serious risks and safeguarding concerns that can arise when there is a lack of vetting or oversight were recently brought to light by the Irish Times, which reported the findings of an internal investigation by the Child and Family Agency in July 2023 into a private provider of emergency accommodation for children in State care, known as Ideal Care Services. The internal investigation found that Garda vetting files of staff had been "fabricated", personnel files contained "fictitious accounts of conversations with fictitious persons who were presented as referees" for staff, and there was "clear evidence" that Garda vetting declarations "had been altered post-issue". The internal investigation also found that in some cases, staff of Ideal Care Services were allowed to work with children without up-to-date Garda vetting because the company had accepted historic vetting clearance from previous employment placements. The investigation report noted that this was contrary to the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.[403]

[400] Section 20 has not yet commenced and requires a commencement order under section 1(3) of the 2012 Act.

[401] Department of Justice, *Minister McEntee moves to reform vetting arrangements and legislation* <https://www.gov.ie/en/press-release/c935f-minister-mcentee-moves-to-reform-vetting-arrangements-and-legislation/>accessed on 5 April 2024.

[402] Dáil Éireann Debates 20 March 2024 vol 1051 no 3 <https://www.oireachtas.ie/en/debates/question/2024-03-20/963/#pq_963> accessed on 5 April 2024.

[403] Power, 'Care home used by Tusla 'fabricated' pre-employment checks of staff, posing major risk to young people in its care' *The Irish Times* (28 February 2024) <https://www.irishtimes.com/ireland/social-affairs/2024/02/28/care-home-used-by-tusla-fabricated-pre-employment-checks-of-staff-posing-major-risk-to-young-people-in-its-care/> accessed on 5 April 2024; Harrison, 'How vulnerable children were put at risk by Ireland's state care system' *The Irish Times* (11 March 2024) <https://www.irishtimes.com/podcasts/in-the-news/scandal-of-staff-vetting-failures-at-care-company-for-vulnerable-children/> accessed on 5 April 2024.

(i) Post-conviction prohibition orders

[18.44] Section 20 of the Sex Offenders (Amendment) Act 2023 ("2023 Act"), which commenced on 13 November 2023, inserted Part 4A into the Sex Offenders Act 2001 ("2001 Act").[404] Part 4A concerns prohibitions on working with children and "vulnerable persons" which is, in effect, a form of temporary barring. When imposing a sentence, the court is required to consider whether to also impose a prohibition on the offender engaging in relevant work.[405] The court must have regard to the need to protect children and "vulnerable persons" from serious harm from the offender and the need to prevent the commission of sexual offences by the offender.[406] The term of imprisonment and the prohibition period combined shall not exceed the duration of the maximum term of imprisonment that may be imposed in respect of the sexual offence concerned.[407] The court may specify a particular type or category of relevant work to which the prohibition applies.[408] A person on whom a sentence, including a prohibition, is imposed who does not comply with the prohibition shall be guilty of an offence.[409] This is a useful protective provision, and one which the Commission recommends should be expanded to the adult safeguarding context. This is discussed in further detail in section 5(b) below.

(b) Vetting, disclosure and barring in England and Wales, Northern Ireland and Scotland

(i) England and Wales and Northern Ireland

[18.45] The main function of the Disclosure and Barring Service ("DBS") is to protect the public by providing DBS checks to employers, enabling them to make safer recruitment decisions and by barring persons who pose a risk to children or at-risk adults from working in certain roles.[410] DBS checks are criminal record

[404] Sex Offenders (Amendment) Act 2023 (Commencement) Order 2023 (SI No 539 of 2023), reg 2(c).

[405] Section 26C(1) of the Sex Offenders Act 2001 (inserted by section 20 of the Sex Offenders (Amendment) Act 2023).

[406] Section 26C(2) of the Sex Offenders Act 2001 (inserted by section 20 of the Sex Offenders (Amendment) Act 2023).

[407] Section 26D(2) of the Sex Offenders Act 2001 (inserted by section 20 of the Sex Offenders (Amendment) Act 2023).

[408] Section 26D(4) of the Sex Offenders Act 2001 (inserted by section 20 of the Sex Offenders (Amendment) Act 2023).

[409] Section 26G(1) of the Sex Offenders Act 2001 (inserted by section 20 of the Sex Offenders (Amendment) Act 2023).

[410] Home Office and Disclosure and Barring Service, *Disclosure and Barring Service (DBS) Framework Document* (April 2020) at para 1.1 <https://assets.publishing.service.gov.uk/media/65704d7d9462260705c569e9/DBS_Framework_Document.pdf> accessed on 5 April 2024.

checks, similar to those conducted by the National Vetting Bureau in Ireland.[411] The DBS maintains adults' and children's barred lists which prohibit certain people from working with at-risk adults and children.[412] There are various laws that currently apply to the provision of vetting information in England, Wales and Northern Ireland, for example, the Safeguarding Vulnerable Groups Act 2006,[413] the Protection of Vulnerable Groups (Scotland) Act 2007,[414] the Protection of Vulnerable Groups (Scotland) Act 2007 (Vetting Information) Regulations 2010,[415] the Protection of Freedoms Act 2012[416] and the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007.[417]

[18.46] The DBS issues criminal record certificates under section 113A of the Police Act 1997, as it has effect in England and Wales. Employers can check the criminal record of job applicants.[418] These certificates give details of every relevant piece of information relating to the applicant or state that no such information is on record.[419] Basic checks show unspent convictions and conditional cautions.[420] Standard checks show spent and unspent convictions, cautions, reprimands and final warnings.[421] Enhanced checks disclose the same information as a standard check, as well as any information the chief officer of the police force reasonably believes to be relevant and should be included on the certificate.[422] Enhanced checks with barred lists consist of an enhanced check as well as any information relating to whether the individual is barred from regulated activity relating to at-risk adults or children.[423]

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[411] Para 8(1)(d) of Schedule 8 to the Protection of Freedoms Act 2012.

[412] Paras 8(1)(a) and 8(1)(b) of Schedule 8 to the Protection of Freedoms Act 2012.

[413] See section 30 of the Safeguarding Vulnerable Groups Act 2006 (England).

[414] See sections 12, 19, 47-49, 51-53 and 69 of the Protection of Vulnerable Groups (Scotland) Act 2007.

[415] 2010 No 189.

[416] See sections 72, 75-76 and Schedule 7 of the Protection of Freedoms Act 2012 (England, Wales and Northern Ireland).

[417] See regulations 32 and 46 of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 (2007 No 1351 (NI 11)).

[418] UK Government, *Criminal record checks when you apply for a role* <https://www.gov.uk/criminal-record-checks-apply-role> accessed on 5 April 2024.

[419] Police Act 1997, section 113A(3), as it has effect in England and Wales.

[420] UK Government, *Criminal record checks when you apply for a role*.

[421] UK Government, *Criminal record checks when you apply for a role*.

[422] Sections 113B(3) and 113B(4) of the Police Act 1997, as it has effect in England and Wales.

[423] Sections 113BB(1) and 113BB(2)(a) of the Police Act 1997, as it has effect in England and Wales.

[18.47] England and Wales and Northern Ireland share a definition of "regulated activity"[424] which includes: (a) the provision to an adult of health care by, or under the direction or supervision of, a health care professional; (b) the provision to an adult of relevant personal care;[425] (c) the provision by a social care worker of relevant social work to an adult who is a client or potential client; (d) the provision of assistance in relation to general household matters to an adult who is in need by reason of age, illness or disability; (e) any relevant assistance in the conduct of an adult's own affairs; and (f) activities relating to the provision of health care or relevant personal care to adults that does not fall within the above categories.[426]

[18.48] In Northern Ireland, Access NI provides three types of criminal record checks.[427] Basic checks disclose unspent convictions.[428] Standard checks disclose spent and unspent convictions, informed warnings and other non-court disposals from the Police National Computer.[429] Enhanced checks disclose the prescribed details of relevant matters relating to the applicant recorded in central records and information the chief police officer reasonably believes to be relevant and should be included on the certificate.[430] Access NI defines "relevant information" as non-conviction information that the police believe to be relevant to the role applied for by the person concerned.[431]

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[424] Schedule 4 to the Safeguarding Vulnerable Groups Act 2006, as it has effect in England and Wales; para 7 of Schedule 2 to the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, as it has effect in Northern Ireland.

[425] Para 7(3B) of Schedule 4 to the Safeguarding Vulnerable Groups Act 2006 defines "relevant personal care" as "(a) physical assistance, given to a person who is in need by reason of age, illness or disability, in connection with (i) eating or drinking…(ii) toileting….(iii) washing or bathing, (iv) dressing, (v) oral care, or (vi) the care of skin, hair or nails, (b) the prompting, together with supervision, of a person who is in need of it by reason of age, illness or disability in relation to the performance of any of the activities listed in paragraph (a) where the person is unable to make a decision in relation to performing such an activity without such prompting and supervision, or (c) any form of training, instruction, advice or guidance which (i) relates to the performance of any of the activities listed in paragraph (a), (ii) is given to a person who is in need of it by reason of age, illness or disability, and (iii) does not fall within paragraph (b)."

[426] Para 7(1)(a)-(g) of Schedule 4 to the Safeguarding Vulnerable Groups Act 2006.

[427] AccessNI, *Types of AccessNI checks* <https://www.nidirect.gov.uk/articles/types-accessni-checks>accessed on 5 April 2024.

[428] AccessNI, *Types of AccessNI checks.*

[429] AccessNI, *Types of AccessNI checks.*

[430] Sections 113B(3) and 113B(4) of the Police Act 1997, as it has effect in Northern Ireland.

[431] Access NI, *Information disclosed in a criminal record check* <https://www.nidirect.gov.uk/articles/information-disclosed-criminal-record-check>, accessed on 5 April 2024.

[18.49] An individual must be included in an "adults' barred list" if the DBS is satisfied that the person has engaged in "relevant conduct"[432] and has reason to believe that the person is, has been or might in the future be engaged in regulated activity relating to "vulnerable adults", and it is satisfied that including the person in the barred list would be appropriate.[433]

[18.50] There are three different routes for referral to the DBS.[434] The first route is automatic barring when a person commits a particular offence.[435] The second route is where an individual applies for a job in regulated work or activity and certain information is included on their disclosure certificate.[436] The third route is a discretionary referral from employers where issues have arisen in the workplace.[437]

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[432] "Relevant conduct" is defined as conduct: (a) which endangers an at-risk adult or is likely to endanger an at-risk adult; (b) which, if repeated against or in relation to an at-risk adult, would endanger them or would be likely to endanger them; (c) involving sexual material relating to children; (d) involving sexually explicit images depicting violence against human beings (including possession of such images), if it appears to the DBS that the conduct is inappropriate; and (e) of a sexual nature involving an at-risk adult, if it appears to DBS that the conduct is inappropriate. See para 10(1) of Schedule 3 to the Safeguarding Vulnerable Groups Act 2006, as it applies in England and Wales and para 10(1) of Schedule 1 to the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, as it applies in Northern Ireland.

[433] Para 9(3) of Schedule 3 to the Safeguarding Vulnerable Groups Act 2006, as it applies in England and Wales; para 9 of Schedule 1 to the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, as it applies in Northern Ireland.

[434] Meeting between Law Reform Commission and DBS staff on 12 December 2022. See also, Disclosure and Barring Service, *Disclosure and Barring Service Annual Report and Accounts – For the period 1 April 2021 to 31 March 2022* (HC 577) at page 41 <https://assets.publishing.service.gov.uk/media/62d93c90e90e071e768aa524/ARA_-_Final.pdf> accessed on 5 April 2024.

[435] Meeting between Law Reform Commission and DBS staff on 12 December 2022. See also, Disclosure and Barring Service, *Disclosure and Barring Service Annual Report and Accounts – For the period 1 April 2021 to 31 March 2022* (HC 577) at page 41.

[436] Meeting between Law Reform Commission and DBS staff on 12 December 2022. See also, Disclosure and Barring Service, *Disclosure and Barring Service Annual Report and Accounts – For the period 1 April 2021 to 31 March 2022* (HC 577) at page 41.

[437] Meeting between Law Reform Commission and DBS staff on 12 December 2022. See also, Disclosure and Barring Service, *Disclosure and Barring Service Annual Report and Accounts – For the period 1 April 2021 to 31 March 2022* (HC 577) at page 41.

[18.51] The DBS decision-making process has five stages.[438] The first stage involves an initial case assessment.[439] The second stage involves information gathering and assessment to establish the relevant conduct or risk of harm.[440] The third stage involves DBS caseworkers using a structured judgement process risk assessment tool and available information to determine and assess the level of concern as definite concern, some concern or no concern. If the DBS identifies a risk of harm to either children or at-risk adults and considers that barring is an appropriate response, it will be 'minded to bar' and the case progresses to the fourth stage.[441] The DBS then informs the person concerned that it has reached a 'minded to bar' position and the person is entitled to make representations.[442] At stage five, if the DBS does not receive representations and it considers it appropriate to do so, the person will be included in the relevant barred list(s).[443] Where representations are received from the person, the case can reassessed and a decision is made.[444] The person has the right to seek an appeal or review of the decision.[445]

[18.52] The decision to include a person on a barred list does not need court approval.[446] A person included in a barred list can apply to the DBS Appeals and Review Team for a review of their inclusion in a barred list.[447] An appeal can also be made to the Upper Tribunal against a decision to include a person in a

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[438] Disclosure and Barring Service, *DBS referrals guide: referral and decision-making process* (30 March 2022) <https://www.gov.uk/government/publications/dbs-referral-and-barring-decision-making-process/dbs-referrals-guide-referral-and-decision-making-process#:~:text=The%20relevant%20offence%2C%20the%20offence,to%20progress%20to%20stage%20two> accessed on 5 April 2024.

[439] Disclosure and Barring Service, *DBS referrals guide: referral and decision-making process* (30 March 2022).

[440] Disclosure and Barring Service, *DBS referrals guide: referral and decision-making process* (30 March 2022).

[441] Disclosure and Barring Service, *DBS referrals guide: referral and decision-making process* (30 March 2022).

[442] Safeguarding Vulnerable Groups Act 2006, Schedule 3, para 8(4), as it applies to England and Wales; Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, Schedule 1, para 8(4), as it applies to Northern Ireland. See also, Disclosure and Barring Service, *DBS referrals guide: referral and decision-making process* (30 March 2022).

[443] Disclosure and Barring Service, *DBS referrals guide: referral and decision-making process* (30 March 2022).

[444] Disclosure and Barring Service, *DBS referrals guide: referral and decision-making process* (30 March 2022).

[445] Disclosure and Barring Service, *DBS referrals guide: referral and decision-making process* (30 March 2022).

[446] Para 8 of Schedule 3 to the Safeguarding Vulnerable Groups Act 2006, makes no reference to the decision of the DBS being approved by a court.

[447] Paras 18 and 18A of Schedule 3 to the Safeguarding Vulnerable Groups Act 2006.

barred list, or against a decision not to remove them from a barred list,[448] but can only be made on the grounds that the DBS has made a mistake on a point of law or a finding of fact.[449] Unless the Upper Tribunal finds that the DBS did make such a mistake, it must confirm the decision.[450] The Upper Tribunal cannot consider the appropriateness of a decision to include or retain someone's name on a barred list.[451] Case law suggests that the Upper Tribunal should only direct the DBS to remove someone from a barred list where that is the only decision that the DBS could have lawfully reached based on the law and the facts.[452]

[18.53] In Northern Ireland, a person is barred from engaging in regulated activity with adults if they are included in the adults' barred list or its equivalent list in England, Wales or Scotland.[453]

[18.54] An individual that is barred from regulated activity commits an offence if they engage in, seek to engage in, or make an offer to engage in a regulated activity from which they are barred.[454] If convicted on indictment, the person is liable to a fine or imprisonment for a term not exceeding five years, or both.[455]

(ii) Scotland

[18.55] In Scotland, Scottish ministers are responsible for keeping the barred lists.[456] Disclosure Scotland, an executive agency run on behalf of Scottish ministers, currently maintains these lists[457] and processes applications for criminal record certificates under the Police Act 1997.[458]

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448 Section 4(1) of the Safeguarding Vulnerable Groups Act 2006.

449 Section 4(2) of the Safeguarding Vulnerable Groups Act 2006.

450 Section 4(5) of the Safeguarding Vulnerable Groups Act 2006.

451 *Disclosure and Barring Service* v *AB* [2021] EWCA Civ 1575 at para 67.

452 *Disclosure and Barring Service* v *AB* [2021] EWCA Civ 1575 at para 73.

453 Article 7(3) of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007.

454 Section 7(1) of the Safeguarding Vulnerable Groups Act 2006, as it has effect in England and Wales; article 11(1) of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, as it has effect in Northern Ireland.

455 Section 7(2)(a) of the Safeguarding Vulnerable Groups Act 2006, as it has effect in England and Wales; article 11(2) of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, as it has effect in Northern Ireland.

456 Section 1(1) of the Protection of Vulnerable Groups (Scotland) Act 2007.

457 Section 44 of the Protection of Vulnerable Groups (Scotland) Act 2007. See also, Scottish Government, *About Disclosure Scotland* (14 October 2022) <https://www.mygov.scot/about-disclosure-scotland#:~:text=This%20is%20a%20membership%20scheme,with%20children%20and%20protected%20adults> accessed on 5 April 2024.

458 Part V of the Police Act 1997.

[18.56] The Protection of Vulnerable Groups Scheme gathers and discloses information about individuals who engage in, or who wish to engage in, regulated work with children or adults.[459] When someone participates in the Scheme, their scheme record is updated whenever new vetting information is discovered.[460] "Vetting information" includes information which the chief officer of a relevant police force reasonably believes to be relevant in relation to the type of regulated work the scheme member engages in or wishes to engage in, and which ought to be included on their record.[461]

[18.57] Regulated activities include caring for adults and providing assistance, advice or guidance.[462] Provisions relating to teaching, instructing, training and supervising protected adults, and being in sole charge of protected adults, have not yet been commenced in Scotland.[463]

[18.58] Enhanced criminal record certificates may include information about the applicant's suitability to engage in regulated activity with adults.[464] This information includes whether the applicant is barred from engaging in regulated activity with adults, as well as the details, if applicable, of the circumstances which led to the previous barring of the applicant.[465] It can also include information about whether the Scottish ministers intend to list the applicant in the barred lists.[466]

[18.59] In Scotland, if a person is deemed unsuitable to work with adults, they must be included in the adults' barred list.[467] A two-step assessment is carried out to decide if a person should be included in the barred list.[468] The first step involves evaluation of the material received and consideration of whether the person should be included on the list.[469] The second step involves Disclosure Scotland making a decision about whether to list the person in either or both barred lists.[470] When making the decision to list a person, Disclosure Scotland can

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[459] Section 44 of the Protection of Vulnerable Groups (Scotland) Act 2007.

[460] Section 47 of the Protection of Vulnerable Groups (Scotland) Act 2007.

[461] Section 49(1) of the Protection of Vulnerable Groups (Scotland) Act 2007.

[462] Paras 2 and 5 of Schedule 3 to the Protection of Vulnerable Groups (Scotland) Act 2007.

[463] Paras 3 and 4 of Schedule 3 to the Protection of Vulnerable Groups (Scotland) Act 2007.

[464] Section 113CB(1) of the Police Act 1997, as it has effect in Scotland.

[465] Sections 113CB(2)(a) and 113CB(2)(b) of the Police Act 1997, as it has effect in Scotland.

[466] Section 113CB(2)(c) of the Police Act 1997, as it has effect in Scotland.

[467] Section 16 of the Protection of Vulnerable Groups (Scotland) Act 2007.

[468] Scottish Government, *Consideration assessment* (28 March 2023) <https://www.mygov.scot/pvg-scheme-lists/consideration-assessment> accessed on 5 April 2024.

[469] Scottish Government, *Consideration assessment* (28 March 2023).

[470] Scottish Government, *Consideration assessment* (28 March 2023).

consider representations made by the person and information obtained from the police, public bodies and regulated work providers that could be relevant to the regulated work concerned.[471]

[18.60] Disclosure Scotland proceedings are confidential, with no public hearings taking place.[472] Decisions of Disclosure Scotland do not need court approval.[473] A decision by Disclosure Scotland can be appealed to the sheriff,[474] who either confirms the decision to list the person or directs Disclosure Scotland to remove the person from the list(s).[475] The sheriff's decision can be appealed to the sheriff principal,[476] whose decision can be appealed to the Inner House of the Court of Session.[477]

[18.61] A person commits an offence if they do, seek or agree to do any regulated work from which they are barred.[478] However it is a defence for a person to prove that they did not know, and could not reasonably be expected to have known, that they were barred from that regulated work, or that the work was regulated work.[479] It is also an offence for organisations to offer regulated work to barred individuals.[480] However it is a defence for an organisation to prove that it did not know, and could not reasonably be expected to have known, that the individual was barred from doing regulated work.[481]

5. Addressing gaps in the existing regulatory frameworks

[18.62] While certain professionals and occupational groups in the health and social care professions are regulated in Ireland, there are key actors who are not regulated. The regulation of social care workers began on 30 November 2023

[471] Section 17(2) of the Protection of Vulnerable Groups (Scotland) Act 2007.

[472] Royal College of Nursing, *Disclosure and Barring Service (DBS) and Disclosure Scotland (DS)* <https://www.rcn.org.uk/get-help/rcn-advice/disclosure-and-barring-service> accessed on 5 April 2024.

[473] Sections 15 and 16 of the Protection of Vulnerable Groups (Scotland) Act 2007.

[474] Sections 21(1) and 22(1) of the Protection of Vulnerable Groups (Scotland) Act 2007. The primary role of the sheriff is to act as a judge of first instance, and they can work in both civil and criminal jurisdictions.

[475] Sections 21(3) and 22(3) of the Protection of Vulnerable Groups (Scotland) Act 2007.

[476] Section 23(1) of the Protection of Vulnerable Groups (Scotland) Act 2007.

[477] Section 23(2) of the Protection of Vulnerable Groups (Scotland) Act 2007.

[478] Section 34(1) of the Protection of Vulnerable Groups (Scotland) Act 2007.

[479] Section 34(2) of the Protection of Vulnerable Groups (Scotland) Act 2007.

[480] Section 35(1) of the Protection of Vulnerable Groups (Scotland) Act 2007.

[481] Section 33(6) of the Protection of Vulnerable Groups (Scotland) Act 2007. Section 36 of the Protection of Vulnerable Groups (Scotland) Act 2007 extends these provisions to personnel suppliers.

with the launch of the Social Care Workers Register and the regulation of social care workers by CORU.[482] However HCAs and HCSAs remain unregulated in Ireland. Currently, Garda vetting is the only means to prevent an unregulated worker in respect of whom abuse or harm concerns have been raised from moving to a new job and continuing to perpetuate abuse or harm.

[18.63] The Commission is of the view that the existing situation, in which there are neither minimum standards of training required to operate as a HCA or HCSA nor any post-employment regulation of HCAs or HCSAs, poses a significant risk to at-risk adults in Ireland. The Commission acknowledges that regulation of a non-statutory occupational group presents practical challenges. However, as can be seen in the neighbouring jurisdictions of England and Wales, Scotland and Northern Ireland, such challenges are not insurmountable and there are ways to protect the public.

[18.64] This section outlines the Commission's recommendations on the regulation of HCAs and HCSAs, howsoever described, and additional sources of regulatory protection in respect of professional and occupational groups, including recommendations on post-conviction prohibition orders.

[18.65] In respect of those working in a paid or voluntary capacity with at-risk adults across all sectors, this section of this Chapter outlines the Commission's recommendations in respect of reform of vetting legislation and the introduction of post-conviction prohibition orders.

(a) Recommendations on the regulation of Health Care Assistants (HCAs) and Health Care Support Assistants (HCSAs)

[18.66] For the State, regulation holds the promise of guarding itself against the accusation of neglect, but also implies the cost of additional resources that are required to do so.[483] It has been observed that the cost of regulation is a thorny issue.[484] As the administrative costs of regulation are traditionally borne by members of the profession, the proportionality of the costs of creating a regulatory system for HCAs and HCSAs, and the potential benefits to patient and public safety that would flow from such regulation, would need to be

[482] See, for example, 'Social Care Workers to be regulated as new statutory register opens' *CORU* (30 November 2023) <https://coru.ie/news/news-for-the-public/social-care-workers-to-be-regulated-as-new-statutory-register-opens.html>accessed on 5 April 2024.

[483] Ahern, Doyle and Timonen, "Regulating Home Care of Older People: The Inevitable Poor Relation?" (2007) 29(1) Dublin University Law Journal 374.

[484] Glackin, "The Evolving Role of the Healthcare Assistant and its Implications for Regulation in the Republic of Ireland – A Case Study Approach" (PhD thesis, University of Northumbria 2016) at page 170.

carefully weighed and considered when designing such a regulatory system.[485] While the Commission regards regulation as beneficial in principle, the design of such a regulatory system is beyond the scope of this Report.

[18.67] Mills, Ryan and Scott-Byrne note that:

> statutory regulation becomes more desirable where there is a problem (or potential problem) with the regulation of a profession that is unlikely to be solved in any other way or that would be inefficient or ineffective to solve any other way.[486]

[18.68] Furthermore, the authors state that the following principles are useful when determining whether statutory regulation is the appropriate course of action in a particular case: (a) the benefits of statutory regulation should outweigh the costs; (b) statutory regulation should be considered if it is necessary to protect the public; (c) statutory regulation should be the most appropriate way to regulate that occupation; (d) it should not be possible to address the risks posed by those professional services through other mechanisms; and (e) statutory regulation should be both practical and possible.[487]

[18.69] Regulation can help protect patients and the public by providing a register of individuals who undertake a defined type of work.[488] A literature review carried out by Drennan and others from University College Cork and the University of Leeds, which subsequently underpinned the HSE's Review of the Role and Function of Health Care Assistants, highlighted the following benefits that could flow from the regulation of HCAs: (a) protection of the public; (b) improvement of educational standards of HCAs; (c) standardisation of the role of, and definition of the scope of practice of, HCAs; (d) control access to employment as a HCA; (e) provide recognition of the role of HCA; and (f) assist in workforce planning for HCAs.[489]

[18.70] The Commission is of the view that the same benefits could flow from the regulation of HCSAs. As HCSAs provide services in clients' homes, behind closed

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[485] Glackin, "The Evolving Role of the Healthcare Assistant and its Implications for Regulation in the Republic of Ireland – A Case Study Approach" (PhD thesis, University of Northumbria 2016) at page 170.

[486] Mills, Ryan and Scott-Byrne, *Disciplinary Procedures in the Professions* 2nd ed (Bloomsbury Professional 2023) at para 1.20.

[487] Mills, Ryan and Scott-Byrne, *Disciplinary Procedures in the Professions* 2nd ed (Bloomsbury Professional 2023) at para 1.20.

[488] Mid Staffordshire NHS Foundation Trust, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry – Volume 3: Present and future* (HC 989-III) at para 23.133.

[489] Drennan, Hegarty, Savage, Brady, Prendergast, Howson, Murphy, Spilsbury, *Provision of the Evidence to Inform the Future Education, Role and Function of Health Care Assistants in Ireland* (University College Cork and University of Leeds September 2018) at page 26.

doors, regulation could provide greater protection to clients. Given the multiplicity of titles used across the sector for the role of HCSAs, the use of one standardised title would bring clarity to service users and the public.

[18.71] Both HCAs and HCSAs provide intimate and vital care to patients but neither patients nor the public are provided with any effective protection from those who are unfit for the role of HCA or HCSA.[490] The HSE has considered that regulation of HCAs would create security for care recipients and assure organisations that HCAs are trained according to established standards.[491] Both Drennan and Glackin have found that HCAs in Ireland are increasingly working alone, and with a lack of supervision, which is a risk to patient safety and quality of service.[492] The literature review carried out by Drennan and others from University College Cork and the University of Leeds recognised support amongst HCAs for regulation of their profession, and the protection of the public was cited as the main reason for the regulation of HCAs.[493]

[18.72] A lack of common and continuous education and training for HCAs and HCSAs poses a risk to the public.[494] Currently, there are variable standards of training for HCAs and HCSAs, and very little continuing and in-service education and training.[495] The European Commission has recommended that prior to registration, HCAs should successfully complete all relevant and mandated education and training.[496] The same standards should apply to HCSAs. Knowing that workers have mandatory and regulated continuous education can give

[490] Mid Staffordshire NHS Foundation Trust, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry – Volume 3: Present and future* (HC 989-III) at page 1498 (vol 3).

[491] HSE, *Review of Role and Function of Health Care Assistants* (December 2018) at para 11.4.

[492] Drennan, Hegarty, Savage, Brady, Prendergast, Howson, Murphy, Spilsbury, *Provision of the Evidence to Inform the Future Education, Role and Function of Health Care Assistants in Ireland* (University College Cork and University of Leeds September 2018) at page 17; Glackin, "The Evolving Role of the Healthcare Assistant and its Implications for Regulation in the Republic of Ireland – A Case Study Approach" (PhD thesis, University of Northumbria 2016) at page 200.

[493] Drennan, Hegarty, Savage, Brady, Prendergast, Howson, Murphy, Spilsbury, *Provision of the Evidence to Inform the Future Education, Role and Function of Health Care Assistants in Ireland* (University College Cork and University of Leeds September 2018) at page 25.

[494] Drennan, Hegarty, Savage, Brady, Prendergast, Howson, Murphy, Spilsbury, *Provision of the Evidence to Inform the Future Education, Role and Function of Health Care Assistants in Ireland* (University College Cork and University of Leeds September 2018) at page 25.

[495] HSE, *Review of Role and Function of Health Care Assistants* (December 2018) at para 11.6. See also, Glackin, "The Evolving Role of the Healthcare Assistant and its Implications for Regulation in the Republic of Ireland – A Case Study Approach" (PhD thesis, University of Northumbria 2016) at page 197.

[496] Braeseke, Hernández, Dreher, Birkenstock, Filkins, Preusker, Stöcker, *Final Report on the Project – Development and Coordination of a Network of Nurse Educators and Regulators to the European Commission, DG SANCO* (SANCO/1/2009) at page 60.

patients and the public a positive overview of the care they receive.[497] But if the educational entry requirements are set too high, there is a risk that some prospective workers may be discouraged from applying for job opportunities.[498]

[18.73] Regulation of HCAs and HCSAs could standardise their roles and define their scope of practice. In Ireland, a consequence of the variability in training of HCAs is that there is a lack of understanding regarding the competencies of HCAs, which in turn has consequences in relation to the tasks that can be delegated to HCAs or, in the case of HCSAs, what tasks they can be expected to undertake.[499] There are no set practice parameters for HCAs in Ireland.[500] When defining the scope of practice of HCAs and HCSAs, it should not be defined so narrowly or prescriptively that HCAs and HCSAs cannot perform certain tasks that both they and their patients would find beneficial, for example, going for a walk with a patient.[501] Regulation can ensure the recognition of the additional and unseen duties that unregulated care providers currently undertake, so that they can be rewarded for undertaking such duties.[502] Having a defined scope of practice could offer clarity and reaffirm the safe boundaries of practice for HCAs, HCSAs and any delegating professionals.[503]

[18.74] Importantly, regulation can control access to the professions of HCAs and HCSAs. The current lack of traceability of, or the lack of access to the employment records of, unregistered HCAs or HCSAs poses a risk to the

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[497] Conyard, Metcalfe, Corish, Flannery, Hannon, Rusk, Yeates, Codd, *Healthcare Assistants and Qualified Carers, A Trained but Untapped Underutilised Resource: A Population-Based Study in Ireland of Skillset, Career Satisfaction, Wellbeing and Change Across All Sectors and Care Settings: Full Report* (2020 University College Dublin) at page 33.

[498] Department of Health, *Report of the Strategic Workforce Advisory Group on Home Carers and Nursing Home Healthcare Assistants* (15 October 2022) at page 9.

[499] Drennan, Hegarty, Savage, Brady, Prendergast, Howson, Murphy, Spilsbury, *Provision of the Evidence to Inform the Future Education, Role and Function of Health Care Assistants in Ireland* (University College Cork and University of Leeds September 2018) at page 19.

[500] HSE review at para 11.6. See also, Glackin, "The Evolving Role of the Healthcare Assistant and its Implications for Regulation in the Republic of Ireland – A Case Study Approach" (PhD thesis, University of Northumbria 2016) at page 197.

[501] Ahern, Doyle and Timonen, "Regulating Home Care of Older People: The Inevitable Poor Relation?" (2007) 29(1) Dublin University Law Journal 374.

[502] Conyard, Metcalfe, Corish, Flannery, Hannon, Rusk, Yeates, Codd, *Healthcare Assistants and Qualified Carers, A Trained but Untapped Underutilised Resource: A Population-Based Study in Ireland of Skillset, Career Satisfaction, Wellbeing and Change Across All Sectors and Care Settings: Full Report* (2020 University College Dublin) at page 32.

[503] Glackin, "The Evolving Role of the Healthcare Assistant and its Implications for Regulation in the Republic of Ireland – A Case Study Approach" (PhD thesis, University of Northumbria 2016) at page 199.

public.[504] At present, there is nothing to stop a HCA or HCSA who has been dismissed from a role from gaining new employment in a similar setting shortly thereafter.[505] Regulation can also be an appropriate way to inhibit poor practice by HCAs and HCSAs.[506]

[18.75] Glackin recommends that the regulation of HCSAs in particular should be prioritised in the public interest.[507] Working alone, unsupervised, and with patients in their own homes, can cause concern.[508] Glackin states that risks can be magnified when procedures are carried out in less controlled settings, when compared to a hospital, for example.[509]

[18.76] Regulation need not be elaborate, costly or cumbersome. There are means to achieve oversight, standard-setting and accountability without entirely mirroring the sophisticated regulatory architecture that applies to doctors, nurses and other statutory professions. The implementation of the recommendations contained in the HSE's Review of the Role and Function of Health Care Assistants would considerably improve the current position.[510] Those recommendations include the protection of the HCA title[511] and the registration of HCAs.[512]

[18.77] The Commission endorses the HSE's recommendation in favour of the regulation of HCAs.[513] The Commission is also in favour of the regulation of

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504 Glackin, "The Evolving Role of the Healthcare Assistant and its Implications for Regulation in the Republic of Ireland – A Case Study Approach" (PhD thesis, University of Northumbria 2016) at page 197.

505 Glackin, "The Evolving Role of the Healthcare Assistant and its Implications for Regulation in the Republic of Ireland – A Case Study Approach" (PhD thesis, University of Northumbria 2016) at page 201.

506 Conyard, Metcalfe, Corish, Flannery, Hannon, Rusk, Yeates, Codd, *Healthcare Assistants and Qualified Carers, A Trained but Untapped Underutilised Resource: A Population-Based Study in Ireland of Skillset, Career Satisfaction, Wellbeing and Change Across All Sectors and Care Settings: Full Report* (2020 University College Dublin) at page 116, recommendation 11.

507 Glackin, "The Evolving Role of the Healthcare Assistant and its Implications for Regulation in the Republic of Ireland – A Case Study Approach" (PhD thesis, University of Northumbria 2016) at page 201.

508 Glackin, "The Evolving Role of the Healthcare Assistant and its Implications for Regulation in the Republic of Ireland – A Case Study Approach" (PhD thesis, University of Northumbria 2016) at page 179.

509 Glackin, "The Evolving Role of the Healthcare Assistant and its Implications for Regulation in the Republic of Ireland – A Case Study Approach" (PhD thesis, University of Northumbria 2016) at page 179.

510 HSE, *Review of Role and Function of Health Care Assistants* (December 2018).

511 HSE, *Review of Role and Function of Health Care Assistants* (December 2018) at para 14.1.

512 HSE, *Review of Role and Function of Health Care Assistants* (December 2018) at para 14.18.

513 HSE, *Review of Role and Function of Health Care Assistants* (December 2018) at paras 14.1 and 14.18.

HCSAs. As demonstrated above, the regulation of HCAs and HCSAs could provide greater protection to the public. By setting out mandatory minimum education and training requirements, patients could be protected and the roles of HCAs and HCSAs could be standardised in Ireland. A defined scope of practice could also provide clarity to HCAs, HCSAs and any delegating professionals.[514] Regulation of HCAs and HCSAs could also place controls on those who can access employment and could help to inhibit poor practice.[515]

R. 18.1 **The Commission recommends that** health care assistants and health care support assistants should be regulated in Ireland to ensure the:

(a) protection of the public;

(b) establishment of minimum educational and training requirements for health care assistants and health care support assistants;

(c) standardisation of the roles of health care assistants and health care support assistants;

(d) establishment of defined scopes of practice for health care assistants and health care support assistants; and

(e) implementation of controls on access to employment as a health care assistant or health care support assistant.

(b) Recommendations on additional sources of regulatory protection: barred lists and post-conviction prohibition orders

[18.78] In the UK, barred lists exist as a way to limit access to certain types of employment for people who have perpetrated harm or abuse against children or "vulnerable adults" where that action does not necessarily reach or exceed the criminal threshold. People placed on these lists are prohibited from working in regulated activities. Inclusion on a barred list lasts for life unless the person appeals or seeks a review of the decision.[516] A barred person in the UK has the right to request a review of a decision by the Disclosure and Barring Service to

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[514] Glackin, "The Evolving Role of the Healthcare Assistant and its Implications for Regulation in the Republic of Ireland – A Case Study Approach" (PhD thesis, University of Northumbria 2016) at page 199.

[515] Conyard, Metcalfe, Corish, Flannery, Hannon, Rusk, Yeates, Codd, *Healthcare Assistants and Qualified Carers, A Trained but Untapped Underutilised Resource: A Population-Based Study in Ireland of Skillset, Career Satisfaction, Wellbeing and Change Across All Sectors and Care Settings: Full Report* (2020 University College Dublin) at page 116, recommendation 11.

[516] Unlock, *DBS Barring – Representations, reviews and appeals* <https://unlock.org.uk/advice/barring-representations-reviews-and-appeals/#:~:text=Inclusion%20on%20a%20DBS%20barred,you%20appeal%20or%20seek%20review.>accessed on 5 April 2024.

bar them once the minimum barring period has elapsed.[517] If a person was aged under 18 when barred, they can request a review after one year.[518] If the person was aged 18 to 24 when barred, they can request a review after five years. If the person was aged 25 or over when barred, they can request a review after 10 years.[519] It is an offence for a barred person to carry out regulated activities, and it is an offence for an employer to employ a barred person to carry out regulated activities.

[18.79] In Ireland, no such lists exist. However section 20 of the Sex Offenders (Amendment) Act 2023 ("2023 Act") inserted Part 4A, comprising of sections 26A to 26G, into the Sex Offenders Act 2001 ("2001 Act"). Section 26D of the 2001 Act provides the court with a power to prohibit a person from working with children or "vulnerable persons".[520]

[18.80] Given that section 20 of the 2023 Act recently commenced on 13 November 2023, it is currently unclear how a prohibition will operate in practice. However with regard to section 26D(2) of the 2001 Act and comments made by the Deputy Minister for Justice in Dáil Éireann debate on the basis of legal advice provided by the Office of the Attorney General on the operation of section 20 of the Sex Offenders (Amendment) Bill, which ultimately became section 20 of the 2023 Act, the prohibition may operate in practice in the following manner.

[18.81] The aggregate of the sentence of imprisonment and the prohibition period shall not exceed the duration of the maximum term of imprisonment that may be imposed in respect of the sexual offence concerned.[521] For example, if the maximum term of imprisonment that may be imposed in respect of a particular sexual offence is ten years and the sentence of imprisonment was five years and an offender served five years, the prohibition period imposed on that offender may be up to, but not longer than, five years. This is because in this example, the aggregate of the sentence of imprisonment and the prohibition period (i.e. five years and five years, which amounts to ten years in aggregate) cannot exceed the duration of the maximum term of imprisonment (i.e. ten years).

[18.82] Having regard to section 26D(2) of the 2001 Act, as inserted by section 20 of the 2023 Act, it has been stated that the prohibition will not operate as a cure-all for children and "vulnerable persons" because the aggregate of the sentence of

[517] DBS, *Factsheet 2: Referral and barring decision-making process* (V2.3 2013) at page 9 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226163/dbs-factsheet-02.pdf>accessed on 5 April 2024.

[518] DBS, *Factsheet 2: Referral and barring decision-making process* (V2.3 2013) at page 9.

[519] DBS, *Factsheet 2: Referral and barring decision-making process* (V2.3 2013) at page 9.

[520] Section 20 of the Sex Offenders (Amendment) Act 2023.

[521] Section 26D(2) of the Sex Offenders Act 2001 (inserted by section 20 of the Sex Offenders (Amendment) Act 2023).

imprisonment and the prohibition period cannot exceed the duration of the maximum term of imprisonment that may be imposed in respect of the sexual offence concerned.[522]

[18.83] In response to this statement, the Deputy Minister for Justice stated in the Dáil Éireann debate on section 20 of the Sex Offenders (Amendment) Bill, which ultimately became section 20 of the 2023 Act, that according to legal advice provided by the Office of the Attorney General, the prohibition cannot exceed the duration of the maximum term of imprisonment that may be imposed in respect of a particular sexual offence. According to such legal advice, an outright prohibition would amount to a penalty, not a civil order, and a prohibition added to a term of imprisonment cannot exceed the duration of the maximum term of imprisonment that may be imposed in respect of a particular sexual offence because if it were to exceed such duration, it would impede upon the constitutional rights of an offender, in particular their right to earn a livelihood that is guaranteed by Article 40.3.1° of the Constitution.[523]

[18.84] With regard to section 26D of the 2001 Act which provides a power for a court to impose a prohibition, it is important to note that this is a post-conviction measure and provides for a court order. It does not neatly equate with the UK system wherein 'soft intelligence' can operate to limit a person's employment prospects.

[18.85] In Ireland, the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 ("2012 Act") requires certain scheduled organisations to refer specified information to the National Vetting Bureau.[524] The definition of "specified information" in section 2 of the 2012 Act states that only information received by the National Vetting Bureau from the Garda Síochána or scheduled organisations constitutes "specified information". Therefore information of concern that is received by the National Vetting Bureau from non-scheduled organisations which does not meet the criminal threshold will not constitute "specified information" and will not be included in a Garda vetting disclosure.

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[522] As observed by Deputy Clarke in Dáil Éireann Debates 18 November 2021 vol 1014 no 3 <https://www.oireachtas.ie/en/debates/debate/dail/2021-11-18/34/> accessed on 5 April 2024.

[523] Select Committee on Justice, Official Report of Select Committee on Justice, Sex Offenders (Amendment) Bill 2021: Committee Stage (26 April 2022) at page 27 <https://data.oireachtas.ie/ie/oireachtas/debateRecord/select_committee_on_justice/2022-04-26/debate/mul@/main.pdf> accessed on 5 April 2024. See also Dáil Éireann Debates vol 1028 no 1 <https://data.oireachtas.ie/ie/oireachtas/debateRecord/dail/2022-10-19/debate/mul@/main.pdf> accessed on 5 April 2024.

[524] Section 19(1) of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. The organisations obliged to refer specified information to the Garda Síochána are set out in Schedule 2 to the 2012 Act.

[18.86] As an alternative to full statutory regulation of currently unregulated HCAs and HCSAs, barring is superficially attractive. It has the advantage of potentially presenting a cost-effective alternative to regulation,[525] with the obvious and appealing advantage that it could allow for unregulated workers to be tracked so they cannot continue to malpractice or perpetrate abuse against at-risk adults. Barring would have the advantage of its application not being restricted to HCAs and HCSAs; it would also capture unregulated paid and voluntary workers who regularly come into contact with at-risk adults across all sectors. It could also prevent regulated professionals who have their registrations cancelled from subsequently working with at-risk adults in an unregulated profession. From a public safety perspective, this would be an improvement upon current Garda vetting because it would allow information of concerns about a person from a wide range of organisations to be considered when determining whether a person should be placed on a barred list. Presently, only "specified information" concerning a finding or allegation of harm to a person that is received by the National Vetting Bureau from the Garda Síochána or scheduled organisations is considered in the Garda vetting process.[526]

[18.87] A downside of barring is the binary nature of the system.[527] Representation or mitigation cannot reduce the severity of the decision to bar an individual. In order to be successful, such representations or claims must outweigh the factors that lead to a decision that a person should be included on the adults' barred list.[528]

[18.88] In Ireland, it is a constitutional imperative that a fair balance be struck between the protection of at-risk adults and the fair treatment of workers.[529] There are significant constitutional implications of barring someone from carrying out a certain role or activity. The right to a good name and the right to earn a livelihood are constitutionally protected rights, and Article 40.3 of the Constitution requires the protection of these rights from "unjust attack". The UK government has also struggled to balance the importance of the protection of

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[525] Spencer-Lane, "Modernising the regulation of health and social care professionals: the Law Commissions' final report and draft Bill" (2014) 16(6) Journal of Adult Protection 411 at page 415.

[526] Schedule 2 to the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 lists the scheduled organisations.

[527] Hussein, Martineau, Stevens, Manthorpe, Rapaport, Harris, "Accusations of misconduct among staff working with vulnerable adults in England and Wales: their claims of mitigation to the barring authority" (2009) 31(1) Social Welfare and Family Law 17 at page 20.

[528] Hussein, Martineau, Stevens, Manthorpe, Rapaport, Harris, "Accusations of misconduct among staff working with vulnerable adults in England and Wales: their claims of mitigation to the barring authority" (2009) 31(1) Social Welfare and Family Law 17 at page 20.

[529] Michael Mandelstam, *Safeguarding Adults and the Law: An A-Z of Law and Practice* 3rd ed (2019) at page 65.

"vulnerable persons" and the seriousness of barring a person, the latter which may result in the loss of employment or stigmatisation.[530]

[18.89] While barred lists can provide a more expedient alternative to regulation, in light of the constitutional implications that may arise from the placement of a person on a barred list, in particular with respect to their right to a good name and their right to earn a livelihood, the Commission is of the view that statutory regulation is preferable to barring, as a means of balancing the rights of individual workers and the need to protect the public. Barring is also more reactive than preventative, and might fall foul of constitutional requirements of due process, fair procedures and natural justice. Furthermore, the creation of a barring system to sit parallel to the existing vetting system, which would likely require new expertise, may not be the most efficient approach to protect the public. For these reasons, the Commission does not recommend the adoption in Ireland of a barring system of the type operated in the neighbouring jurisdictions of England and Wales, Scotland and Northern Ireland.

[18.90] The Commission is of the view that protection of at-risk adults, and the public in general, could be strengthened if the existing vetting process in Ireland was supplemented by post-conviction prohibition orders of the kind contained in Part 4A of the 2001 Act, comprising of sections 26A to 26G. These sections were inserted into the 2001 Act by section 20 of the 2023 Act, which commenced on 13 November 2023.[531] Section 26C of the 2001 Act provides for a duty of a court to consider the imposition of a "sentence including a prohibition".[532] Section 26D of the 2001 Act provides a power for a court to impose a prohibition on an offender. The prohibition relates to relevant work that is the subject of the prohibition. During a prohibition period, a person on whom a "sentence including a prohibition" is imposed shall be guilty of an offence under the 2001 Act if they: (a) apply to another person to be employed by that person to do prohibited work; (b) enter into a contract of employment to do prohibited work; (c) apply to another person to do prohibited work on the other person's behalf (whether in return for payment or for any other consideration or not); (d) enter into a contract for services to do prohibited work; or (e) do prohibited work.[533]

[18.91] In the adult safeguarding context, the Commission is of the view that post-conviction prohibition orders could be introduced in primary legislation in Ireland to prohibit persons who have been convicted of offences under adult safeguarding legislation or assisted decision-making legislation, or whose

[530] Michael Mandelstam, *Safeguarding Adults and the Law: An A-Z of Law and Practice* 3rd ed (2019) at page 65.

[531] Sex Offenders (Amendment) Act 2023 (Commencement) Order 2023 (SI No 539 of 2023), regulation 2(c).

[532] See section 26D(1) of the Sex Offenders Act 2001.

[533] Section 26G(1) of the Sex Offenders Act 2001.

victims were at-risk adults, from engaging in work or activities where such persons would have access to, or contact with, at-risk adults. In this regard, it is useful to note that the Commission's Criminal Law (Adult Safeguarding) Bill 2024 contains provisions on post-conviction prohibition orders. Such orders could be imposed in addition to any penalty imposed by a court, and non-compliance with such order could constitute an offence.

[18.92] In addition, the Commission recommends the establishment of a system of mandatory re-vetting to ensure greater protection for at-risk adults in all relevant sectors. To achieve this end, the Government could consider the commencement of section 20 of the 2012 Act.

[18.93] While the Commission considers that the establishment of a barring system is not appropriate in the Irish constitutional context, it is of the view that there should be greater latitude for the courts to impose post-conviction prohibition orders.

R. 18.2 **The Commission recommends that** barred lists should not be established in Ireland.

R. 18.3 **The Commission recommends that** post-conviction prohibition orders should be introduced in primary legislation in Ireland to prohibit persons who have been convicted of offences under adult safeguarding legislation or assisted decision-making legislation, or whose victims were at-risk adults, from engaging in work or activities where such persons would have access to, or contact with, at-risk adults.

R. 18.4 **The Commission recommends that** a system of mandatory re-vetting should be introduced for persons subject to mandatory vetting in respect of relevant work or activities under the National Vetting Bureau (Children and Vulnerable Persons) Act 2012

CHAPTER 19
ADULT SAFEGUARDING AND THE CRIMINAL LAW

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1. Introduction

[19.1] At present, there are few criminal offences in Ireland that specifically criminalise actions or inactions committed against at-risk adults.[534] Of course, the general criminal law applies where an offence is committed against an at-risk adult, but it can be difficult to proceed with prosecutions and secure convictions where the at-risk adult is unable to be interviewed, or give evidence at trial about what happened to them. The Commission's aim in this project is to draw all the pieces of the regulatory and enforcement systems for adult safeguarding together. As adult safeguarding involves multiple health and social care professionals and services, different regulators, various care settings (both public and private) and many different bodies, agencies, and organisations from numerous sectors, there is potential for partial policy solutions to emerge.[535]

[19.2] The Commission has therefore carefully considered possible reform of the criminal law in addition to the proposed civil law reforms outlined throughout this Report, in the pursuit of a comprehensive legal framework for adult safeguarding. Having considered consultees' submissions and having undertaken comparative research and an assessment of existing Irish criminal legislation in this jurisdiction, the Commission has concluded that reform of the criminal law is necessary, if the effectiveness of the Commission's proposed regulatory framework is to be maximised. New offences are necessary to take account of the complexity of the dynamics of dependence in familial and caring relationships and the communication challenges that some at-risk adults experience.

[19.3] The Commission is conscious of the extraordinary work done by carers, both on a voluntary and remunerated basis, and healthcare professionals who look after at-risk adults in all types of care settings. It recognises that frequently, failures in care in professional care settings are a result of systemic issues, such as shortages of staff, challenging workloads, inadequate procedures, and insufficient or unsuitable alternative placements for at-risk adults who pose a risk to their peers.[536] It is also important to bear in mind that where failures of care occur outside of professional care settings, for example, where a family member is caring for an at-risk adult at home, lack of support services such as access to respite or economic supports can exacerbate the risk of abuse, neglect

[534] One example of a criminal offence that can be committed against people who may be at-risk adults is the offence of ill-treatment or wilful neglect under section 145 of the Assisted Decision-Making (Capacity) Act 2015. See also sections 21 and 22 of the Criminal Law (Sexual Offences Act) 2017.

[535] See Quigley, "Policy making, adult safeguarding and public health: a formula for change?" (2014) 16(2) The Journal of Adult Protection 268 at page 71.

[536] Bogg, Collins, Freedland QC, Herring, Criminality at Work (Oxford University Press 2020) at pages 269, 273, 282, and 289.

or ill-treatment.[537] In some cases, a carer looking after an at-risk adult may be an at-risk adult themselves, which can affect their ability to effectively provide the necessary care.

[19.4] The Commission does not intend that the offences it proposes would apply where an unintended error or accident occurs that is beyond the control of the carer, care provider or person in contact with the at-risk adult. In developing its proposals, the Commission was mindful of the risk that the introduction of criminal offences could serve to deter people from vital caring work that is often isolating and underappreciated in Irish society. In formulating the criminal offences recommended in this Chapter, the Commission seeks to strike a balance between not criminalising unintentional or inadvertent harm or failures in care and ensuring that those providing care to at-risk adults are deterred from, and held to account for, intentionally or reckless abusing, neglecting or ill-treating a person in their care.

[19.5] While prevention is of course preferrable to the inevitably reactive approach of the criminal law, the Commission believes that certain actions or inactions in respect of at-risk adults requires effective criminalisation to protect at-risk adults and to act as a deterrence. At-risk adults may be highly dependent on their family members, friends, carers, and health and social care professionals to carry out daily activities, and this level of dependency, and inability to protect themselves from harm can increase their likelihood of being abused, neglected, ill-treated, exploited or controlled.

[19.6] There are significant gaps in the legal protections that ought to be afforded to at-risk adults who rely on others for care or support with daily living. Ill-treatment and neglect of adults are not specifically criminalised in Irish law. Neglect short of death is not criminalised. Failures in care that result in the

[537] Carers Australia, Let's Be Clear on the Value of Carers <https://www.carersaustralia.com.au/lets-be-clear-on-the-value-of-carers/> accessed 9 April 2024; Local Government Association and Director of Adult Social Services (England and Wales), Carers and safeguarding: a briefing for people who work with carers <https://www.local.gov.uk/parliament/briefings-and-responses/carers-and-safeguarding-briefing-people-who-work-carers> accessed 9 April 2024. A briefing note by the Local Government Association and the Association of Directors of Adult Services in England and Wales, highlights that where a carer intentionally or unintentionally abuses or neglects the adult they are caring for, often, the carer:

> has unmet or unrecognised needs of their own including health needs, are themselves vulnerable, have little insight or understanding of the vulnerable person's condition or needs, has unwillingly had to change his or her lifestyle, are not receiving practical or emotional support from other family members, are feeling emotionally or socially isolated, undervalued or stigmatised, has other responsibilities such as family or work, has no personal or private space or life outside of the caring environment, has frequently requested help but problems have not been solved, is being abused by the vulnerable person or feels underappreciated by the vulnerable person or exploited by relatives or services.

exposure of at-risk adults to serious risk of harm or sexual abuse are not currently criminalised. However, there are specific offences that criminalise child cruelty and endangerment, as discussed below. Undoubtedly, there is a distinction between children and at-risk adults, as children are inherently dependent on their caregivers, whereas that is not always the case with at-risk adults. In saying that, the abuse, neglect, ill-treatment or exposure to harm of at-risk adults is unquestionably reprehensible and deserving of criminalisation, as at-risks adults may also be unable to protect themselves from harm.

[19.7] In examining the need to reform the criminal law to better protect at-risk adults, this Chapter examines:

- existing criminal provisions that protect at-risk adults from abuse or neglect, and their limitations by reference to previous cases involving the abuse or neglect of at-risk adults;
- criminal provisions related to the abuse, neglect, endangerment and exposure of children to risk of serious harm or sexual abuse, and why similar offences should be introduced in respect of at-risk adults;
- criminal provisions that protect at-risk adults in other jurisdictions;
- the need for specific offences to address coercive control or coercive exploitation of at-risk adults;
- penalties and ancillary orders and provisions.

[19.8] Ultimately, the Commission recommends the introduction of the following offences:

- an offence of intentional or reckless abuse, neglect or ill-treatment;
- an offence of exposure to risk of serious harm or sexual abuse;
- an offence of coercive control that extends to a broader range of relationships than the current offence in section 39 of the Domestic Violence Act 2018;
- an offence of coercive exploitation.

[19.9] The Commission sets out these offences in its Criminal Law (Adult Safeguarding) Bill. The rationale for the introduction of these offences can be found in this Chapter.

[19.10] Additionally, the Chapter outlines the existing regulatory offences under the Health Act 2007 and the Mental Health Act 2001 that apply to care providers of residential centres for people with disabilities and older persons and approved centres for people with mental disorders. These regulatory offences can be prosecuted by the Health Information and Quality Authority ("HIQA") and the Mental Health Commission ("MHC"). The criminal offences proposed by the Commission in this Chapter apply equally to natural persons and to care

providers who are bodies corporate or unincorporated bodies. However, it is important to recognise that the proposed criminal provisions do not operate in a vacuum and that HIQA (particularly the Chief Inspector of Social Care Services) and the MHC have prosecutorial powers to address failures in care by care providers (including senior managers and directors), and have other regulatory tools at their disposal such as cancellation of registration, or varying conditions of registration or imposing new conditions to improve standards and the quality of care.

2. Context and terminology

(a) Existing offences: addressing single acts of significant endangerment and violence rather than neglect or exposure

[19.11] This section will briefly examine some relevant existing criminal law offences that can apply to abuse of at-risk adults. Currently, the emphasis in the legislation is on single (mainly assaultive) incidents. Some noteworthy adult safeguarding events in recent Irish history that had criminal law aspects are also explored to illustrate the limitations of existing criminal offences.

[19.12] The term "abuse" encapsulates a wide range of behaviours that harm others physically or psychologically. Achieving a definition that neatly describes abuse is difficult.[538] Abuse can involve physical and sexual violence, fraud and deception as well as psychological violence (threats, coercion, harassment, stalking, overt racism and other forms of bigotry). It can take the form of deprivation of liberty as well as neglect of varying degrees of severity. All of these acts are already criminalised, and it is of course the case that the general criminal law operates to protect everyone from harm, irrespective of whether they are otherwise considered to be at risk of harm.

[19.13] There is a comprehensive existing legal framework to criminalise incidents where harm is caused which can be directly attributed to another person, as well as where a person is put at risk of life-changing injuries or death (endangerment, which can be intentional or reckless but it can be difficult to prosecute). With one narrow exception,[539] the neglect of adults is not

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[538] For example, in The National Standards for Residential Services for Children and Adults with Disabilities, HIQA defines abuse as:

> any act, or failure to act, which results in a breach of a vulnerable person's human rights, civil liberties, physical and mental integrity, dignity or general well being, whether intended or through negligence, including sexual relationships or financial transactions to which the person does not or cannot validly consent, or which are deliberately exploitative. Abuse may take a variety of forms.

See Health Information and Quality Authority, *The National Standards for Residential Services for Children and Adults with Disabilities* (HIQA 2014) at page 107.

[539] Section 145 of the Assisted Decision-Making (Capacity) Act 2015.

criminalised. As will be seen below, this approach is at odds with the position in other jurisdictions, and indeed the approach of the criminal law in Ireland that applies to the protection of children.[540]

[19.14] At the time of writing, there is only one adult neglect offence on the Irish Statute Book. It can be found in the Assisted Decision-Making (Capacity) Act 2015. The section makes it an offence for a "decision-making assistant, co-decision-maker, decision-making representative, attorney, or designated healthcare representative of a relevant person" to ill-treat or wilfully neglect a "relevant person".[541] It seems anomalous, and unduly narrow, that such an offence should apply only to those involved in the support of decision-making for adults who may be at-risk, but that no similar offence applies if residents of the same household or others who have caring responsibilities wilfully neglect or ill-treat an at-risk adult. A gap can be identified insofar as the protection that comes with criminalisation only applies to a very narrow category of at-risk adults, who lack capacity or whose capacity is in question in respect of one or more matters. A person with decision-making capacity in respect of all matters, but who is completely physically incapacitated has no equivalent criminal law protection from wilful neglect or ill-treatment, even though they may also be unable to protect themselves from harm.

[19.15] Various forms of assault are criminalised by the Non-Fatal Offences against the Person Act 1997. Sections 2, 3 and 4 of the Act provide for offences of assault, assault causing harm and assault causing serious harm respectively, while section 5 provides for the offence of threatening to kill or cause serious harm. The Criminal Justice (Public Order) Act 1994 also provides an offence of assault "with intent to cause bodily harm or to commit an indictable offence".[542] For that offence, there is no requirement that harm is actually caused to the victim, but rather that the assault was committed with that intent.

[19.16] Existing offences are focused on deliberate, often once-off, acts of violence – assault, assault causing harm and assault causing serious harm. Neglect is different. Neglect can result from both indifference and deliberate disregard. It

[540] There are a number of offences in relation to children that could broadly be termed neglect/failure of caring duty offences: cruelty (section 246 of the Children Act 2001); allowing a child to beg (section 247 of the Children Act 2001); being drunk in charge of a child under 7 years of age (section 9 of the Summary Jurisdiction (Ireland) Act 1908) and endangerment of a child (section 176 of the Criminal Justice Act 2006).

[541] Section 145 of the Assisted Decision-Making (Capacity) Act 2015. A relevant person is defined in the Act as follows: (a) a person whose capacity is in question or may shortly be in question in respect of one or more than one matter, (b) a person who lacks capacity in respect of one or more than one matter, or (c) a person who falls within paragraphs (a) and (b) at the same time but in respect of different matters, as the case requires. See section 2 of the Assisted Decision-Making (Capacity) Act 2015.

[542] Section 18 of the Criminal Justice (Public Order) Act 1994.

can include ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, and the withholding of the necessities of life such as medication, adequate nutrition, bathing facilities and heating.[543] By contrast with the once-off assaults which are criminalised by the Non-Fatal Offences against the Person Act 1997, neglect can occur by small omissions which build up over time to cause harm to an individual. As noted by Myers, “neglect takes time”.[544] So while each act or omission does not necessarily in and of itself cause harm to a criminal extent, the duration and persistence of the neglect can be cumulative and ultimately harmful.

[19.17] While neglect forms a sizeable proportion of concerns raised with the HSE National Safeguarding Office in respect of adults,[545] non-fatal neglect of an at-risk adult is not currently criminalised. Where neglect leads to death, the offence of manslaughter by gross negligence may apply. However, a great many cases will not be fatal and so a gap in the law’s protection can be seen in respect of neglect that may be dangerous (although without resulting harm) or cumulatively harmful.

(i) Áras Attracta

[19.18] The Áras Attracta scandal illustrates the limitations of existing legislation. The scandal came to light when an investigative reporter obtained CCTV footage of the mistreatment of residents with intellectual disabilities at a residential facility. Six staff members were prosecuted for physical abuse.[546] The undercover report, broadcast on RTÉ’s Prime Time programme, showed some residents at a unit of Áras Attracta care centre in Swinford being force-fed, slapped, kicked, physically restrained and shouted at.

[19.19] One case, which involved the defendant staff member sitting on a resident, was prosecuted in the District Court, where it was described by the trial judge as an “offensive, downgrading invasion of [the victim’s] bodily integrity”.[547] Three

[543] Health Service Executive, *Safeguarding Vulnerable Persons at risk of Abuse: National Policy and Procedures – Frequently Asked Questions* (HSE 2014) at page 9.

[544] Myers, *Myers on Evidence in Child, Domestic, and Elder Abuse cases* 4th ed (Wolters Kluwer 2005) at page 910.

[545] According to the HSE National Safeguarding Office’s Annual Report 2022, 8% (1,270 instances) of all abuse cases reported were categorised as “neglect”. For further data, see HSE National Safeguarding Office, *Annual Report 2022* (2022) at pages 29 to 32.

[546] Shiel, “Six in court for alleged assault of Áras Attracta patients” The *Irish Times* (12 June 2015) <https://www.irishtimes.com/news/crime-and-law/courts/district-court/six-in-court-for-alleged-assault-of-aras-attracta-patients-1.2247334> accessed 9 April 2024.

[547] Shiel, “Áras Attracta worker imprisoned for sitting on intellectually disabled client” *The Irish Times* (8 February 2016) <https://www.irishtimes.com/news/crime-and-law/courts/district-court/aras-attracta-worker-imprisoned-for-sitting-on-intellectually-disabled-client-1.2527030#:~:text=After%20being%20found%20guilty%2C%20McLoughlin,visibly%20upset%20by%20the%20ruling.> accessed 9 April 2024.

other members of staff were also found guilty of charges of assault.[548] The offences prosecuted were contrary to section 2 of the Non-Fatal Offences against the Person Act 1997. That is the lowest level assault provided for by the Non-Fatal Offences against the Person Act 1997. The offence can only be prosecuted summarily in the District Court, without a jury, and it carries a maximum penalty of six months' imprisonment. It is therefore, in law, a minor offence. It is the only offence where assault can be prosecuted without the ingredient of harm or without intent to cause harm.[549]

[19.20] As will be seen below, the position is different in respect of children. Section 246 of the Children Act 2001 criminalises a broad range of behaviours against children that constitute abuse and ill-treatment.[550] Those behaviours are prosecuted under the umbrella term "cruelty". The section 246 offence is prosecutable on indictment, with a potential penalty of seven years' imprisonment.[551] It is an offence that is frequently prosecuted.[552] It can be convincingly argued that a similar offence tailored to at-risk adults would have better reflected the seriousness of the offending and the appalling mistreatment of the residents of Áras Attracta. The distinctive aspect of the section 276 offence is that an assault is not required for the abusive behaviour to be criminalised. As the Áras Attracta cases demonstrate, an assault is not an essential element of cruelty.

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[548] Shiel, "Áras Attracta worker imprisoned for sitting on intellectually disabled client" *The Irish Times* (8 February 2016) <https://www.irishtimes.com/news/crime-and-law/courts/district-court/aras-attracta-worker-imprisoned-for-sitting-on-intellectually-disabled-client-1.2527030#:~:text=After%20being%20found%20guilty%2C%20McLoughlin,visibly%20upset%20by%20the%20ruling.> accessed 9 April 2024.

[549] As a reminder, the Non-Fatal Offences against the Person Act 1997 provides for offences of assault (section 2), assault causing harm (section 3) and assault causing serious harm (section 4). The Criminal Justice (Public Order) Act 1994 provides an offence of assault with intent to cause bodily harm (where no evidence of harm needs to be proven).

[550] Section 246(1) of the Children Act 2001 provides that it is an offence for any person who has custody, charge or care of a child "wilfully to assault, ill-treat, neglect, abandon or expose the child, or cause or procure or allow the child to be assaulted, ill-treated, neglected, abandoned or exposed in a manner likely to cause unnecessary suffering or injury to the child's health or seriously to affect his or her wellbeing".

[551] The offence is also prosecutable summarily with a potential penalty of 12 months' imprisonment.

[552] According to provisional statistics from the Central Statistics Office, Gardaí recorded 266 incidents of this offence in 2022, 291 incidents in 2021, 338 incidents in 2020, 308 incidents in 2019 and 346 incidents in 2018. See for example, Central Statistics Office, Recorded Crime Q4 2022 https://www.cso.ie/en/releasesandpublications/ep/p-rc/recordedcrimeq42022/detailedoffencegroup/ accessed 9 April 2024. Figures released by the Office of the Director of Public Prosecutions, on request, detail that in 2022 there were 21 cases where directions to prosecute for child neglect were issued involving 22 suspects. In 2021 there were 55 cases with 63 suspects, in 2020 there were 55 cases and 61 suspects, in 2019 there were 36 cases and 44 suspects and in 2018 there were 28 cases and 30 suspects.

(ii) DPP v Joel and Costen

[19.21] *The People (DPP) v Joel and Costen*[553] concerned the extent of the duty owed by a daughter, Eleanor Joel, and her partner, Jonathan Costen, to Eleanor's mother, Evelyn who suffered from multiple sclerosis. The accused were both charged with the unlawful killing of Evelyn by neglect. Evelyn had resided in the house of the accused persons prior to her death. She had refused hospital treatment. When Jonathan Costen's mother eventually called an ambulance, she was in a deplorable condition.[554] Neither the cause of death nor the duty of care owed to her were clear cut. Eleanor Joel and Jonathan Costen were convicted of manslaughter in the Circuit Court, but their convictions were quashed on appeal. The link between the actions and omissions of the accused persons and the death of Evelyn was not sufficiently clear.

[19.22] Particular issues arose as to whether the appellants' actions were sufficient to establish a duty of care, as her daughter asserted that her mother had refused assistance and Jonathan Costen had repeatedly asked Evelyn to move out of the house.[555] Questions also arose regarding the role of the HSE in caring for Evelyn,

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[553] *The People (DPP) v Joel and Costen* [2016] IECA 120, [2016] 2 IR 363.

[554] *The People (DPP) v Joel and Costen* [2016] IECA 120 at para 3, [2016] 2 IR 363 at para 3.

[555] The duty to act may arise from (1) an obligation to act or assist imposed by statute; (2) a failure to perform a contractual obligation; (3) in some circumstances the relationship between an accused and victim; or, (4) if a person has voluntarily taken on the responsibility to care for another individual, they may be held criminally liable if they fail to fulfil that responsibility. See *The People (DPP) v Joel and Costen* [2016] IECA 120 at paras 45-47, [2016] 2 IR 363 at paras 45-47. For Eleanor Joel, the State argued that the duty of care arose because she was the victim's daughter (category 3 above). However, the appellant argued that her mother had constantly refused her help. For Jonathan Costen, the State argued that the duty arose because of his relationship with Eleanor Joel (the victim's daughter) and because he was in the house and assumed the responsibility of caring for the victim (category 4 above). However, Jonathan Costen argued that he owed no duty of care to Evelyn, as he fell into none of the categories above, and in relation to category 4, he could not be said to have assumed responsibility for the care of Evelyn, as he continuously asked her to leave the house. See *The People (DPP) v Joel and Costen* [2016] IECA 120 at paras 44 to 52, [2016] 2 IR 363 at paras 44 to 52.

One of Jonathan Costen's grounds for appeal against his conviction was that the trial judge failed to tell the jury that they would have to be satisfied that Costen voluntarily assumed the duty (as he met none of the other categories) and failed to tell the jury that there was no general duty on Costen to act in the circumstances of the case. The Court of Appeal stated that there was "some substance" to the criticism of the trial judge's direction in that regard. It agreed that the trial judge misstated Costen's defence regarding the duty of care to the jury and commented that "[t]he question of whether or not Mr. Costen owed a duty of care is a very significant issue indeed seen from the perspective of his legal team. It seems to the Court that it was understandable that the defence would have wanted it made clear to the jury that Mr. Costen could only be convicted if the prosecution had established beyond reasonable doubt that as an exception to the general situation, Mr. Costen had assumed a responsibility. It was desirable that it be made clear to the jury at the starting point, the general position is that there is no obligation to care for another, but that there are exceptions to that and it was for the prosecution to establish beyond reasonable doubt that Mr. Costen came within one of those exceptional categories." Costen succeeded on this

as the appellants argued that the neglect and inadequacies on the part of the HSE, local housing authorities and the council caused Evelyn's death or contributed to her death in a very substantial way.[556]

[19.23] To convict a person of manslaughter, responsibility for death must be established. The Court of Appeal in *The People (DPP) v Joel and Costen* stated that "in cases of manslaughter, the jury should be told that the issue is whether the actions or omissions of the accused was a substantial cause of the death".[557] Unlike other jurisdictions, Ireland does not specifically criminalise non-fatal neglect of adults (with the exception of the offence in the Assisted Decision-Making (Capacity) Act 2015. Ultimately, the Court of Appeal decided to quash both convictions as both appellants succeeded on a number of grounds.[558]

(iii) The Brandon Report

[19.24] A spotlight was placed on peer-to-peer abuse in congregated settings in the aftermath of the Brandon report.[559] In that case, concerns regarding the sexually abusive behaviour of a man with intellectual disabilities (referred to as 'Brandon' in the report) were first identified in 1997. In the period 2003 to 2011, he engaged in a vast number of highly abusive and sexually intrusive behaviours.[560] A review by the National Independent Review Panel ("NIRP") found evidence available on file that suggested that he "regularly targeted particular individuals and was able to identify particularly vulnerable residents whom he pursued

ground of appeal. See *People (DPP) v Joel and Costen* [2016] IECA 120 at paras 6, 17 to 27, [2016] 2 IR 363 at paras 6, 17 to 27.

[556] *The People (DPP) v Joel and Costen* [2016] IECA 120 at paras 17 to 27, [2016] 2 IR 363 at paras 17 to 27. In particular, the appellants contended that the Gardaí did not conduct an effective investigation into whether healthcare professionals and local authority officials were responsible for Evelyn's death, and that this jeopardised their right to a fair trial. This argument did not find favour with the Court of Appeal who stated that the Gardaí "cannot be criticised for focusing on the role of Ms. Joel and Mr. Costen". The appellants also argued that there was gross negligence on the part of others. The Court of Appeal determined that the fact that witnesses, including the public health nurse, were not "called to give evidence nor were they even tendered and thus were not available for cross-examination rendered the trial unsatisfactory".

[557] *The People (DPP) v Joel and Costen* [2016] IECA 120 at para 33, [2016] 2 IR 363 at para 33. The prosecution contended that the test in Ireland was whether the defendant's actions were "related to the death in a more than a minimal way" and the trial judge favoured that view.

[558] *The People (DPP) v Joel and Costen* [2016] IECA 120 at para 53, [2016] 2 IR 363 at para 53.

[559] National Independent Review Panel, *Independent Review of the Management of Brandon: The National Independent Review Panel – Brandon Report for Publication* (NIRP 2021).

[560] These behaviours of Brandon included: exposing himself and masturbating in the presence of others, inappropriate touching of other residents inside and outside their clothing, entering the bedrooms of residents during the night, and verbal and physical aggression to other residents and staff.

relentlessly".[561] A previous look-back review determined that at least 108 sexual inappropriate behaviours were committed against fellow residents from 2003 to 2011.[562] Despite repeated reports from staff,[563] the risk 'Brandon' posed remained mismanaged and avoidable harm was caused to numerous residents.[564]

[19.25] The NIRP report stated that many factors contributed to the 'Brandon' situation including the clinical environment of the centre, a lack of external management oversight and leadership from the HSE and a lack of training for staff to properly implement policies and procedures.[565] Separately, a 2022 HIQA report identified gaps in safeguarding arrangements in HSE residential centres in Donegal, including poor quality surveillance of the centres by the HSE and generic and ineffective auditing and oversight.[566]

[19.26] In cases such as that of 'Brandon', the potential for criminal law intervention where one at-risk adult harms another at-risk adult may be limited. The accused may lack the capacity to understand the criminal nature of the act. They may not have the ability to participate in an investigative interview and if prosecuted, they might ultimately be found to be unfit to be tried. If the accused does have capacity and is fit to be tried, there is ample existing law on sexual offences that can be used. However, as will be seen below, a distinction can again be seen between adults and children in respect of the criminalisation of those who place others at risk of sexual abuse. Legislation criminalises knowingly or recklessly exposing children to sexual abusers,[567] but there is no equivalent protection in

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[561] National Independent Review Panel, *Independent Review of the Management of Brandon: The National Independent Review Panel – Brandon Report for Publication* (NIRP 2021) at page 5. The NIRP published the executive summary of the Brandon Report in November 2021. There have been calls for the publication of the full report which have not been acceded to by the HSE. For further discussion, see Chapter 17.

[562] National Independent Review Panel, *Independent Review of the Management of Brandon: The National Independent Review Panel – Brandon Report for Publication* (NIRP 2021) at page 2.

[563] Staff raised concerns with the director of nursing at the time, as well as the Gardaí.

[564] For example, the NIRP report noted that 'Brandon' was move to a house on the complex to live by himself away from other residents, which resulted in "a sharp reduction in the number of sexual assaults recorded". However, he was moved back to a house with other residents just over a year and a half later.

[565] National Independent Review Panel, *Independent Review of the Management of Brandon: The National Independent Review Panel – Brandon Report for Publication* (NIRP 2021) at pages 9 and 10.

[566] Health Information and Quality Authority, *Regulation and Monitoring of Social Care Services – Overview report of governance and safeguarding in HSE designated centres for people with disabilities in Donegal in January 2022* (HIQA 2022) at pages 7 and 10.

[567] Section 176 of the Criminal Justice Act 2006.

respect of at-risk adults that criminalises carers, senior managers, care providers, or other bodies corporate.

(b) A vindication of rights approach to criminalisation

[19.27] The Irish Association of Social Workers has said that:

> the key lesson of the 'Brandon' report; that we must "move away from viewing safeguarding through a clinical, medicalised lens and instead operate from a rights-based model with a broad range of professional expertise and perspectives.[568]

[19.28] Centuries of infantilisation and substituted decision-making mean that comparisons between at-risk adults and children are often viewed as highly paternalistic. The Commission is acutely aware of that. However, to ignore the lessons that can be learned from child safeguarding, which in Ireland is a much more embedded concept than adult safeguarding, would, in the Commission's view, be to do a disservice to at-risk adults who are in danger and who are or may be subjected to abuse, neglect and ill-treatment without adequate criminal sanction. In assessing the law in relation to child protection, the Commission is in no way comparing at-risk adults with children. Rather, the Commission questions (on both practical grounds and on the basis of equality) the rationale for limiting the protection of a specific offence of cruelty (which encompasses abuse, neglect and ill-treatment) to children exclusively. The Commission questions the degree to which Irish criminal law complies with the UN Convention on the Rights of Persons with Disabilities ("UNCRPD"), which Ireland ratified in March 2018.

[19.29] Article 16(1) and 16(5) of the UNCRPD respectively provide that:

> States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.
>
> …
>
> States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

[568] Irish Association of Social Workers, *Position Paper on Adult Safeguarding: Legislation, Policy and Practice* (IASW 2022) at page 16.

[19.30] As is discussed in Chapter 4, the State has an obligation to protect and vindicate the constitutional rights of individuals, including, for example, their right to life, right to bodily integrity, right to dignity and right to protection of the person.[569] The European Convention on Human Rights ("ECHR") also provides for a range of individual rights. Notably, the European Court of Human Rights has held that there is an obligation on States to effectively enforce criminal law regimes in order to vindicate the ECHR rights of individuals, such as the right to life and prohibition of torture or ill-treatment.[570] The Commission is of the view that the criminal offences proposed in this Chapter are necessary to vindicate the rights of at-risk adults and allow the State to fulfill its obligations under the Constitution, the ECHR and the UNCRPD.

[19.31] The need for criminal law to protect children from physical and sexual abuse and neglect has long been recognised. Despite that long-standing recognition, lessons are still being learned and child protection in Ireland has been the subject of major reform in recent years, including legislation, constitutional reform and considerably more formalised processes in child protection.[571] The consequence is that there are notable differences in the protection afforded by the criminal law to children and at-risk adults, and that divergence is longstanding.

[19.32] The distinction can be rationalised by arguing that children are inherently vulnerable and dependent, whereas adults, generally speaking, are not. However, some adults are at a considerably greater risk of abuse, neglect or ill-treatment than some children. The public health system and compulsory school attendance combine to give a degree of State oversight of child welfare.[572] There are reporting obligations and there is broad awareness among professionals of their duties to prevent harm and abuse of children.[573] By comparison, there is much more scope for at-risk adults to remain undetected by the State's radar.[574] On its face, the bald distinction between children and at-

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[569] See in particular discussion in section 2(a), (d), (f), (g) in Chapter 4.

[570] For a discussion of the ECHR rights engaged in the adult safeguarding context see section 4 of Chapter 5. In particular, for analysis on the positive obligations on ECHR signatories see discussion of the *LCB v UK* case of the European Court of Human Rights in section 4(a) of Chapter 4 and the discussion of the prohibition of torture in section 4(e).

[571] See Phelan and Davis, "Lessons Learned: Public Health Nurses Practice in Safeguarding Children in the Republic of Ireland" (2015) 2(1) Global Pediatric Health 1.

[572] See, for example, Bullock, Stanyon, Glaser and Chou, "Identifying and Responding to Child Neglect: Exploring the Professional Experiences of Primary School Teachers and Family Support Workers" (2019) 28(3) Child Abuse Review 209.

[573] See the Children First Act 2015 and Department of Children and Youth Affairs, *Children First National Guidance for the Protection and Welfare of Children* (DCY 2017).

[574] For example, a 2022 application to the High Court concerned a young woman who was found (as a consequence of a child welfare intervention with her younger siblings) in a distressed and very neglected state, having not left her home in a number of years. See

risk adults is difficult to justify. If an adult has a carer with whom there is a relationship of dependence, in the Commission's view, it is equally desirable that the carer should be deterred by the criminal law from seriously abusing, neglecting or ill-treating the person in receipt of their care. The law in relation to neglect and cruelty assumes counterfactually that all adults are independent and self-reliant.

[19.33] The Criminal Law (Sexual Offences) Act 2017 criminalises sexual contact with individuals who would be considered at-risk adults.[575] It is an offence to engage in a sexual act with a "protected person", or to invite, induce, counsel or incite a "protected person" to engage in a sexual act.[576] It is also an offence to engage in a sexual act with a "relevant person" if you are a person in authority.[577] The rationale for a distinction in relation to sexual abuse and physical abuse, neglect and ill-treatment is difficult to understand, particularly given that abuse and neglect can result in serious harm and even, in extreme cases, death.

(c) Application of proposed offences – "relevant person" and who can commit the offences

[19.34] A standalone criminal law statute is required to give effect to the recommendations in this Chapter on the reform of the criminal law. The Commission's proposed offences are contained in its Criminal Law (Adult

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O'Riordan, "Extremely vulnerable' woman can be taken from family home for assessment, judge says" *The Irish Times* (11 February 2022) <https://www.irishtimes.com/news/crime-and-law/courts/high-court/extremely-vulnerable-woman-can-be-taken-from-family-home-for-assessment-judge-says-1.4799830>accessed 9 April 2024. In another case the High Court ordered the removal of a woman from her home against her mother's wishes in circumstances in which it was alleged the woman had not left her bedroom in nearly two years. See O'Riordan, "Woman alleged not to have left bedroom in nearly two years can be transferred to hospital with use of reasonable force, court rules" *The Irish Times* (30 March 2023) <https://www.irishtimes.com/crime-law/courts/2023/03/30/woman-alleged-not-to-have-left-bedroom-in-nearly-two-years-can-be-transferred-to-hospital-with-use-of-reasonable-force-court-rules/#:~:text=The%20judge%20was%20satisfied%2C%20notwithstanding,woman's%20best%20interests%2C%20he%20said.> accessed 9 April 2024.

[575] Part 3 of the Criminal Law (Sexual Offences) Act 2017.

[576] Section 21 of the Criminal Law (Sexual Offences) Act 2017. A protected person is defined as a person who lacks the capacity to consent to a sexual act if he or she is, by reason of a mental or intellectual disability, or mental illness, incapable of (a) understanding the nature, or the reasonably foreseeable consequences, of that act, (b) evaluating relevant information for the purposes of deciding whether or not to engage in that act, or (c) communicating his or her consent to that act by speech, sign language or otherwise.

[577] Section 22 of the Criminal Law (Sexual Offences) Act 2017. A relevant person for the purposes of the section is defined as a person who has a mental or intellectual disability or mental illness of such a nature of degree that it severely restricts their ability to guard themselves against serious exploitation. A person in authority is defined as any person who is responsible for the education, supervision, training, treatment, care of welfare of the relevant person as part of a contract for services.

Safeguarding) Bill 2024 in appended to this Report. Situating criminal offences in a dedicated Criminal Law (Adult Safeguarding) Act would be beneficial from the perspective of raising public knowledge and awareness, and thereby increasing deterrence, in relation to the proposed new offences. It would also clarify the role and responsibility of the Garda Síochána for the investigation of criminal adult safeguarding offences. Such a responsibility might not be immediately apparent if the offences were set out in the proposed civil Adult Safeguarding Bill 2024, which is a much larger piece of draft civil legislation.

(i) "Relevant person"

[19.35] Throughout this Report, the Commission uses the term "at-risk adult" to refer to adults who might be at risk of harm and it recommends that various legislative measures should be introduced to protect such persons. The rationale for using a broad and inclusive term of "at-risk adult" that does not place emphasis on any particular characteristics of the person is discussed in detail in Chapter 2. While the term "at-risk adult" can reasonably be used in the Commission's Adult Safeguarding Bill 2024 without any difficulties, the Commission considers that the criminal law requires more certainty and specificity. Those who commit a criminal offence in the adult safeguarding context need to know who it applies in relation to, so that they understand and are aware that their actions or inactions are criminal. For that reason, the Commission determined that it is necessary to use a term that is hinged on particular characteristics of adults in the criminal context to provide certainty.

[19.36] The term "vulnerable person" appears frequently on the Statute Book in similar formulations.[578] Generally speaking, the various enactments define a "vulnerable person" as a person, other than a child, whose capacity to guard himself or herself against violence, exploitation or abuse, whether physical, sexual or emotional, by another person is significantly impaired though:

(a) a physical disability, illness or injury;
(b) a disorder of the mind, whether as a result of mental illness or dementia, or
(c) an intellectual disability.[579]

[19.37] As discussed in Chapter 2, various stakeholders and experts in adult safeguarding have expressed the view that using the term "vulnerable" to refer to adults who may be at-risk of harm is "stigmatising, labelling [and]

[578] See for example, section 3 of the Sex Offenders (Amendment) Act 2023; section 75 of the Criminal Justice (Forensic Evidence and DNA Database System) Act 2014 and section 1 of the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012.

[579] See for example section 2(1) of the Sexual Offenders Act 2001 as amended by section 3(c) of the Sex Offenders (Amendment) Act 2023.

patronising" and unfairly focuses attention on the particular characteristics of the adult at risk of harm rather than the context of the abuse or the actions of the perpetrator.[580] The Commission wishes to avoid using the term "vulnerable" for that reason and instead considers that the term "relevant person" should be adopted for the purposes of the proposed offences in its draft Criminal Law (Adult Safeguarding) Bill 2024. It recommends that the criminal offences it proposes in its Criminal Law (Adult Safeguarding) Bill 2024 should apply where a person commits an offence against a "relevant person" and that the term "relevant person" should be defined as follows:

> "relevant person" means a person, other than a child, whose ability to guard himself or herself against violence, exploitation or abuse, whether physical, sexual or emotional, or neglect, by another person is significantly impaired through one, or more, of the following:
>
> (a) a physical disability, a physical frailty, an illness or an injury;
> (b) a disorder of the mind, whether as a result of mental illness or dementia;[581]
> (c) an intellectual disability;
> (d) autism spectrum disorder.

[19.38] The above definition is similar to definitions of "vulnerable person" in existing primary legislation, although importantly, it does not use the stigmatising and labelling term "vulnerable person". The Commission believes it is appropriate to include autism spectrum disorder to ensure that the definition of "relevant person" applies to the widest possible category of persons who may be at risk of harm while also keeping the definition sufficiently precise to enable it to be applied in the criminal law context. The Commission is aware that some people may find the use of the term "autism spectrum disorder" offensive. For example, a recent paper on Disability Language and Terminology prepared by the National Disability Authority provides that medical language should be avoided and that the "term "autism spectrum disorder" is offensive to many in the autism community".[582] However, the paper acknowledges that the use of medical

[580] Health Service Executive, *HSE Safeguarding Vulnerable Persons at Risk of Abuse – Report of the Consultation Focus Groups* (HSE 2018) <https://www.hse.ie/eng/about/who/socialcare/safeguardingvulnerableadults/phase%202%20report%20on%20focus%20group%20submissions.pdf> accessed 9 April 2024 at page 7.

[581] The Commission understands that some stakeholders consider this wording to be out of date and archaic. The Oireachtas may wish to consider whether more modern language should be used across the definitions of "vulnerable persons" or "relevant persons" in this context in the Irish Statute Book. The Commission determined that it is preferrable to use the wording that is currently used in legislation.

[582] National Disability Authority, *Advice Paper on Disability Language and Terminology* (NDA 2022) at page 8< https://nda.ie/publications/nda-advice-paper-on-disability-language-and-terminology> accessed 6 April 2024.

language may be appropriate in reference to specific legislation.[583] The term is commonly used in court judgments,[584] and the Commission considers that the need for specificity in the criminal law requires a concrete definition that is widely understood. Much like other categories of persons included in the "relevant person" definition proposed by the Commission, many people with autism spectrum disorder may never be at risk of harm or in need of protection. However, the Commission prefers to err on the side of inclusiveness, as it may be the case that some individuals with autism spectrum disorder experience challenges protecting themselves from harm and can therefore be considered at-risk adults who warrant the protection of the criminal law.

R. 19.1 **The Commission recommends that** the criminal offences it proposes in its Criminal Law (Adult Safeguarding) Bill 2024 should apply where a person commits an offence against a "relevant person" and that the term "relevant person" should be defined as follows:

> "relevant person" means a person, other than a child, whose ability to guard himself or herself against violence, exploitation or abuse, whether physical, sexual or emotional, or neglect, by another person is significantly impaired through one, or more, of the following—
>
> (a) a physical disability, a physical frailty, an illness or an injury;
>
> (b) a disorder of the mind, whether as a result of mental illness or dementia;
>
> (c) an intellectual disability;
>
> (d) autism spectrum disorder.

(ii) Who can commit the offences?

[19.39] Each of the proposed offences outlined in the Commission's Criminal Law (Adult Safeguarding) Bill 2024 sets out criteria regarding who can commit the offences against the relevant person. This will be discussed further below in respect of each offence. The Commission takes the view that, subject to the specific criteria in each offence, natural persons, bodies corporate and unincorporated bodies can commit the proposed offences. The use of "any person" in the Criminal Law (Adult Safeguarding) Bill 2024 is intended to apply to carers, health and social care professionals, family members, friends, and others, as well as care providers and other bodies corporate or unincorporated bodies who may be caring for a relevant person or organising their care.

[583] National Disability Authority, *Advice Paper on Disability Language and Terminology* (NDA 2022) at page 8< https://nda.ie/publications/nda-advice-paper-on-disability-language-and-terminology> accessed 6 April 2024.

[584] See for example, *M.D v Minister for Social Protection* [2024] IECA 28 at page 2 and *M.B v Health Service Executive* [2023] IECA 286 at page 2.

[19.40] The Commission includes in its Criminal Law (Adult Safeguarding) Bill 2024 provision for where an offence is committed by a body corporate, by a person purporting to act on behalf of a body corporate or by an individual or an unincorporated body, to ensure that persons in authority of the body and managers, secretaries and other officers at the time of the offence, can be found guilty in addition to the body corporate or unincorporated body, in certain circumstances. It must be proven that the offence was committed with their consent or approval or that it was attributable to neglect on their part.

[19.41] For example, this means that where a care provider (who is a body corporate) commits an offence, the director of the company and other senior figures, including managers may also be found guilty of the offence where their culpability can be proven. This is important to bear in mind when considering the Commission's proposed offences below.

3. Abuse, neglect or ill-treatment

[19.42] In seeking to identify the appropriate approach to criminalising intentional or reckless abuse, neglect or ill-treatment of relevant persons, it is useful to examine comparable offences in Ireland as well as comparable offences in other jurisdictions.

(a) Section 246 of the Children Act 2001

[19.43] An offence enacted in 2001 to criminalise child cruelty and neglect closely mirrors 1908 legislation,[585] demonstrating that the vulnerability of children to neglect and physical abuse has long been recognised. Similar risk factors can apply to relevant persons. They may depend on caretakers who abuse them, or they may be unable to disclose abuse to which they are being subjected. The Children Act 2001 uses the term "cruelty" to describe a wide variety of mistreatment of persons under 18:

> It shall be an offence for any person who has the custody, charge or care of a child wilfully to assault, ill-treat, neglect, abandon or expose the child, or cause or procure or allow the child to be assaulted, ill-treated, neglected, abandoned or exposed, in a manner likely to cause

[585] The Children Act 1908 provided: "[i]f any person over the age of sixteen years, who has the custody, charge, or care of any child or young person willfully assaults, ill-treats, neglects, abandons, or exposes such child or young person, or causes or procures such child or young person to be assaulted, ill-treated, neglected, abandoned, or exposed, in a manner likely to cause such child or young person unnecessary suffering or injury to his health (including injury to or loss of sight, or hearing, or limb, or organ of the body and any mental derangement), that person shall be guilty of misdemeanor".

> unnecessary suffering or injury to the child's health or seriously to affect his or her wellbeing.[586]

[19.44] It is noteworthy that the offence criminalises neglect, which in ordinary language might be considered to be an omission, and therefore an offence of inadvertence. The offence is not one of inadvertence, however, in that the neglect must be "wilful".

[19.45] In a civil case taken after physical and psychological abuse at Áras Attracta came to light, Senior Counsel for one victim referred to the plaintiff as a "voiceless" woman being treated in a "physically violent and undignified manner", which clearly caused her distress.[587] Voicelessness is an essential factor to be borne in mind in considering reform of the criminal law in respect of relevant persons. It may be that victims are not able to articulate the details of a single, or indeed a series, of abusive incidents. In that regard, the offence in section 246 of the Children Act 2001 is instructive. The inclusion of the reference to "ill-treatment" means that the offence is broad enough to capture a wide range of abusive behaviours that could come within that definition. Not only is actual harm criminalised, so too is exposing a child to risk. Whereas the Non-Fatal Offences against the Person Act 1997 criminalises assault (section 2), assault causing harm (section 3) and assault causing serious harm (section 4), evidence is generally required from the victim as to the lack of consent and as to the harm caused. The Director of Public Prosecutions can face difficulties in proving that an assault caused "harm" or "serious harm" where the victim is unable to testify, make a statement or participate in interview, due to memory loss or communication difficulties. In the view of the Commission, an offence mirroring section 246 of the Children Act 2001 is required to criminalise abuse, neglect or ill-treatment of relevant persons— where there is no requirement to prove harm.

[19.46] It is important to emphasise that minor abuse, neglect or ill-treatment of children is not currently criminalised. Rather, abuse, neglect or ill-treatment must be such as is likely to cause unnecessary suffering or injury to health, or to seriously affect a child's well-being. A similar threshold is appropriate in any extension to adult victims. In Áras Attracta, the only prosecutable offences appear to have been an offence contrary to section 2 of the Non-Fatal Offences against the Person Act 1997, which criminalises assault without the requirement to prove that harm was caused by the assault. The maximum available penalty for that offence is 6 months' imprisonment reflecting the fact that it is

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[586] Section 246(1) of the Children Act 2001.

[587] Carolan, "Treatment of woman assaulted in Áras Attracta home 'inhuman'" *The Irish Times* (16 November 2017) <https://www.irishtimes.com/news/crime-and-law/courts/high-court/treatment-of-woman-assaulted-in-aras-attracta-home-inhuman-1.3294294> accessed 9 April 2024.

considered by the legislature as a minor offence fit to be tried summarily. By comparison, the potential penalty for the offence in section 246 of the Children Act 2001 is 7 years' imprisonment on indictment.[588] The child cruelty offence is prosecutable summarily or on indictment which affords prosecutors flexibility in determining the seriousness of the crime. If an offence similar to that in section 246 of the Children Act 2001 existed in respect of adults, it would, in the view of the Commission, have been a more appropriate offence for prosecution to reflect the seriousness of the Áras Attracta incidents.

[19.47] Equally the use of "custody, charge or care of" in the Children Act 2001 denotes a connection that is not necessarily predicated on a particular familial relationship, but rather is broad enough to capture any person in whose care the child is at a relevant time. In other jurisdictions, the concept of "household" has been used for liability to attach in cases of abuse of adults, with the term "household" defined loosely.[589] In England, Wales and Northern Ireland, for example, a person is regarded as a:

> member of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it.[590]

(b) Other jurisdictions

(i) England and Wales

[19.48] In England and Wales, there are some specific criminal offences that criminalise the ill-treatment or wilful neglect of adults. These offences are spread across three different pieces of legislation: the Mental Health Act 1983, the Mental Capacity Act 2005 and the Criminal Justice and Courts Act 2015. These offences have been frequently prosecuted, and in formulating its proposed offence, the Commission carefully considered many high profile cases in which the offence of ill-treatment or wilful neglect was prosecuted.

[19.49] Ill-treatment or wilful neglect of in-patients under the Mental Health Act 1983 is an offence in England and Wales. Section 127 of the Act provides:

> (1) It shall be an offence for any person who is an officer on the staff of or otherwise employed in, or who is one of the managers of, a hospital, independent hospital or care home—

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[588] Section 246(2)(b) of the Children Act 2001.

[589] See, for example, in England and Wales, section 5(4) of the Domestic Violence, Crime and Victims Act 2004 (England, Wales and Northern Ireland).

[590] Section 5(4) of the Domestic Violence, Crime and Victims Act 2004 (England, Wales and Northern Ireland).

(a) to ill-treat or wilfully to neglect a patient for the time being receiving treatment for mental disorder as an in-patient in that hospital or home; or

(b) to ill-treat or wilfully to neglect, on the premises of which the hospital or home forms part, a patient for the time being receiving such treatment there as an out-patient.

(2) It shall be an offence for any individual to ill-treat or wilfully to neglect a mentally disordered patient who is for the time being subject to his guardianship under this Act or otherwise in his custody or care (whether by virtue of any legal or moral obligation or otherwise).[591]

[19.50] This offence is restricted in that it only applies to staff or people employed in or managing a hospital or care home and therefore its application is confined to particular care settings.[592] It has been prosecuted in a number of cases, including in the infamous Winterbourne View case, in which two nursing and nine support care workers admitted to charges of ill-treating patients with learning disabilities contrary to section 127 of the Mental Health Act 1983.[593] A BBC Panorama undercover reporter witnessed the staff hitting, slapping and taunting patients.[594] There is no equivalent offence in the Irish Mental Health Act 2001.

[19.51] A specific offence of ill-treatment or neglect of a person who lacks decision-making capacity is included in the Mental Capacity Act 2005.[595] It provides an offence that applies:

if a person ("D")—

(a) has the care of a person ("P") who lacks, or whom D reasonably believes to lack, capacity,

[591] Section 127 of the Mental Health Act 1983 (England and Wales).

[592] Bogg, Collins, Freedland QC, Herring, *Criminality at Work* (Oxford University Press 2020) at page 275.

[593] McGregor, "Winterbourne View care staff jailed for abuse" *Community Care* (26 October 2012) <https://www.communitycare.co.uk/2012/10/26/winterbourne-view-care-staff-jailed-for-abuse/> accessed 9 April 2024; BBC, "Winterbourne View: Care workers jailed for abuse" *BBC* (26 October 2023) <https://www.bbc.com/news/uk-england-bristol-20092894> accessed 9 April 2024.

[594] Lakhani, "Six workers jailed over Winterbourne View abuse" Independent (26 October 2012) <https://www.independent.co.uk/news/uk/crime/six-workers-jailed-over-winterbourne-view-abuse-8227880.html> accessed 9 April 2024.

[595] Section 44 of the Mental Capacity Act 2005 (England and Wales).

(b) is the donee of a lasting power of attorney, or an enduring power of attorney … created by P, or

(c) is a deputy appointed by the court for P.[596]

[19.52] Post-legislative scrutiny is of assistance in assessing the formula adopted under the Mental Capacity Act 2005. Various witnesses suggested that the underuse of the section was in part due to the lack of clarity on what the person is required to lack capacity to decide.[597] There has also been judicial criticism of the lack of specificity and it has been said to be "so vague that it fails the test of sufficient certainty" required of a criminal offence.[598]

[19.53] In contrast to the approach under the Mental Health Act 1983, the perpetrator of the offence under the Mental Capacity Act 2005 in England and Wales does not need to be employed to be guilty of the offence of ill-treatment or neglect. It can apply to a paid or unpaid carer. Likewise, the offence can occur in any care setting, including private dwellings, family homes and nursing homes.[599]

[19.54] The section 44 offence under the Mental Capacity Act 2005 was prosecuted in the case of *R v Patel*[600] which concerned a registered nurse working in a nursing home who called an ambulance when a resident had a heart attack.[601] She was instructed to perform CPR repeatedly by the emergency services advisor, but she refused to do so stating that CPR was not permitted in the nursing home and she did not have the equipment required.[602] There was no rule banning CPR and no equipment is necessary to perform the procedure. In a postmortem, it was determined that the resident suffered a cardiac arrest and there was a low survival rate for this particular type, meaning that he was unlikely to survive even if CPR was performed.[603] Patel was found guilty of wilful neglect for failing to provide medical treatment which she knew was required. On appeal, she argued that the trial judge wrongly directed the jury that "neglect could be established even if it was unlikely that the appellant's inaction caused any

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[596] Section 44 of the Mental Capacity Act 2005 (England and Wales).

[597] House of Lords, Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: post-legislative scrutiny* (House of Lords 2014) at page 104.

[598] *R v Hopkins*, *R v Priest* [2011] EWCA 1513.

[599] Blogg, Collins, Freedland QC, Herring, *Criminality at Work* (Oxford University Press 2020) at page 275. Under the Mental Health Act 1983, the offence can only occur in a hospital or nursing home.

[600] [2013] EWCA Crim 965.

[601] Patel did not call the ambulance immediately, instead she opted to phone the resident's son in America first.

[602] *R v Patel* [2013] EWCA Crim 965 at para 14.

[603] *R v Patel* [2013] EWCA Crim 965 at paras 17 and 18.

adverse consequence".[604] This was rejected by the Court of Appeal as there is no requirement in section 44 to establish harm or likelihood of harm.[605] She also argued that the judge failed to direct the jury appropriately about the meaning of "wilfully", in particular, he directed the jury that the stress or panic that may have been experienced by the appellant was not a defence.[606] This was also rejected by the Court of Appeal who stated that "neglect is wilful if a nurse or medical practitioner knows that it is necessary to administer a piece of treatment and deliberately decides not to carry out that treatment, which is within their power but which they cannot face performing".[607]

[19.55] The meaning of wilful neglect was also discussed in the case of *R v Turbill and Broadway,*[608] a case involving staff of a care home who were charged with the wilful neglect of a resident under section 44 of the Mental Capacity Act 2005.[609] The Court of Appeal stated that "[t]he neglect must be 'wilful' and that means something more is required than a duty and what a reasonable person would regard as a reckless breach of that duty."[610] The trial judge equated carelessness or negligence with wilful neglect in his directions to the jury, and the Court of Appeal determined that they are not the same.[611] It quashed the convictions as the trial judge's directions on the meaning of wilful neglect were not sufficiently clear, and he failed to explain to the jury that there was a subjective element to

[604] Patel contended that the resident's death was due to end stage dementia and the resident being in the end stages of life rather than her failure to act.

[605] *R v Patel* [2013] EWCA Crim 965 at para 34. The Court of Appeal stated that the "actus reus of this offence is complete if a nurse or medical practitioner neglects to do that which should be done in the treatment of the patient". It agreed with the prosecution that Patel could not know and did not know the consequences of not performing CPR on the resident, and it was "purely fortuitous" that it turned out after the fact that CPR was unlikely to save the resident's life.

[606] *R v Patel* [2013] EWCA Crim 965 at para 30.

[607] *R v Patel* [2013] EWCA Crim 965 at para 42. They found that where Patel was acting at a time of stress would be a matter for the trial judge to take into account in sentencing, which he did.

[608] *R v Turbill and Broadway* [2013] EWCA Crim 1422.

[609] The facts of the case were that a man who suffered from Alzheimer's disease, osteoarthritis and hypertension became agitated and a carer was asked to put him to bed two hours earlier than normal by a lead carer. Nobody checked on him after that. He was found collapsed on the floor the following morning partially dressed, semiconscious and partially hypothermic, there was no evidence his bed had been slept in. Luckily, he did not suffer any serious injury or harm. The prosecution argued that each of the accused carers had a duty to the man and wilfully neglected him, and they were convicted.

[610] *R v Turbill and Broadway* [2013] EWCA Crim 1422 at para 19.

[611] *R v Turbill and Broadway* [2013] EWCA Crim 1422 at para 19.

the test.[612] Ormerod and Laird suggest that "'wilful' is now generally accepted to mean intention or subjective recklessness".[613]

[19.56] Section 44 of the Mental Capacity Act 2005 was also prosecuted in the case of *R v Lindsay Kenyon*[614] which concerned an experienced care worker working in a residential home for older people who, after hearing news that she would not be promoted to Senior Care Assistant, omitted to perform many of her duties as a carer over the course of her shift.[615] When there was a changeover of staff for the night shift, they found residents in a "distressed state" in the lounge covered in faeces and urine, which suggested that the carers on the earlier shift had not changed the residents, or settled them in bed.[616] Kenyon appealed her sentence of eight months imprisonment, and contended that this was excessive as the trial judge failed to give weight to "the lack of aggravating features and did not reflect the substantial mitigation".[617] She requested that her exemplary record as a carer previous to this once off incident should have been taken into account, as should the lack of long-term consequences for the residents. The Court of Appeal rejected this argument and held that the sentence could not be described as "manifestly excessive" due to the number of residents affected and the "display of petulant behaviour" that exposed "vulnerable persons" in need of protection to appalling conditions justified the high sentence.[618]

[19.57] Other Court of Appeal decisions that considered prosecutions under section 44 of the Mental Capacity Act 2005 include *R v Heaney,*[619] *R v Strong*,[620] and *R v*

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[612] *R v Turbill and Broadway* [2013] EWCA Crim 1422 at paras 19 to 23.

[613] Ormerod and Laird, *Smith, Hogan and Ormerod's Criminal Law,* 15th ed (Oxford University Press 2018) at page 712.

[614] *R v Lindsay Kenyon* [2013] EWCA Crim 2123.

[615] *R v Lindsay Kenyon* [2013] EWCA Crim 2123 at para 5. She threatened to resign on the spot, but the manager persuaded her to continue with her shift.

[616] Many residents were asking for food and drink which lead the night shift carers to believe that they either had not been fed or were fed much earlier in the day. The four other carers on the shift were also prosecuted, but only Kenyon was found guilty. See *R v Lindsay Kenyon* [2013] EWCA Crim 2123 at paras 6 and 7.

[617] *R v Lindsay Kenyon* [2013] EWCA Crim 2123 at para 3.

[618] *R v Lindsay Kenyon* [2013] EWCA Crim 2123 at para 10.

[619] R v Heaney [2011] EWCA Crim 2682. In this case the perpetrator was a senior carer working at a care home who put excessive quantities of sugar and some vinegar in the tea of one of the residents and assaulted another by slapping the resident across the head. She appealed the length of her sentence in the Court of Appeal. It was reduced from 9 months to 6 months for two counts.

[620] *R v Strong* [2014] EWCA Crim 2744. In this case, the perpetrator was a junior employee who took part in humiliating, bullying and ill-treating older and "vulnerable" people in her care alongside two other experienced carers, who were the principal offenders. The two other carers pleaded guilty to offences under section 44. One of these carers was also convicted of the offence of engaging in sexual activity with a female with a mental disorder by a care worker contrary to section 38(1) of the Sexual Offences Act 2003 (England and Wales).

Kurtz.[621] Media coverage and updates from the Crown Prosecution Service in England and Wales suggests that this offence is regularly prosecuted,[622] often if there is a guilty plea the person may receive a fine, unpaid work or a suspended sentence instead of a custodial sentence.[623]

Strong's conduct involved taking a video of (1) one of the other accused looking at the vagina of a 96 year old woman, and (2) one of the accused poking another victim repeatedly in the face and sending it to one of the other accused. She also took a photograph of a 78 year old woman with dementia lying on the floor and sent this to one of the accused, and a violent and abusive text exchange followed. Strong appealed the length of her sentence and the Court of Appeal reduced her sentence from 12 month's imprisonment to 6 months due to her limited role in the cruel and exploitative behaviour, her genuine remorse and early guilty plea.

[621] *R v Kurtz* [2018] EWCA Crim 2743. In this case, a daughter was convicted of the offence of wilfully neglecting her mother, in respect of whom she was the donee of an enduring power of attorney, contrary to section 44 of the Mental Capacity Act 2005. Her mother had a history of mental illness including bipolar disorder, depression and OCD and frequently failed to cooperate with medical professionals. The main accusation was that Kurtz wilfully neglected her mother over a long period of time, and in particular, she failed to arrange for her mother to be provided with proper medical treatment. Her mother "lived in a squalor and her health deteriorated until she died". She was found in a sitting position sitting in her own urine and faeces and she had sores and burns on her body as a result. She was also malnourished and covered in dirt with her hair matted and nails unkempt. Kurtz called paramedics to the house on the day her mother died and told them that her mother did not want help, had been refusing food, and was unable to stand for a long time. The Court noted that "[w]hen the paramedics lifted her body from her seat, her clothes fell apart" which suggested she had not changed her clothes for many months. Kurtz was sentenced to 30 months imprisonment. Her conviction was overturned by the Court of Appeal, as the trial judge did not require the prosecution to prove that Kurtz's mother lacked capacity, which the Court of Appeal determined was a requirement to prove the offence under section 44. See *R v Kurtz* [2018] EWCA Crim 2743 at paras 7 to 16 and 74.

[622] See for example, BBC, "Cawston Park: Carer who struck vulnerable man is jailed for nine months" *BBC* (5 April 2023) https://www.bbc.com/news/uk-england-norfolk-65191238 accessed 9 April 2024; Crown Prosecution Service, Care worker jailed for abusing woman with dementia (February 2023) <https://www.cps.gov.uk/north-west/news/care-worker-jailed-abusing-woman-dementia> accessed 9 April 2024; BBC, "Swansea: Sex threats care home manager jailed for neglect" *BBC* (7 January 2022)<https://www.bbc.com/news/uk-wales-59915620> 9 April 2024; BBC, "Swansea: Two carers found guilty of offences against vulnerable" *BBC* (21 October 2021) < https://www.bbc.com/news/uk-wales-58999572> accessed 9 April 2024; BBC, "Kendal senior care home worker jailed for mistreating residents" *BBC* (3 November 2020) https://www.bbc.com/news/uk-england-cumbria-54794452 accessed 9 April 2024; BBC, "'Evil' Yasmin May abused vulnerable at Illogan Highway care home" *BBC* (16 October 2015) <https://www.bbc.com/news/uk-england-cornwall-34552877> accessed 9 April 2024; BBC, "Hillcroft nursing home staff sentenced for resident abuse" *BBC* (10 January 2014) <https://www.bbc.com/news/uk-england-lancashire-25676842> accessed 9 April 2024; The Guardian, "Care workers found guilty of abusing dementia patients 'for laughs'" The Guardian (28 November 2013)<https://www.theguardian.com/society/2013/nov/28/care-workers-guilty-mistreating-dementia-sufferers> accessed 9 April 2024.

[623] Carter, "Perpetrators of adult abuse 'getting derisory sentences'" *Community Care* (14 September 2016) https://www.communitycare.co.uk/2016/09/14/perpetrators-adult-abuse-getting-derisory-sentences/ accessed 9 April 2024.

[19.58] As outlined above, the Irish assisted decision-making legislation has a similar provision that applies in respect of decision-making assistant, co-decision-maker, decision-making representative, attorney or designated healthcare representative as opposed to carers.[624]

[19.59] In response to serious failures in care in an NHS Trust, an independent review was established to review patient safety in England in 2013.[625] A lacuna was identified in that while there were existing offences criminalising those who ill-treat or wilfully neglect children, and criminalising the ill-treatment of adults who lack capacity or who are subject to the Mental Health Act 1983, there were no offences to criminalise those who ill-treat or wilfully neglect adults who have full capacity.[626] The review recommended that the Government should create a new general offence of wilful or reckless neglect or mistreatment that applies both to organisations and individuals.[627] To that end, sections 20 and 21 of the Criminal Justice and Courts Act 2015 introduced specific offences of ill-treatment or neglect of an adult by care workers and care providers.

[19.60] Section 20 of the Criminal Justice and Courts Act 2015 created an offence for care workers who ill-treat or wilfully neglect those in their care. A care worker is someone "who, as paid work" provides either health care for an adult or child or social care for an adult (with certain exceptions).[628] This category includes

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[624] Section 145 of the Assisted Decision-Making (Capacity) Act 2015 makes it an offence for a "decision-making assistant, co-decision-maker, decision-making representative, attorney or designated healthcare representative for a relevant person..." to ill-treat or wilfully neglect a "relevant person".

[625] The National Advisory Group on the Safety of Patients in England, *A Promise to Learn - A Commitment to Act: Improving the Safety of Patients in England* (2013) at page 33.

[626] The National Advisory Group on the Safety of Patients in England, *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England* (2013) at page 33; Laird," Filling a Lacuna: The Care Worker and Care Provider Offences in the Criminal Justice and Courts Act 2015" (2016) 37(1) Statute Law Review 1.

[627] The National Advisory Group on the Safety of Patients in England, *A Promise to Learn - A Commitment to Act: Improving the Safety of Patients in England* (2013) at page 34. The review group repeatedly emphasised that new legislation should avoid criminalising unintended errors and that a person "should not be convicted of this new offence unless it can be shown the failure was the fault of the individual alone and the individual was acting in a reckless or wilful manner".

[628] Section 20(3) of the Criminal Justice and Courts Act 2015 (England and Wales). Health care that is excluded from the offence is set out in Schedule 4 of the Criminal Justice and Courts Act 2015 (England and Wales). The explanatory notes state that the purpose of defining the individual offence to "paid work" was to "ensure that informal arrangements, such as unpaid family carers and friends, are not captured by the offence". The exclusion also covers an unpaid volunteer who gets their travel costs reimbursed, or an informal family carer who occasionally receives a contribution towards their expenses. See Explanatory Notes to the Criminal Justice and Courts Act 2015 (England and Wales) at para 217.

supervisors, managers, directors or similar officers or individuals providing such care.[629] Section 20(1) provides:

> [i]t is an offence for an individual who has the care of another individual by virtue of being a care worker to ill-treat or wilfully to neglect that individual.[630]

[19.61] This offence was recently prosecuted in respect of nine defendants who were care workers in the case of Whorlton Hall, a specialist hospital for people with severe mental health issues and learning disabilities.[631] Five were cleared of all charges, but four were found guilty of ill-treating patients.[632] The four convicted carers received suspended sentences.[633] The offending was brought to light after it was captured on camera by an undercover reporter for BBC's Panorama programme. The conduct included:

- One of the accused deliberately snapping balloons in the presence of a female patient who was scared of them and mocking another patient's communication difficulties by speaking to her in French.
- One of the accused threatening a female patient that he would send male carers to her room, when she was afraid of men and preferred female carers.
- One of the accused threatening a male patient with violence and encouraging him to fight.

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[629] Section 20(3) of the Criminal Justice and Courts Act 2015 (England and Wales). The explanatory memorandum states that the intention behind this section is to ensure that "the individual offence can apply to any individual perpetrator, not just those on the "front line" of care provision". It notes that the offence will only apply where the individual, supervisor, director "has themselves directly committed ill-treatment or wilful neglect". They do not commit the individual offence as a result of the acts or omissions of others they supervise. See Explanatory Notes to the Criminal Justice and Courts Act 2015 (England and Wales) at para 215.

[630] Section 20(1) of the Criminal Justice and Courts Act 2015 (England and Wales).

[631] Samuel, "Four care staff convicted of mistreating people with learning disabilities at hospital" *Community Care* (3 May 2023) https://www.communitycare.co.uk/2023/05/03/four-care-staff-convicted-of-mistreating-people-with-learning-disabilities-at-hospital/ accessed 9 April 2024.

[632] Hetherington, "Whorlton Hall: Sentencing of former care workers delayed" *The Northern Echo* (7 July 2023) https://www.thenorthernecho.co.uk/news/23640273.whorlton-hall-sentencing-former-care-workers-delayed/ accessed 9 April 2024; BBC, "Whorlton Hall: Four guilty of ill-treating hospital patients" *BBC* (27 April 2023) https://www.bbc.com/news/uk-england-tees-65416650 accessed 9 April 2024; BBC, "Whorlton Hall verdicts: Can further scandals be prevented?" *BBC* (28 April 2023) https://www.bbc.com/news/uk-65388035 accessed 9 April 2024.

[633] Jagger and Harris, "Whorlton Hall: Four carers sentenced for abusing hospital patients" *BBC* (19 January 2024) < https://www.bbc.com/news/uk-england-tees-68021858> accessed 9 April 2024.

- One of the accused instructing a male patient to lie on the floor to demonstrate a restraint and simulating performing an elbow drop wrestling move from a chair and encouraging another male patient to fight.[634]

[19.62] It was also prosecuted in the case of *R v Mutyambizi*,[635] where a care worker in a care home was captured on CCTV installed by a resident's family, ill-treating the resident. The care worker attempted to feed the resident yoghurt while the resident was lying down and pushed the resident's mouth several times trying to get the yoghurt into her mouth.[636] Later, the resident needed her clothing and bedding to be changed after having a bowel movement. The care worker was seen forcibly grabbing the resident by the wrist and pulling her off the bed.[637] Mutyambizi was convicted of ill-treatment or wilful neglect by a care worker and sentenced to 12 months' imprisonment. She subsequently appealed

[634] BBC, "Whorlton Hall: Four guilty of ill-treating hospital patients" *BBC* (27 April 2023) https://www.bbc.com/news/uk-england-tees-65416650 accessed 9 April 2024. For other examples, see also: Sky News, "Wife and lover from Bognor Regis jailed for enslaving disabled husband in filthy conditions" *Sky* (14 July 2023) https://news.sky.com/story/wife-and-lover-from-bognor-regis-jailed-for-enslaving-disabled-husband-in-filthy-conditions-12921228 accessed 9 April 2024; BBC News, "Care home worker jailed for abusing patients with dementia" *BBC News* (3 July 2023) https://www.bbc.com/news/uk-england-derbyshire-66091463 accessed 9 April 2024; Manaro, "Care home nurse given community order after distressed woman dragged from toilet and left in urine-stained bed" *Yorkshire Evening Post* (26 January 2021) https://www.yorkshireeveningpost.co.uk/news/crime/care-home-nurse-given-community-order-after-distressed-woman-dragged-from-toilet-and-left-in-urine-stained-bed-3113266 accessed 9 April 2024; West Mercia Police, Investigation into ill-treatment by a carer worker leads to prison sentence https://www.westmercia.police.uk/cy-GB/news/west-mercia/news/2020/march/investigation-into-ill-treatment-by-a-care-worker-leads-to-prison-sentence/ accessed 9 April 2024; BBC, "Exeter carer who left patients soaked in urine jailed" *BBC* (20 December 2019) https://www.bbc.com/news/uk-england-devon-50865012 accessed 9 April 2024; BBC, "Colchester care worker jailed after 'lashing out' at 'vulnerable' man" *BBC* (26 July 2019) https://www.bbc.com/news/uk-england-essex-49128807 accessed 9 April 2024 and The Tenby Observer, "Care worker hit patient with her own care plan" *The Teny Observer* (15 July 2019) https://www.tenby-today.co.uk/news/999/care-worker-hit-patient-with-her-own-care-plan-474685 accessed 9 April 2024.

[635] *R v Mutyambizi* [2019] EWCA Crim 1617. The care worker had previous convictions, including for theft or obtaining a pecuniary advantage by deception of older residents in a care home where she worked, for which she had received sentences of 4 months and 8 months imprisonment.

[636] *R v Mutyambizi* [2019] EWCA Crim 1617 at para 4.

[637] *R v Mutyambizi* [2019] EWCA Crim 1617 at para 4.

her sentence, arguing that it was manifestly excessive.[638] Her appeal was dismissed by the Court of Appeal.[639]

[19.63] Section 21 of the Criminal Justice and Courts Act 2015 provides for a specific offence that applies to care providers whose activities are managed or organised in a way which amounts to a gross breach of duty of care. Section 21(2) of the Criminal Justice and Courts Act 2015 defines a "care provider" as:

> (a) a body corporate or unincorporated association which provides or arranges for the provision of —
> (i) health care for an adult or child, other than excluded health care, or
> (ii) social care for an adult, or
> (b) an individual who provides such care and employs, or has otherwise made arrangements with, other persons to assist him or her in providing such care.[640]

[19.64] A care provider commits an offence under the 2015 Act if:

> (a) an individual who has the care of another individual by virtue of being part of the care provider's arrangements ill-treats or wilfully neglects that individual;
> (b) the care provider's activities are managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected; and
> (c) in the absence of the breach, the ill-treatment or wilful neglect would not have occurred or would have been less likely to occur.[641]

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[638] *R v Mutyambizi* [2019] EWCA Crim 1617 at para 13. She argued that other similar cases suggest that the typical sentence for these offences is between 6 to 9 months imprisonment or a suspended sentence.

[639] The Court of Appeal, in rejecting these submissions, concluded that the trial judge was right to consider that her previous convictions were an aggravating factor. It noted that where lighter sentences were imposed in previous cases, those care workers were of previous good character, whereas Mutyambizi was not, as she was previously convicted of committing offences against older or "vulnerable" people where she worked. See *R v Mutyambizi* [2019] EWCA Crim 1617 at para 19.

[640] Section 21(2) of the Criminal Justice and Courts Act 2015 (England and Wales).

[641] Section 21(1) of the Criminal Justice and Courts Act 2015 (England and Wales). Some care providers are excluded from this offence under section 22 of this Act. However, these exclusions apply to local authorities and persons carrying out functions of a local authority in relation to certain functions in the areas of education, childcare and social services for children and young people. See section 22 of the Criminal Justice and Courts Act 2015 (England and Wales).

[19.65] The Explanatory Notes to the Criminal Justice and Courts Act 2015 state that the "overall approach" of the offence is modelled on the offence of corporate manslaughter and homicide set out in the Corporate Manslaughter and Corporate Homicide Act 2007 (the "2007 Act").[642] The intention was to "resolve the difficulties associated with proving to the required level for a criminal offence the element of wilfulness on the part of the organisation".[643] As a result of the 2007 Act, it is not necessary to identify a single individual who could be considered the "directing mind" of the organisation or to prove that such a single individual behaved wilfully, so that the whole organisation can be considered guilty of the offence.[644] Instead, the 2007 Act focuses on the way the organisation managed or organised its work or activities, and on the duty of care it owed towards the victim of the offence.[645] The Explanatory Notes provide that section 21 of the Criminal Justice and Courts Act 2015 takes a similar approach by examining whether the organisation "has conducted its affairs in a way that amounts to a gross breach of a duty of care owed towards someone who has been a victim of ill-treatment or wilful neglect by the care provider's employee or another individual engaged by it".[646]

(ii) Scotland

[19.66] Section 315 of the Mental Health (Care and Treatment) (Scotland) Act 2003 makes it an offence for a carer or member of staff or someone working in or managing a hospital to ill-treat or wilfully neglect a patient with a mental disorder to whom they are providing care or treatment.[647]

[19.67] Section 83 of the Adults with Incapacity (Scotland) Act 2000 makes it an offence for any person exercising powers under the Act relating to the personal welfare of an adult to ill-treat or wilfully neglect that adult. It replicates the criminal

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[642] Explanatory Notes to the Criminal Justice and Courts Act 2015 (England and Wales) at para 232.

[643] Explanatory Notes to the Criminal Justice and Courts Act 2015 (England and Wales) at para 232

[644] Explanatory Notes to the Criminal Justice and Courts Act 2015 (England and Wales) at para 232.

[645] Explanatory Notes to the Criminal Justice and Courts Act 2015 (England and Wales) at para 232.

[646] Explanatory Notes to the Criminal Justice and Courts Act 2015 (England and Wales) at para 232. Section 24 of the Criminal Justice and Courts Act 2015 sets out how the care provider offence applies to unincorporated associations. It provides that for the purposes of section 21, which contains the offence set out above, and section 23 (concerning penalties for committing the offence), "an unincorporated association is to be treated as owing whatever duties of care it would owe if it were a body corporate".

[647] Section 31(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003. It expressly excludes the Scottish Ministers.

offence that existed under section 105 of the Mental Health (Scotland) Act 1984.[648] An adult is defined in the Act as a person over the age of 16.[649]

[19.68] Like England and Wales, Scotland has care worker and care provider offences.[650] Section 26 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 provides that an individual commits an offence if the individual:

> (a) has the care of another individual by virtue of being a care worker, and
> (b) ill-treats or wilfully neglects that individual.

[19.69] A care worker is defined in section 28(1) of the Act as an employee or volunteer who provides adult health or adult social care, an individual who supervises or manages those employees or volunteers, or a director or similar officer of an organisation whose employees or volunteers provide such services.[651]

[19.70] Scotland also has a care provider offence. A "care provider" is defined in the relevant legislation as a body corporate, a partnership or unincorporated association that "provides or arranges for the provision of" adult health care or adult social care.[652] It also includes an individual who "provides that care and employs, or has otherwise made arrangements with, other persons to assist with the provision of that care".[653] Section 27 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 provides for an offence where :

> (a) an individual who has the care of another individual by virtue of being part of the care provider's arrangements ill-treats or wilfully neglects that individual,[654]

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[648] Explanatory Notes to the Adults with Incapacity (Scotland) Act 2000 para 394. Section 105 of the Mental Health (Scotland) Act 1984 made it an offence for a person working in or managing a hospital or nursing home to ill-treat or wilfully neglect a patient receiving treatment for a mental disorder as an in-patient in a hospital or nursing home, or to ill-treat or wilfully neglect a patient receiving treatment as an out-patient on the premises of the hospital or nursing home. It also provided that it was an offence for any individual to ill-treat or wilfully neglect a patient who is subject to their guardianship.

[649] Section 1(6) of the Adults with Incapacity (Scotland) Act 2000.

[650] Section 26 and 27 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.

[651] Section 28(2) provides that an employee means an individual in paid employment, whether under a contract of service or apprenticeship or contract for services. A volunteer is defined as a volunteer of a body, other than a public or local authority where the activities are not carried out for profit.

[652] Section 28(3)(a) of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.

[653] Section 28(3)9b) of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.

[654] Section 27(2) of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 provides that an individual is "part of a care provider's arrangements" if the individual is not the care provider but, "provides adult health care or adult social care as part of the adult health care or adult social care provided or arranged for by the care provider". This includes an

(b) the care provider's activities are managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected, and

(c) in the absence of the breach, the ill-treatment or wilful neglect would not have occurred or would have been less likely to occur.[655]

(iii) New Zealand

[19.71] In New Zealand, as in England and Wales, children and "vulnerable adults" are categorised together in an offence of ill-treatment or neglect, contrary to section 195 of the Crimes Act 1961. The section provides:

> (1) Every one is liable to imprisonment for a term not exceeding 10 years who, being a person described in subsection (2), intentionally engages in conduct that, or omits to discharge or perform any legal duty the omission of which, is likely to cause suffering, injury, adverse effects to health, or any mental disorder or disability to a child or vulnerable adult (the victim) if the conduct engaged in, or the omission to perform the legal duty, is a major departure from the standard of care to be expected of a reasonable person.
>
> (2) The persons are—
>
> (a) a person who has actual care or charge of the victim; or
>
> (b) a person who is a staff member of any hospital, institution, or residence where the victim resides.[656]

[19.72] Section 195 was amended by the Crimes Amendment Act (No. 3) 2011 following recommendations of the New Zealand Law Commission. It recommended extending the offence to "vulnerable adults" and children under 18 and the adoption of an objective "gross negligence" test.[657] Previously, the offence only applied in respect of children under the age of 16, and not "vulnerable adults". It also previously provided that an offence is committed where a person "wilfully ill-treats or neglects the child, or wilfully causes or permits the child to be ill-treated" in a manner likely to cause unnecessary suffering. "Wilfully" previously qualified the whole offence, which meant that "the ill-treatment must have been inflicted deliberately with a conscious appreciation that it was likely to cause

individual who is not the care provider, but supervises or manages individuals providing care or is a director or similar officer of an organisation which provides care.

[655] Section 27(1) of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.

[656] Section 195 of the Crimes Act 1961 (New Zealand).

[657] Law Commission (New Zealand), Review of Part 8 of the Crimes Act 1961: Crimes Against the Person (LC NZ 2009) at page 53.

unnecessary suffering".[658] This was criticised by the Law Commission as it meant that the test is entirely subjective and in practice "ignorance or thoughtlessness is a defence".[659] It suggested that the word "wilfully" be removed and replaced with a "gross negligence" test that would require the jury to be satisfied that the conduct "was a major departure from the standard of care to be expected of a reasonable person" meaning that ignorance or thoughtlessness "would no longer absolve a defendant from liability".[660]

[19.73] The author of *Adams on Criminal Law* notes that as well as broadening the scope of the offence to cover "vulnerable adults", the amendments to section 195 substitute "an objective gross negligence test of liability for the previous requirement that the ill-treatment or neglect be 'wilful', and extending liability to a limited range of persons who may have no direct charge or responsibility for the welfare of the child or vulnerable adult".[661] He also notes that establishing the exposure of the victim to the risk of harm "goes beyond simple carelessness and constitutes 'a major departure from the standard of care to be expected of a reasonable person'".[662] It needs to be shown that the behaviour is "itself markedly at variance with the normal expectations applicable to those responsible for the care and oversight of others".[663]

[19.74] The author of *Adams on Criminal Law* states that:

> [I]t would appear that the requirement that the defendant 'intentionally' engage in conduct or omit to discharge or perform any legal duty, must be read as meaning simply that the conduct or failure to act must be more than merely accidental. Any other interpretation would mean that the defendant would have to be at least aware of the likelihood of harm resulting from their behaviour, which would not only effectively reinstate the requirement of wilfulness, leaving the charge open to a defence of simple ignorance or thoughtlessness, but would also be inconsistent with the specific provision that the behaviour need

[658] France J, Adams on Criminal Law Looseleaf 3rd ed (Thompson Reuters 1991) at para CA195.07; *R v Hende* [1996] 1 NZLR 153 (CA).

[659] Law Commission (New Zealand), Review of Part 8 of the Crimes Act 1961: Crimes Against the Person (LC NZ 2009) at pages 8 and 53.

[660] Law Commission (New Zealand), Review of Part 8 of the Crimes Act 1961: Crimes Against the Person (LC NZ 2009) at page 53.

[661] France J, *Adams on Criminal Law* 3rd ed Looseleaf (Thompson Reuters 1991) at para CA195.01.

[662] France J, *Adams on Criminal Law* 3rd ed Looseleaf (Thompson Reuters 1991) at para CA195.01.

[663] France J, *Adams on Criminal Law* 3rd ed Looseleaf (Thompson Reuters 1991) at para CA195.01.

> only be grossly negligent ... Once the jury is satisfied that the defendant's behaviour was such as to create a real risk of one or more of the relevant consequences — and in most cases this is unlikely to be an issue since most prosecutions will occur as a response to harm rather than in anticipation of it — the only question will be whether that behaviour was a major departure from the standard of care to be expected of a reasonable person. No further finding of intention or advertence to risk will be required.[664]

(iv) California

[19.75] California is considered to provide the most specialised treatment of "elder abuse" of all the American States and territories.[665] An elder abuse offence applies in California to persons aged over 65 years of age and "dependent adults".[666] Section 368 of the California Penal Code provides:

> A person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health is endangered...[667]

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[664] France J, Adams on Criminal Law 3rd ed Looseleaf (Thompson Reuters 1991) at para CA195.07. The author references the case of *Bentley v R* [2018] NZCA 371 at para 19 where the Court rejected the defence that it was necessary to prove that the defendant had a "conscious appreciation of the relevant risk", and confirmed under section 195 the "mens rea element is simply whether [the] conduct was engaged in intentionally, not accidentally" as any other interpretation would mean "the amendment would not have achieved its clear purpose".

[665] Meirson, "Prosecuting Elder Abuse: Setting the Gold Standard in the Golden State" (2008) 60(2) Hastings Law Journal 431 at page 432.

[666] Section 368(h) of the California Penal Code provides that a "dependant adult" means "a person regardless of whether the person lives independently, who is between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age". It also includes adults who are admitted as inpatients to a 24-hour health facility under the Health and Safety Code.

[667] Section 368 of the California Penal Code (California).

[19.76] The provision has been criticised for its inclusion of subjective rather than objective elements in relation to suffering. Meirson notes that:

> [t]he failing of California's elder abuse law is its focus on the subjective experience of the elder victim.

[19.77] He states that these sections "exclude objective analysis of mistreatment, focusing instead on whether the infliction caused is unjustifiable physical pain or mental suffering" and this is problematic due to the "nature of the victims the law is intended to protect".[668]

[19.78] Meirson makes points that are relevant for consideration of any potential Irish offence. Pointing to the reticence of the victims captured by the offence to cooperate with prosecution,[669] he argues that a better approach would see an objective element that could be established with medical evidence to the effect that injuries would be consistent with pain and suffering.[670] In other words, in circumstances where the ability or willingness of a victim to participate in a prosecution is never guaranteed, a greater level of protection is afforded by offences that can be objectively established. The Irish offence of child cruelty is one such example.[671] No testimony is required from a child victim as to suffering for the offence to be established.

(v) Australian Capital Territory (Australia)

[19.79] In the Australian Capital Territory ("ACT"), sections 36A, 36B and 36C of the Crimes Act 1900 relate to the abuse or neglect of "vulnerable persons".[672] A "vulnerable person" under the ACT legislation is defined for the purposes of sections 36A, 36B and 36C as someone with a disability or who is at least 60 years of age and who has a disorder, illness, disease or an impairment that

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[668] Meirson, "Prosecuting Elder Abuse: Setting the Gold Standard in the Golden State" (2008) 60(2) Hastings Law Journal 431 at page 432.

[669] "Most elders do not report abuse due to shame, stoicism, recalcitrance, diminished mental faculties, or due to their reliance on their abusers. Even when abuse is detected and reported by third parties, such as doctors or agents of Adult Protective Services, many elders refuse to cooperate with prosecutors." Meirson states that "without any elder abuse victim's testimony and participation in the prosecution, it is possible for the perpetrator of the abuse to escape a criminal conviction because the prosecution might not be able to prove every element of the crime, that is, that the perpetrator inflicted unjustifiable physical pain or mental suffering upon the elder victim". See Meirson, "Prosecuting Elder Abuse: Setting the Gold Standard in the Golden State" (2008) 60(2) Hastings Law Journal 431 at pages 432 and 433.

[670] Meirson, "Prosecuting Elder Abuse: Setting the Gold Standard in the Golden State" (2008) 60(2) Hastings Law Journal 431 at page 444.

[671] Section 246(1) of the Children Act 2001.

[672] These new sections were introduced by section 5 of the Crimes (Offences Against Vulnerable People) Legislation Amendment Act 2020 (ACT).

substantially reduces their capacity to communicate, learn or move.[673] It also includes adults who are socially isolated for any other reason and unable to participate in community life.[674]

[19.80] Section 36A(1), which criminalises abuse of a "vulnerable person", is as follows:

> (1) A person commits an offence if—
>
> (a) the person is responsible for providing care to a vulnerable person; and
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> (b) the person engages in abusive conduct towards the vulnerable person; and
>
> (c) the conduct results in—
>
> (i) harm to the vulnerable person; or
>
> (ii) a financial benefit for the person or someone else associated with the person; and
>
> (d) the person is reckless about—
> (i) if the vulnerable person suffers harm — causing the harm; or
> (ii) if the person or someone else associated with the person obtains a financial benefit — obtaining the benefit.

[19.81] A person is deemed to be "providing care to a vulnerable person" if the defendant exercises control over any aspect of the care required by the vulnerable person, irrespective of whether the care is short or long term.[675] "Abusive conduct" is defined broadly as an act or omission that is directed at the "vulnerable person", that is of a violent, threatening, intimidating, or sexually inappropriate nature that negatively affects a "vulnerable person" in a number of ways specified in section 36A(5)(b) of the 1900 Act.[676] This conduct also

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[673] Section 36A(5) of the Crime Act 1900 (ACT). The disorder, illness or disease must affect "the person's thought processes, perception of reality, emotions or judgment or otherwise results in disturbed behaviour". The impairment can be intellectual, psychiatric, sensory or physical in nature.

[674] Section 36A(5) of the Crime Act 1900 (ACT).

[675] Section 36A(2) of the Crimes Act 1900 (ACT).

[676] Section 36A(5) of the Crimes Act 1900 (ACT). It includes any act or omission directed at the vulnerable person and is reasonably likely to "make the vulnerable person dependent on or subordinate to the abusive person", "isolate the vulnerable person from friends or family", "limit the vulnerable person's access to services needed by the vulnerable person", "deprive or restrict the vulnerable person's freedom of action", "frighten, humiliate, degrade or punish the vulnerable person" that is not reasonably necessary for the safe and effective care of the person or anyone else.

applies to defendants who are associated with relevant institutions or groups of institutions such as care homes or other such private entities.

[19.82] Defences to this include: (a) that a defendant's conduct was reasonable under all the circumstances, (b) that the actions of a defendant (associated with a relevant institution providing care) complied with the procedures of the relevant institution or were undertaken in accordance with the direction of a person in an authority in said institution, or (c) that the abusive conduct happened due to circumstances beyond the control of the defendant.[677]

[19.83] Section 36C of the Crimes Act 1990 criminalises neglect of "vulnerable persons". A person commits an offence where the person is responsible for providing care for a "vulnerable person" and "recklessly or negligently fails to provide the "vulnerable person" with the necessaries of life that are a necessary part of the care the person is responsible for providing (which includes adequate food, clothing, shelter, hygiene and health care)[678] and this failure to provide causes serious harm to the "vulnerable person".[679] The child cruelty offence in this jurisdiction which includes neglect does not require proof of harm or serious harm – instead it looks at whether the cruelty "was in a manner likely to cause unnecessary suffering or injury".[680] In contrast, under section 36C, there is a requirement to prove that failing to provide necessaries of life causes serious harm to the "vulnerable person". Section 36C includes provisions which provide for defences identical to section 36A.

(vi) Western Australia

[19.84] In Western Australia, section 262 of the Criminal Code Act Compilation Act 1913 places a duty to provide necessaries of life on "every person having charge of another who is unable by reason of age, sickness, mental impairment, detention or any other cause, to withdraw himself from such charge and who is unable to provide himself with the necessaries of life". The obligation can arise by contract, by law or by reason of any act by the person to provide that person with the necessaries of life.[681] It is an offence under section 304 of the same Act to fail to perform this duty. This section provides that if a person omits to do any act that should be done by virtue of the person's duty, or unlawfully does

[677] Section 36A(3) of the Crimes Act 1900 (ACT).

[678] Section 36C(5) of the Crime Act 1900 (ACT).

[679] Section 36C(1) of the Crime Act 1900 (ACT). A person is responsible for providing care to a vulnerable person, if the defendant "exercises control over any aspect of the care needed by the vulnerable person". This is the case irrespective of whether the care is provided on a short or long-term basis.

[680] Section 246 of the Children Act 2001

[681] Section 262 of the Criminal Code Act Compilation Act 1913 (WA).

any act, which results in bodily harm or endangerment of the life, health or safety of the person to whom they owe the duty, they commit an offence.[682]

[19.85] Similar duties to provide necessities of life and offences for failing to do so are set out in legislation in other states and territories, including, New South Wales,[683] Northern Territory,[684] Tasmania,[685] South Australia,[686] and Queensland.[687]

(vii) Ontario (Canada)

[19.86] In Ontario, Canada, section 215(2) of the Criminal Code sets out an offence of failing to perform the duty to provide necessaries of life to a spouse, common-law partner or person under their care. Section 215(1) creates a legal duty whereby certain categories of people are required to provide the "necessaries of life" to those under their care.[688] Section 215(1)(b) of the Criminal Code provides that everyone is under a legal duty to provide necessaries of life to their spouse or common-law partner.[689] Section 215(1)(c) provides that everyone is under a duty to provide necessaries of life to a person under their charge if that person:

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[682] Section 304 of the Criminal Code Act Compilation Act 1913 (WA).

[683] In New South Wales, section 44 of the Crimes Act 1900 (NSW) makes it an offence for a person who is under a legal duty to provide another person with the necessities of life to "intentionally or recklessly" fail to provide that person with such necessities without reasonable excuse if the failure causes "a danger of death or causes serious injury, or the likelihood of serious injury".

[684] In Northern Territory, section 183 of the Criminal Code Act 1983 (NT) provides that any person who is charged with the duty of providing another person with necessaries of life and "unlawfully fails to do so whereby the life of that other person is or is likely to be endangered or his health is or is likely to be permanently injured" is guilty of an offence.

[685] In Tasmania, section 144 of the Criminal Code Act 1924 (Tas) places a duty on every person "having charge of another who is unable by reason of age or sickness, unsoundness of mind, detention or any other cause to withdraw himself from such charge, and who is unable to provide himself with the necessaries of life, to provide such necessaries for that other person". Section 152 of the same Act provides that it is a criminal offence for any person to omit to perform their duty without lawful excuse where the omission causes death, grievous bodily harm, endangerment of life or permanent injury to health of the person to whom the duty is owed. The threshold for this offence is much higher than in other Australian States.

[686] Section 14A of the Criminal Law Consolidation Act 1935 (SA) establishes an offence of failing to provide necessary food, clothing or accommodation to a child or vulnerable adult without lawful excuse, where a person is liable to provide food, clothing or accommodation.

[687] In Queensland, section 285 of the Criminal Code Act 1889 (Qld) places a duty to provide necessaries and its provision is nearly identical to the one outlined above in respect of Western Australia. Section 324 of the same Act makes it an offence for any person charged with the duty of providing necessaries of life to fail to do so without lawful excuse, where the person's life is or is likely to be endangered, or their health is or is likely to be permanently injured.

[688] Section 215(1) of the Criminal Code (Ontario).

[689] Section 215(1) of the Criminal Code (Ontario).

(i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and

(ii) is unable to provide himself with necessaries of life.[690]

[19.87] The Canadian case of *R v Peterson* illustrates the application of the offence. In that case, a son was found liable for the neglect of his elderly father, who was later diagnosed with Alzheimer's disease.[691] The accused and his father occupied the same house. It was held that objectively, the son's failure clearly endangered his father's life given the father's inability to prepare food, the lack of food in his apartment, the lack of facilities in which to wash or go to the bathroom and the father's living conditions, which were described by an expert as "very unsafe" and "very unhygienic".[692] Importantly, the offence allowed for the prosecution of Peterson for the serious harm caused by his neglect, rather than limiting the offence to cases of death (as would be the case in this jurisdiction).

[19.88] In *Peterson,* the Court of Appeal noted, "the objective basis of liability includes an assessment of whether the person in charge could have acted other than he or she did".[693] This assessment took into account the resources at the disposal of the accused and – in the case at hand – previous efforts and offers by the community to assist in the care of the father. In particular, the Court of Appeal noted that the accused "could have called a community agency for help and did not".[694] The accused argued that his father was a fiercely independent and stubborn man who refused his help and would not listen to any of his children and as a result, the father could not be said to be under his care.[695] The Court of Appeal stated that:

> In assessing whether one person is in the charge of another, the relative positions of the parties and their ability to understand and

[690] Section 215(1)(c) of the Criminal Code (Ontario).

[691] *R v Peterson* (2005) 203 OAC 364 (CA). For analysis of this case and similar cases see Wilton, "What's Love Got to Do with It? – Caring for Vulnerable Adults Through the Lens of the Criminal Justice System" [2021] Canadian Legal Information Institute 1068.

[692] *R v Peterson* (2005), 203 OAC 364 (CA) at para 22.

[693] *R v Peterson* (2005), 203 OAC 364 (CA) at para 36.

[694] *R v Peterson* (2005), 203 OAC 364 (CA) at para 48.

[695] *R v Peterson* (2005), 203 OAC 364 (CA) at para 28. The Court of Appeal stated that: "[i]nsofar as the legal test for determining when a person is under the charge of another is concerned, the evidence that Arnold did not wish to bathe or change his clothes does not negate the appellant's having charge of him. The evidence simply supports the conclusion that Arnold had a mental disability that prevented him from exercising sound judgment to provide himself with the necessaries of life. This disability cannot be used by Dennis as a defence for failing to provide Arnold with the necessaries of life." See *R v Peterson* (2005), 203 OAC 364 (CA) at para 48.

> appreciate their circumstances is a factor to consider. A parent who is not in full possession of his or her faculties may not appreciate that he or she cannot provide himself or herself with the necessaries of life and may not have the capacity to understand that he or she is in an unsafe or unhealthy environment that is likely to cause permanent injury. Just as some contributory negligence by the victim is not a defence to a charge of criminal negligence, the inability of the victim to appreciate his or her need for necessaries and the victim's unwillingness to cooperate is not a defence for an accused charged with failure to provide necessaries. If the parent is otherwise in the child's charge and the child cannot care for the parent due to the parent's refusal to accept care, the child is obliged to seek the help of a community agency.

[19.89] The Court of Appeal agreed with the trial judge’s rationale for finding that the accused was in charge of his father.[696] The trial judge emphasised that the accused controlled his father’s living conditions and kept him in an unsafe environment,[697] and that he had control over his personal care.[698] The trial judge determined that the father was dependent, unable to provide himself with the necessaries of life,[699] and incapable of withdrawing himself from the accused’s charge due to his age and dementia.

(c) Reform proposals

[19.90] The Commission considers that the case for a new offence of abuse, neglect and ill-treatment in respect of certain adults (“relevant persons”) is well established.

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[696] It noted that the trial judge’s reasons are sufficient and did not disclose any error in law. Accordingly, the appeal of the conviction was dismissed. The sister of the accused submitted evidence that her brother did provide their father with the necessities of life. The Court of Appeal determined that as she had not entered the house for at least six months prior to the accused being apprehended, she was incapable of testifying about whether her brother failed to provide their father with the necessities of life. See *R v Peterson* (2005) 203 OAC 364 (CA) at paras 47 and 49.

[697] The accused locked doors to the rooms he occupied in the house, with the full knowledge that his father did not have a working kitchen, bathing facilities or a functional toilet that was easily accessible for a person in his condition. See *R v Peterson* (2005) 203 OAC 364 (CA) at para 45.

[698] The accused took steps to obtain the power of attorney to make decisions about his father’s care, along with his sister, and therefore had the ability to make such decisions. The trial judge determined that the accused chose not to make decisions that would result in [his father] receiving the necessaries of life. See *R v Peterson* (2005) 203 OAC 364 (CA) at para 45.

[699] The father was unable to feed himself and required someone else to cook for him, he also needed assistance in choosing appropriate clothing and maintaining his personal hygiene. See *R v Peterson* (2005) 203 OAC 364 (CA) at para 45.

As discussed above, a similar offence exists in respect of children in Ireland,[700] and other jurisdictions have adopted specific offences in relation to at-risk adults or people receiving care. If such an offence had been available at the time of the Áras Attracta prosecutions, it would have better reflected the gravity of the offending behaviour. Considering at-risk adults can be wholly dependent on those who provide care to them as is the case with children, it is important that they are offered equal protection in law by criminalising abuse, neglect or ill-treatment of relevant persons.

[19.91] The Commission considers that this offence should be based on a caring responsibility that exists either by virtue of a contractual or remunerated caring arrangement, by virtue of cohabitation, or by the assumption of voluntary caring responsibility. As with all the proposed offences, the Commission takes the view that the criminal law requires specificity and for that reason, the offence shall apply to any adult who provides care for a relevant person, or who resides in the same household as a relevant person. "Care" should be defined as personal care, including help with medical, physical, intellectual or social needs. "Provides care" should include where a person exercises control over any aspect of the care of a relevant person who requires care, regardless of whether the care is short, or long, term.

[19.92] The Commission recommends that an offence of intentional or reckless abuse, neglect or ill-treatment should be enacted, modelled on the cruelty offence set out in section 246 of the Children Act 2001. For the detailed provision, see the Criminal Law (Adult Safeguarding) Bill 2024. The Commission considers that such an offence is flexible enough to have potential application in situations such as that which arose in Áras Attracta, and in the cases of son in law in the Evelyn Joel case in Ireland and the husband of the carer in the Anthony Sootheran case in the UK by virtue of including persons who reside in the same household as the victim.[701]

[19.93] It is important to specify that intentionality or recklessness on the part of the offender is required for the offence to be made out. This ensures that accidents, unintended errors, and mistakes on the part of someone caring for, or residing in the same household as a relevant person, are not criminalised.

[19.94] An important aspect of the proposed offence is that it is capable of being established without the testimony of the victim. Existing assault offences are reliant on proof of harm, which often can only be provided by the victim,

[700] Section 246(1) of the Children Act 2001 provides that it is an offence to wilfully assault, ill-treat, neglect, abandon or expose a child, or cause or procure a child to be ill-treated, neglected, abandoned or exposed, "in a manner likely to cause unnecessary suffering or injury to the child's health or serious affect his or her wellbeing".

[701] See discussion later in this Chapter at paragraph 20.105.

especially if there is no medical evidence.[702] In the Áras Attracta prosecutions, the surreptitiously obtained CCTV was the key evidence. Victims who are non-verbal, or who have deficits in their memory or in their cognitive functioning are at a considerable – sometimes insurmountable – disadvantage when it comes to participation in a criminal process that relies substantially on oral evidence. The offence proposed by the Commission is objective, in that it relies on evidence of the behaviour of the accused, not on how the victim experienced that behaviour. The reference to "in a manner likely to cause suffering or injury to the person's health or seriously to affect his or her wellbeing" means that that evidence of actual suffering or harm is not required. This works well in child neglect cases and avoids a need for children to give evidence.

[19.95] The approach in England and Wales of using the concept of household, loosely defined so as to bring within its remit even more casual members of the wider family and friend group who do not necessarily reside together, is not, in the Commission's view appropriate for Ireland. Confining the offence to those who reside in the same household provides greater particularity, as residence is a matter relatively easily determined. It does not require debates to be engaged in as to intimacy or former intimacy. It includes "live-in" carers, foster and stepchildren and is broader than, for example, reference to membership of a family. It takes account of the potential for family members who may be estranged, mindful of the point made by stakeholders that there should not be an automatic duty on adult children to care for their parents. Some adult children may have been victims of abuse by the parent who is now an at-risk adult. Adult children are entitled to cut ties with their parent. If, however, they live with their parent, and their parent requires care, the duty to refrain from abuse, neglect or ill-treatment comes into play.

[19.96] The Commission believes that a person may be found guilty of an offence notwithstanding:

(a) the death of the relevant person in respect of whom the offence is committed, or
(b) that actual suffering or injury to the health of the relevant person, or the risk of such suffering or injury, was avoided by the action of another.

[19.97] The proposed provision provides for an alternative verdict in murder/manslaughter prosecutions, which is an important practical provision. The proposed offence includes provision for an alternative verdict which states that on the trial of any person for the murder or manslaughter of a relevant person, the court or the jury, as the case may be, may, if satisfied that the

[702] Other than section 2 of the Non-Fatal Offences against the Person Act 1997.

accused is guilty of an offence under the intentional or reckless abuse neglect or ill-treatment offence find the accused guilty of that offence. This means that a person can be convicted of the proposed lesser offence of intentional or reckless abuse, neglect or ill-treatment if there is insufficient evidence to establish murder or manslaughter, but the evidence is sufficient to prove the offence proposed in this section.

R. 19.2	**The Commission recommends that** a broad abuse, neglect or ill-treatment offence should be enacted in the Criminal Law (Adult Safeguarding) Bill 2024, modelled on the cruelty offence set out in section 246 of the Children Act 2001.

4. Exposure to risk of serious harm or sexual abuse

(a) Section 176 of the Criminal Justice Act 2006

[19.98] Section 176 of the Criminal Justice Act 2006 criminalises "reckless endangerment of children", that is to say exposing children to the risk of serious harm or sexual abuse. Section 176(2) provides:

> A person, having authority or control over a child or abuser, who intentionally or recklessly endangers a child by—
>
> (a) causing or permitting any child to be placed or left in a situation which creates a substantial risk to the child of being a victim of serious harm or sexual abuse, or
> (b) failing to take reasonable steps to protect a child from such a risk while knowing that the child is in such a situation,
>
> is guilty of an offence.[703]

[19.99] The offence is an interesting example of the criminalisation of inaction. Again, it is not necessary to establish that serious harm was caused, nor that sexual abuse was perpetrated. It is sufficient to establish that a person who had authority or control over a child or over an abuser knew of the risk and failed to protect a child from it. The penalty is potentially ten years' imprisonment when prosecuted on indictment.[704] As already stated, there is no equivalent offence in respect of adults. Had the 'Brandon' case occurred in a children's residential setting, there would have been potential exposure to substantial criminal penalties for failing to take reasonable steps to protect residents and exposing them to the risk of serious harm or sexual abuse.

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[703] Section 176(2) of the Criminal Justice Act 2006.

[704] Section 176(4) of the Criminal Justice Act 2006.

(b) Other jurisdictions

(i) England, Wales and Northern Ireland

[19.100] In England, Wales and Northern Ireland, section 5 of the Domestic Violence, Crime and Victims Act 2004 provides for an offence of causing or allowing a child or vulnerable adult to die or suffer serious physical harm. The offence occurs when someone who is a member of the same household as the victim (not limited to living together), who had frequent contact with the victim, failed to take reasonable steps to protect the victim from a risk of serious harm or death which they could have foreseen.[705] The offence imposes a positive duty on members of a household to protect the "vulnerable".[706]

[19.101] This offence was successfully prosecuted in the case of *R v Mills*, where three members of the deceased's household were found liable under the provision when the victim, who had a substantial learning disability, was murdered by another member of the household.[707] The three offenders were the perpetrator's mother, who lived in the house, the perpetrator's girlfriend, who did not live in the house but frequently visited, and a lodger who slept on the floor in the house. There was no evidence to suggest they were directly involved in causing the injuries that resulted in victim's death. However, the Court noted that "they must all have been aware of his prolonged suffering and the seriousness of his condition and the conduct of at least two of them went beyond a mere failure to help". The mother and girlfriend of the perpetrator were found to have taken active steps to prevent the victim getting the medical attention required that may have saved his life. The issue before the Court of Appeal was the sentence imposed and whether it was unduly lenient for each of the offenders.

[705] Section 5(1) of the Domestic Violence, Crime and Victims Act 2004 (England, Wales and Northern Ireland).

[706] A person is considered a member of a particular household, even if they do not live in that household, if they visit it so often and for periods of time that they can reasonably be regarded as a member of it. See section 5(4) of the Domestic Violence, Crime and Victims Act 2004 (England, Wales and Northern Ireland). A vulnerable adult is defined as "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". The inclusion of "or otherwise" means that the "vulnerability" need not be of long-standing. All that is required is that an adult is significantly impaired in their ability to protect themselves from violence, abuse or neglect. See section 5(6) of the Domestic Violence, Crime and Victims Act 2004 (England, Wales and Northern Ireland).

[707] *R v Mills* [2017] EWCA Crim 559.

[19.102] Initially, the offence applied in fatal cases only. However, in 2012, the section was amended to extend it to include serious physical harm as well as death.[708] The offence, set out in section 5, now provides:

> (1) A person ("D") is guilty of an offence if—
>
> (a) a child or vulnerable adult ("V") dies or suffers serious physical harm as a result of the unlawful act of a person who—
>
> (i) was a member of the same household as V, and
>
> (ii) had frequent contact with him,
>
> (b) D was such a person at the time of that act,
>
> (c) at that time there was a significant risk of serious physical harm being caused to V by the unlawful act of such a person, and
>
> (d) either D was the person whose act caused the death or serious physical harm or—
>
> (i) D was, or ought to have been, aware of the risk mentioned in paragraph (c),
>
> (ii) D failed to take such steps as he could reasonably have been expected to take to protect V from the risk, and
>
> (iii) the act occurred in circumstances of the kind that D foresaw or ought to have foreseen.[709]

[19.103] The decision to extend the offence to "serious harm" was made following analysis by the Crown Prosecution Service and the Metropolitan Police, which was noted in parliamentary debates on the Domestic Violence, Crimes and Victims (Amendment) Bill. Both agencies had identified numerous cases that were not prosecutable under existing legislation which they believed could have been prosecuted if the offence on the statute book facilitated prosecution in cases of serious harm.[710]

[19.104] Ormerod and Laird have criticised the lack of precision in the offence:

> Despite the attempts to define the key elements, many arbitrary distinctions persist and numerous issues will fall for judicial consideration. In some respects the offence is unsatisfactorily wide; in particular, the crown need not specify whether it is alleged that

[708] See Domestic Violence, Crime and Victims (Amendment) Act 2012 (England, Wales and Northern Ireland).

[709] Section 5 of the Domestic Violence, Crime and Victims Act 2004 (England, Wales and Northern Ireland).

[710] HC Deb 21 Oct 2011, col 1181 and PBC Deb 22 June 2011 col 7.

> D killed/injured or failed to take reasonable steps to prevent the death/serious injury by the other member of the household.[711]

[19.105] They are particularly critical of the breadth of the definition of "household" – a definition that was deliberately left vague.[712] They say:

> The act deliberately leaves undefined the concept of household. This is disappointing for an offence of this seriousness, even with the additional qualifying requirement that D has contact with the victim. Some categories of carer who have regular contact–for example, nannies–are seemingly not caught by the act unless under s 5(4)(b). The focus of the offence is clearly on imposing burdens on household members to police the risk of harm ... The lack of certainty is unsatisfactory in an offence of this nature.[713]

[19.106] The offence was prosecuted following the death of Anthony Sootheran, who was starved to death by his live-in carer. His carer was charged with murder and her husband was found guilty under section 5 of the Domestic Violence, Crime and Victims Act 2004.[714] The couple had moved into the deceased's home and while the husband did not actively look after the deceased, he was in frequent contact with him to the extent that he should have been aware of the risk of serious harm or death to him. The Commission considers that this factual scenario could be captured by its proposed offence of intentional or reckless abuse, neglect or ill-treatment, as that offence can be committed by a person who provides care for a relevant person or a person who resides in the same household as a relevant person.

(ii) New Zealand

[19.107] An applicable legal duty for the purposes of the above offence is the duty to provide necessaries and protect from injury in section 151 of the Crimes Act 1961. Section 151 provides that any person "who has actual care or charge of a person who is a vulnerable adult and who is unable to provide himself or herself with necessaries is under a legal duty—

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[711] Ormerod and Laird, *Smith, Hogan, and Ormerod's Criminal Law* 15th ed (Oxford University Press 2018) at page 637.

[712] Baroness Scotland of Asthal stated in the Grand Committee debate on the Domestic Violence, Crime and Victims Bill that it was a deliberate decision to leave the term "household" to be interpreted by the courts. See HL Deb 21 January 2004. Vol 657, col GC362.

[713] Ormerod and Laird, Smith, Hogan, and Ormerod's Criminal Law 15th ed (Oxford University Press 2018), at page 639.

[714] *R v Rickard and others* [2021] Reading Crown Court. Rickard's appeal against conviction was unsuccessful. See *R v Rickard* [2022] EWCA Crim 667.

(a) to provide that person with necessaries; and
(b) to take reasonable steps to protect that person from injury".[715]

[19.108] Section 194A of the Crimes Act 1961 provides for a specific offence of assault of a person in a family relationship. Section 195A of the same Act provides that a member of the same household as the victim or a member of staff of a hospital, institution or residence where the victim resides and who has frequent contact with the "vulnerable adult" or child is liable to imprisonment for a term not exceeding 10 years if the person:

(a) knew that the victim was at risk of death, grievous bodily harm or sexual assault, and
(b) failed to take reasonable steps to protect the victim from that risk.

[19.109] For the purposes of the offence, a person is to be regarded as a member of a particular household, even if they do not live in that household, if that person is so closely connected with the household that it is reasonable, in the circumstances, to regard him or her as a member of the household.[716] In determining whether a person is so closely connected with a particular household as to be regarded as a member of that household, the Act provides that regard must be given to the frequency and duration of visits to the household and whether the person has a familial relationship with the victim and any other matters that may be relevant in the circumstances.[717]

[19.110] This was a new offence recommended by the New Zealand Law Commission in its Review of Part 8 of the Crimes Act 1961. It believed that those who live in "close proximity" to a child or a vulnerable adult and are in frequent contact with them are "sufficiently close" to justify the imposition of a duty of care.[718] It noted that:

> [n]o duty to intervene in such cases presently exists. It is a situation that falls beyond the scope of any of the existing statutory duties, and in the absence of such a duty, there is no criminal liability for omitting to act. In practice, this means that household members who are neither perpetrators of, nor (legally speaking) parties to, ill

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715 The term "vulnerable" is defined in section 2 of the Crimes Act 1961 (New Zealand) as meaning "a person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person". Again, as with the English and Welsh legislation, the inclusion of "or any other cause" means that the definition is very broad and that a temporary vulnerability will suffice to bring an adult within the section's protection.

716 Section 195A(4)(a) of the Crimes Act 1961 (New Zealand).

717 Section 195A(5) of the Crimes Act 1961 (New Zealand).

718 Law Commission (New Zealand), *Review of Part 8 of the Crimes Act 1961: Crimes Against the Person* (LC NZ 2009) at page 8.

treatment or neglect cannot be held liable for their failure to intervene, no matter how outrageous or how obvious the ill treatment or neglect of the child may be.[719]

[19.111] The author of *Adams on Criminal Law* states that this offence is "framed simply as an offence of omission, imposing no new general duty of care and having no consequences in terms of other offences that impose liability for breaches of legal duties".[720] He compares the section 195A offence to the section 5 offence of the Domestic Violence, Crime and Victims Act 2004 in England, Wales and Northern Ireland and notes that "unlike the English provision, the offence created by s.195A is a prospective one, imposing an obligation on the defendant to act to prevent an anticipated harm without the necessity of providing that the harm has in fact occurred".[721] This is similar to the offence of reckless endangerment of children in Ireland contained in section 176 of the Criminal Justice Act 2006, in that no harm is required for the elements of the offence to be met.

(iii) Australian Capital Territory (Australia)

[19.112] The Australian Capital Territory legislation contains an offence of failure to protect a vulnerable person from a criminal offence.[722] The offence specifically applies to a person in authority in a relevant institution.[723] A person in authority commits the offence if:

(a) there is a substantial risk that a serious offence will be committed against a vulnerable person under the institution's care,

[719] Law Commission (New Zealand), Review of Part 8 of the Crimes Act 1961: Crimes Against the Person (LC NZ 2009) at page 8.

[720] France J, *Adams on Criminal Law* Loosleaf 3rd ed (Thompson Reuters 1991) at para CA195A.01.

[721] France J, *Adams on Criminal Law* Loosleaf 3rd ed (Thompson Reuters 1991) at para CA195A.01. Section 5 of the Domestic Violence, Crime and Victims Act 2004 (England, Wales and Northern Ireland) requires that the child or vulnerable adult must die or suffer serious harm and the person was aware at the time "that there was a significant risk of serious physical harm being caused to [the victim] by the unlawful act of" another person, and the person was aware or ought to have been aware of the risk, they failed to take reasonable steps to protect [the victim] from the risk, and the act occurred in circumstances where the person could have foreseen or ought to have foreseen that risk.

[722] Section 36B of the Crimes Act 1900 (ACT).

[723] Section 36B(1)(a) of the Crimes Act 1900 (ACT). A relevant institution is defined in section 36A(5) as an "entity, other than an individual, that operates facilities for, engages in activities with, or provides services to, vulnerable people under the entity's care, supervision or control", or a group of entities if they "interact with one another, share similar characteristics and collectively have a sense or unity" or "are controlled, managed or governed by another entity".

supervision or control by a person associated with the institution, or another person in authority in the institution, and

(b) the person in authority is aware of the risk, and because of their position in the institution, they could reduce or remove the risk, and

(c) the person in authority recklessly or negligently fails to reduce or remove the risk.[724]

(iv) South Australia (Australia)

[19.113] In South Australia, criminal neglect is an offence.[725] Section 14 of the Criminal Law Consolidation Act 1935 provides that a person is guilty of the offence of criminal neglect if the victim (a vulnerable adult or child) dies or suffers harm as a result of an act, where the defendant had a duty of care to the victim at the time of the act.[726] It has to be shown that the defendant was or should have been aware that there was an "appreciable risk that harm would be caused", the defendant failed to take reasonable steps to protect the victim from harm and the defendant's failure was so serious that it warrants a criminal penalty.[727]

(c) Reform proposals

[19.114] As outlined above, in England, Wales and Northern Ireland, it is an offence to fail to take reasonable steps to protect a child or "vulnerable adult" from the risk of serious harm or death.[728] In Ireland, a similar offence applies in respect of children. It is an offence to expose a child to the risk of serious harm or sexual abuse.[729] While section 3 of the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 provides an offence of failing to disclose information relating to an offence against a "vulnerable person", it does not criminalise failures to act where, by virtue of caring responsibilities, a person could intervene to protect a person that they know is at risk, but fails to do so.

[19.115] The Commission carefully considered the introduction of an offence of exposing a relevant person to a risk of serious harm or sexual abuse, similar to the provision which exists for children in section 176 of the Criminal Justice Act

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[724] Section 36B(1)(b), (c), (d), (e) of the Crimes Act 1900 (ACT).

[725] Section 14 of the Criminal Law Consolidation Act 1935 (SA).

[726] Section 14(1)(a), (b) of the Criminal Law Consolidation Act 1935 (SA).

[727] Section 14(1)(c), (d) of the Criminal Law Consolidation Act 1935 (SA).

[728] Section 5 of the Domestic Violence, Crime and Victims Act 2004 (England and Wales). This offence applies where the person is a member of the same household as the victim or had frequent contact with them and the person was aware or ought to have been aware of the serious risk posed to the victim. See *R v Mills* case discussed above.

[729] Section 176 of the Criminal Justice Act 2006

2006. It considers that such an offence would be particularly useful in fact scenarios similar to the 'Brandon' case, where a resident causing concern due to sexualised behaviour in a residential setting is moved to another area exposing further residents to the risk of being sexually abused without any reasonable steps being taken to protect other residents.

[19.116] It would also be applicable in circumstances where a person is not a person in authority, but otherwise has control of the care of the relevant person or abuser, or has control of the provision of care by the abuser. Where a person is aware that a relevant person is being seriously harmed or sexually abused due to being in close proximity to the adult on a regular basis, even though they are not directly caring for the relevant person themselves, they may have sufficient control over their care or knowledge to know the risks posed and therefore that person should take reasonable steps to intervene.

[19.117] It is not necessary to prove that the relevant person actually experienced serious harm or sexual abuse, although in practice, it may well be that cases where the harm does not materialise are rarely prosecuted. All that needs to be proven is that there was an exposure to a substantial risk of serious harm or sexual abuse that endangered a relevant person.

[19.118] Section 176 of the Criminal Justice Act 2006 defines serious harm as "injury which creates a substantial risk of death or which causes permanent disfigurement or loss or impairment of the mobility of the body as a whole or of the function of any particular member or organ".[730] The Commission questions whether the exclusion of psychological harm that has a significant impact on a person is justified in this day and age. It is not necessary for physical abuse that causes physical injury or death to be perpetrated or serious harm to be caused to a person. Taunting, threatening, humiliating, degrading or emotionally abusing a relevant person has the potential to have a significant impact on a person who is an at-risk adult, particularly if they are exposed to the abuse for a protracted period of time, and the perpetrator is someone who interacts with the relevant person on a frequent basis.

[19.119] People in authority in respect of a relevant person, or an abuser; or people who have control over the care of a relevant person, or abuser, or the provision of care by the abuser ought to be alert to the serious harm that can be caused by exposing a relevant person to psychological harm that has a significant impact on the person. It is useful to consider, for example, a scenario such as the Whorlton Hall case, discussed above at paragraph 20.61, where a manager of a hospital knows that staff members are taunting, humiliating, and threatening patients, and still proceeds to roster those staff members, and does not pursue disciplinary action. The Commission believes that such a factual scenario

[730] Section 176(1) of the Criminal Justice Act 2006.

involves exposure to serious harm of a psychological nature that has a significant impact on the person, and should therefore be criminalised, regardless of whether physical harm was caused.

[19.120] In recent years, Ireland has introduced an offence of coercive control in this jurisdiction, which suggests that thinking has moved on significantly in understanding the serious harm that can be caused from psychological abuse.[731] The Commission also proposes that an offence of coercive control specific to relevant persons should be included in its Criminal Law (Adult Safeguarding) Bill 2024. In that context, restricting serious harm to only death or serious physical harm would be unduly restrictive. For that reason, the Commission takes the view that serious harm should include injury which is of a psychological nature which has a significant impact.

[19.121] The Commission believes that this exposure offence should apply to "persons in authority in relation to a relevant person or abuser" or a person who "otherwise has control of the care of a relevant person or abuser or has control of the provision of care by the abuser". This would capture carers (both familial and paid carers) who expose a relevant person to a risk of serious harm or sexual abuse. For example, if a parent knows that one of their adult children is a relevant person, and leaves that person in the company of a person they know has previous convictions for sexual assault, this could be considered exposure of the relevant person to a risk of serious harm or sexual abuse. Equally, if a manager of a nursing home knows or suspects that a resident has previously abused other residents, but does not report that suspicion or put measures in place to protect other residents, they could also be considered to have exposed relevant persons to the risk of serious harm or sexual abuse – as they have control of the care of relevant persons and the abuser. Likewise, if the care home provider (for example, a nursing home), receives complaints about the behaviour of one of its staff members, which suggests that they may have physically assaulted a resident, and they do not investigate or put safeguarding measures in place, it could be guilty of the offence as it has control of the provision of care by the abuser.

[19.122] The *mens rea* for committing the offence is important to bear in mind. It must be shown that the person in authority intentionally or recklessly endangered a person by exposing them to a risk of serious harm or sexual abuse. This means that a person in authority will not be guilty of this offence unless intentionality or recklessness can be established and proven.

[19.123] The Commission recommends that an offence of exposure of a relevant person to a risk of serious harm or sexual abuse should be enacted in the Criminal Law (Adult Safeguarding) Bill 2024. It should be modelled on the offence in section

[731] Section 39 of the Domestic Violence Act 2018.

176 of the Criminal Justice Act 2006 in respect of children. However, the definition of "serious harm" should include injury which is of a psychological nature which has a significant impact.

R. 19.3 **The Commission recommends that an** offence of exposure of a relevant person to risk of serious harm or sexual abuse should be enacted in the Criminal Law (Adult Safeguarding) Bill 2024. It should be modelled on the offence set out in section 176 of the Criminal Justice Act 2006 in respect of children. However, the definition of "serious harm" should include injury which is of a psychological nature which has a significant impact.

5. Coercive control

(a) Domestic violence orders and applicability of coercive control offence under section 39 of the Domestic Violence Act 2018

[19.124] The Domestic Violence Act 2018 can be used to obtain civil orders such as safety orders, barring orders (including interim and emergency orders) and protection orders in circumstances where a person is being abused or threatened with violence, and the person is in need of protection.[732] These orders may be useful in the adult safeguarding context, where an older adult or an adult living with a disability (who may be an at-risk adult) is being abused or threatened by a non-dependant adult child.[733] These orders are increasingly being sought in the Circuit Courts. It is an offence for a person to contravene these orders.[734] In Chapter 13, the Commission recommends expanding the availability of such orders to certain relationships involving at-risk adults.

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[732] Sections 6, 7, 8, 9, and 10 of the Domestic Violence Act 2018.

[733] See for example, Carolan, "Disabled mother gets temporary barring order against 'dangerous' adult daughter" *The Irish Times* (7 January 2024) <https://www.irishtimes.com/crime-law/courts/2024/01/07/disabled-mother-gets-temporary-barring-order-against-dangerous-adult-daughter/> accessed 9 April 2024; McCurry, "Domestic violence by adult children against parents rises as stress peaks under lockdown" *Irish Independent* (31 October 2020) < https://www.independent.ie/irish-news/domestic-violence-by-adult-children-against-parents-rises-as-stress-peaks-under-lockdown/39688721.html> accessed 9 April 2024; Phelan, "15pc of domestic violence orders 'are brought by parents against adult children'" *Irish Independent* (21 October 2019) < https://www.independent.ie/irish-news/15pc-of-domestic-violence-orders-are-brought-by-parents-against-adult-children/38614561.html> accessed 9 April 2024.

[734] Section 33(1) of the Domestic Violence Act 2018. It is also an offence to refuse to permit the victim or dependent person to "enter in and remain in the place to which the order relates" or to do anything for the purposes of preventing the victim or the dependent from doing so.

[19.125] Coercive control is a relatively new offence in Ireland, introduced by the Domestic Violence Act 2018.[735] It criminalises the psychological and emotional abuse that can be perpetrated through insidious, recurring and long-running coercive and controlling behaviour. The 2018 Act provides that a person commits an offence where he or she knowingly and persistently engages in behaviour that—

(a) is controlling or coercive,
(b) has a serious effect on a relevant person, and
(c) a reasonable person would consider likely to have a serious effect on a relevant person.[736]

[19.126] A person's behaviour is defined under the 2018 Act as having a serious effect on a relevant person (as defined in the 2018 Act) if the behaviour causes the relevant person either to fear that violence will be used against them, or results in serious alarm or distress that has a substantial adverse impact on their usual day-to-day activities.[737] A relevant person is defined as a spouse, civil partner or a current or former intimate partner.[738]

[19.127] An obvious and substantial limitation of the offence in the adult safeguarding context is that the protection afforded by the offence of coercive control only applies to spouses, civil partners or someone who is or was in an intimate relationship with the perpetrator.[739] Cairns states that on the one hand, there is a strong case for such a limitation and narrowness of the applicability of an offence to effectively capture the distinct moral wrong of domestic abuse and to avoid over criminalisation.[740] However, Cairns acknowledges that, on the other hand, it can be argued that if individuals other than partners or ex-partners are capable of experiencing systematic abuse that erodes their freedom and has a significant impact on their daily lives, the offence should be more widely

[735] Section 39 of the Domestic Violence Act 2018, which was commenced on 1 January 2019. See Domestic Violence Act 2018 (Commencement) Order 2018 (SI No 532 of 2018).

[736] Section 39(1) of the Domestic Violence Act 2018.

[737] Section 39(2) of the Domestic Violence Act 2018.

[738] Section 39(4) of the Domestic Violence Act 2018.

[739] Cronin and Coughlan, "Coercive control – the first convictions in Ireland" *Irish Legal News* (14 March 2021) <https://www.irishlegal.com/articles/michelle-cronin-coercive-control-the-first-convictions-in-ireland> accessed on 9 April 2024.

[740] Cairns, "What Counts as 'Domestic'? Family Relationships and the Proposed Criminalization of Domestic Abuse in Scotland" (2017) 21(2) Edinburgh Law Review 262 at pages 265 to 266. She notes that broadening the offence to include broader familial relationships could "dilute and distract from, an understanding of domestic abuse as a symptom and cause of gender inequality".

available to ensure that these individuals are not arbitrarily denied legal protection based on relationship status.[741]

[19.128] Psychological abuse, including recurring or systematic psychological abuse such as coercive control, is not confined to intimate relationships and may, of course, be perpetrated by someone else in a proximate relationship to an at-risk adult. This point was emphasised by Safeguarding Ireland in a 2022 report, where it discussed the possible expansion of the definition to include all persons who inflict this form of abuse, irrespective of the relationship involved.[742] It considers that the Domestic Violence Act 2018 should be amended to ensure the offence of coercive control applies outside of intimate relationships. It noted:

> The narrow scope of the offence of coercive control under the 2018 Act does not adequately capture the nuanced coercive control often exercised over persons who are dependent on the perpetrator for their care.[743]

[19.129] In response to the question posed in the Commission's Issues Paper as to whether any additional legal measures were required to prevent physical, sexual, psychological abuse or neglect, there was strong stakeholder support for the expansion of section 39 of the Domestic Violence Act 2018, which created the offence of coercive control in Irish law, to include wider family arrangements:

- irrespective of whether there is a dependency element;
- irrespective of an intimate relationship; and
- irrespective of whether the abuser lives with the victim.

[19.130] Stakeholders considered that the current provision does not capture all potential living arrangements and different types of domestic abuse, and argued for the extension of the offence of coercive control to carers including non-family members who are carers.

[19.131] Donnelly and O'Brien provide insights into perspectives of Irish social workers across specialities involved in adult safeguarding casework.[744] Their analysis,

[741] Cairns, "What Counts as 'Domestic'? Family Relationships and the Proposed Criminalization of Domestic Abuse in Scotland" (2017) 21(2) Edinburgh Law Review 262 at page 266.

[742] Safeguarding Ireland, *Identifying RISKS, Sharing RESPONSIBILITIES – The Case for a Comprehensive Approach to Safeguarding Vulnerable Adults* (Safeguarding Ireland 2022) at pages 15 to 16 and 54 to 57.

[743] Safeguarding Ireland, *Identifying RISKS, Sharing RESPONSIBILITIES – The Case for a Comprehensive Approach to Safeguarding Vulnerable Adults* (Safeguarding Ireland 2022) at pages 54 to 55.

[744] Donnelly and O'Brien, "Adult Safeguarding Legislation—The Key to Addressing Dualism of Agency and Structure? An Exploration of how Irish Social Workers Protect Adults at Risk in the Absence of Adult Safeguarding Legislation" (2022) 52(6) The British Journal of Social Work 3677.

based on 14 interviews and two focus groups, identified coercive control and undue influence as strong themes emerging from the consultation. Social workers expressed concern that the protection provided by the Domestic Violence Act 2018 does not apply to non-intimate relationships and provided examples of relevant situations where such an offence would be useful from their experience in practice.[745] In the analysis of their findings, the authors stated that the 2018 Act being drafted without a safeguarding lens limits its usefulness and poses a significant risk to the safety and wellbeing of those in non-intimate relationships, which they added is "a clear impediment to a rights-based approach".[746]

[19.132] Sage Advocacy, in a submission to the Garda Inspectorate in relation to its examination of Gardaí responses to domestic abuse, highlighted that the existing coercive control offence does not cover coercive control by adult children over a "vulnerable parent", nor does it cover abuse in residential care settings.[747] Sage Advocacy also pointed to the frequent connection between financial abuse and coercive control. It identified the inadequacy of the existing offence of coercion in section 9 of the Non-Fatal Offences against the Person Act 1997, insofar as that offence requires the use of violence or intimidation, damage to property or stalking/harassment behaviours. It concluded that section 9 "does not necessarily cater for the subtle manipulation often involved with coercive control" and, while it acknowledges the value of the offence of coercive control for the relationships it applies to, "it does not provide the protection of the law to the full range of vulnerable adults who are subjected to coercive control".[748] Sage Advocacy argues that "[a]ll people who are victims of crime or who are being abused clearly should have the same legal protections irrespective of their living situation or their relationship with the perpetrator of abuse."[749] In its response to the Commission's Issues Paper, Sage Advocacy also

[745] Donnelly and O'Brien, "Adult Safeguarding Legislation—The Key to Addressing Dualism of Agency and Structure? An Exploration of how Irish Social Workers Protect Adults at Risk in the Absence of Adult Safeguarding Legislation" (2022) 52(6) The British Journal of Social Work 3677 at page 3685.

[746] Donnelly and O'Brien, "Adult Safeguarding Legislation—The Key to Addressing Dualism of Agency and Structure? An Exploration of how Irish Social Workers Protect Adults at Risk in the Absence of Adult Safeguarding Legislation" (2022) 52(6) The British Journal of Social Work 3677 at page 3691.

[747] Sage Advocacy, Submission to Garda Síochána Inspectorate (January 2022) at page 3 <https://sageadvocacy.ie/wp-content/uploads/2023/12/sage-advocacy-submission-to-garda-siochana-inspectorate_28012022.pdf> accessed 9 April 2024.

[748] Sage Advocacy, Submission to Garda Síochána Inspectorate (January 2022) at page 7 <https://sageadvocacy.ie/wp-content/uploads/2023/12/sage-advocacy-submission-to-garda-siochana-inspectorate_28012022.pdf> accessed 9 April 2024.

[749] Sage Advocacy, Submission to Garda Síochána Inspectorate (January 2022) at page 9 <https://sageadvocacy.ie/wp-content/uploads/2023/12/sage-advocacy-submission-to-garda-siochana-inspectorate_28012022.pdf> accessed 9 April 2024.

called for the expansion of the offence of coercive control to family relationships.[750] This submission is also relevant to the Commission's considerations on whether to introduce an offence of coercive exploitation, discussed below.

(b) Other jurisdictions

(i) England and Wales

[19.133] Section 76 of the Serious Crime Act 2015 provides for an offence of controlling or coercive behaviour in an intimate or family relationship.[751] It provides that the two people must be "personally connected" at the time of the behaviour, meaning (1) they are in an intimate personal relationship together or (2) live together and are members of the same family or previously had an intimate personal relationship with one another.[752] Section 68 of the Domestic Abuse Act 2021, amended section 76 of the Serious Crime Act 2015 to insert subsection (6) to outline what is meant by "members of the same family".[753]

[19.134] Section 76(6) provides that two people are "members of the same family" if any of the following applies:

(a) they are, or have been, married to each other;
(b) they are, or have been, civil partners of each other;
(c) they have agreed to marry one another (whether or not the agreement has been terminated);
(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);
(e) they are, or have been, in an intimate personal relationship with each other;
(f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child …
(g) they are relatives.[754]

[750] Sage Advocacy, *Law Reform Commission Issues Paper – A Regulatory Framework for Adult safeguarding Submission* (2020) <https://sageadvocacy.ie/wp-content/uploads/2023/12/sage-advocacy-submission-to-lrc-200520-final.pdf> accessed 9 April 2024.

[751] Section 76(1) of the Serious Crime Act 2015 (England and Wales).

[752] Section 76(1)(b) and (2) of the Serious Crime Act 2015 (England and Wales).

[753] Section 68(4) of the Domestic Abuse Act 2021 (England and Wales). This change came into operation on 5 April 2023.

[754] Section 76(6) of the Serious Crime Act 2015 (England and Wales). A relative has the meaning given to it in section 63(1) of the Family Law Act 1996, which provides that a relative means "father, mother, stepfather, stepmother, son, daughter, stepson, stepdaughter, grandmother, grandfather, grandson or granddaughter of a person or their spouse, former spouse, civil partner or former civil partner" or "the brother, sister, uncle, aunt, niece, nephew or first

[19.135] The amending legislation also removed the previous co-habitation requirement in response to calls from key stakeholders following a review of domestic violence legislation.[755] This amendment ensures "that post-separation abuse and familial domestic abuse is provided for where the victim and perpetrator do not live together".[756] This means that someone who is "personally connected" with a person, including an at-risk adult can be guilty of coercive and controlling behaviour, regardless of whether they live together. This applies to a broad range of people, as identified above, who may be providing care or support to a family member, spouse, civil partner, or cohabitant.

[19.136] Statutory guidance was issued under section 77 of the Serious Crime Act 2015 and any person or agency investigating offences in relation to controlling or coercive behaviour must have regard to it.[757] It is aimed at statutory and non-statutory bodies working with victims, perpetrators and commissioning services, including the police, criminal justice agencies and other agencies.

(ii) Scotland

[19.137] In 2015, Scotland conducted a consultation on reforming the law to address domestic abuse and sexual offences.[758] It sought views on whether a specific offence of domestic abuse should be created and asked what behaviours not currently criminalised should be included within the scope of the offence.[759] It also queried whether the offence should be restricted to people who are partners or ex-partners or whether it should also include other familial

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cousin (whether of full blood, or half blood or by marriage or civil partnership) of the person or their spouse, former spouse, civil partner or former civil partner". Where two people are cohabitating, or have cohabitated, it also includes those relations listed above belonging to them.

[755] Section 68(4) of the Domestic Violence Act 2021 (England and Wales) omits section 76(2) of the Serious Crimes Act 2015 (England and Wales) which included the cohabitation requirement; Home Office, Policy Paper Amendment to the controlling or coercive behaviour offence (Updated 11 July 2022), see background section of document <https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/amendment-to-the-controlling-or-coercive-behaviour-offence> accessed 9 April 2024.

[756] Home Office, Policy Paper Amendment to the controlling or coercive behaviour offence (Updated 11 July 2022) <https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/amendment-to-the-controlling-or-coercive-behaviour-offence> accessed 9 April 2024.

[757] Home Office, *Controlling or Coercive Behaviour Statutory Guidance Framework* (2023) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1148945/Controlling_or_Coercive_Behaviour_Statutory_Guidance_-_final.pdf> accessed 9 April 2024.

[758] Scottish Government, *Equally Safe: Reforming the law to address domestic abuse and sexual offences* (2015).

[759] Scottish Government, *Consultation Paper – A criminal offence of domestic abuse* (2016) at page 5.

relationships.[760] The majority of respondents agreed that there should be a specific offence of domestic violence, with many suggesting that the law should recognise coercive and controlling behaviours, including isolation from support networks, threats and creating a climate of fear, and psychological control and manipulation.[761]

[19.138] However, 67% of respondents thought that any specific offence of domestic abuse should be restricted to people who are partners or ex-partners, as the dynamics of intimate partner relationships are different to that of other relationships.[762] A number of respondents felt that it was "important to keep a clear focus on domestic abuse within the broader understanding of gender inequality and gender-based violence and coercive control".[763] They were concerned that extending the offence to cover other familial relationships "could lead to a dilution and diminution of the understanding and response to domestic abuse".[764]

[19.139] Those in favour of the offence extending to all familial relationships emphasised the prevalence of familial abuse and the need to address all abuse that occurs within families.[765] Some submissions pointed out that while there are differences in terms of the motivation for the abuse, "many of the abusive techniques are similar and there can be a similar 'power dynamic'".[766] Ultimately, the government determined that the offence should be restricted to people who are partners or ex-partners.[767] The rationale put forward for this approach was that if the offence is to be "meaningfully focused on domestic abuse ... it is important that the definition is not so wide as to effectively cover all abuse or harassment between any two people".[768] The Consultation Paper did not

[760] Scottish Government, *Consultation Paper – A criminal offence of domestic abuse* (2016) at page 5.

[761] Scottish Government, *Consultation Paper – A criminal offence of domestic abuse* (2016) at page 6.

[762] Scottish Government, *Consultation Paper – A criminal offence of domestic abuse* (2016) at page 6.

[763] Scottish Government, *Consultation Paper – A criminal offence of domestic abuse* (2016) at pages 6 to 7.

[764] Scottish Government, *Consultation Paper – A criminal offence of domestic abuse* (2016) at page 7.

[765] Scottish Government, *Consultation Paper – A criminal offence of domestic abuse* (2016) at page 8.

[766] Scottish Government, *Consultation Paper – A criminal offence of domestic abuse* (2016) at page 8.

[767] Scottish Government, *Consultation Paper – A criminal offence of domestic abuse* (2016) at page 11.

[768] Scottish Government, *Consultation Paper – A criminal offence of domestic abuse* (2016) at page 11.

engage specifically with the possibility that it would be useful for the offence to be more broadly applicable to familial relationships particularly where there is a carer relationship that increases the dependence of the individual on their family member. The government noted that:

> there is a particular dynamic to abuse of a person's partner or ex-partner which differs from violence or abuse which may occur within a family between, for example, siblings, or between parents and children, where long-standing legislation concerning child abuse can be used to prosecute parents or guardians who neglect or abuse children in their care.[769]

[19.140] After conducting the necessary consultations, the government enacted the Domestic Abuse (Scotland) Act 2018, which makes it an offence to engage in a course of behaviour which is abusive to one's partner or ex-partner.[770] It outlined in its Consultation Paper, that it preferred to draft the offence in such a way that focused on the "effects" the abuse has on a person, as it took the view that terms such as "coercive control" or "coercive and controlling behaviour" were not "sufficiently precise to achieve legal certainty within a legislative context".[771] In an analysis of the responses to the second Consultation Paper, it was noted that the very great majority of those who made a clear statement on the issue supported the offence being restricted to people who are partners or ex-partners.[772]

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[769] Scottish Government, *Consultation Paper – A criminal offence of domestic abuse* (2016) at page 11.

[770] Section 1 of the Domestic Abuse (Scotland) Act 2018. It must be established that a reasonable person would consider that the course of behaviour is likely to cause the other person physical or psychological harm. It must also be established that the perpetrator intended to cause such harm, or was reckless as to whether they would cause such harm. Psychological harm includes fear, alarm and distress. See section 1(2) and (3) of the Domestic Abuse (Scotland) Act 2018.

[771] Scottish Government, *Consultation Paper – A criminal offence of domestic abuse* (2016) at pages 8 to 9.

[772] It was suggested that an offence that included all forms of relationships would become unwieldly and make enforcing the law difficult. One respondent raised the issue of adults perpetrating abuse on other adults within the same household, and that while some of these people would fall under the Adult Support and Protection (Scotland) Act 2007, others may not, and "it is not immediately clear why only certain persons complaining of intimidating and controlling behaviour are to be afforded this statutory protection". See Robertson, Craigforth, *Analysis of Consultation Responses – Criminal Offence of Domestic Abuse* (Scottish Government 2016) <https://www.gov.scot/binaries/content/documents/govscot/publications/consultation-analysis/2016/09/criminal-offence-domestic-abuse-analysis-consultation-responses/documents/00505326-pdf/00505326-pdf/govscot%3Adocument/00505326.pdf> accessed 9 April 2024.

[19.141] Section 2 of the Domestic Abuse (Scotland) Act 2018 outlines what constitutes abusive behaviour. It includes behaviour that is directed at a partner or ex-partner that is violent, threatening or intimidating.[773] It also includes behaviour directed at a partner or ex-partner, their child or another person that are carried out with the purpose of causing, or a reasonable person would consider would likely cause one or more of the following "effects":

- making the partner/ ex-partner dependent or subordinate to the perpetrator;
- isolating the partner/ ex-partner from friends, relatives or other sources of support;
- controlling, regulating or monitoring the partner/ex-partner's day-to-day activities;
- depriving the partner/ex-partner of, or restricting their freedom of action;
- frightening, humiliating, degrading or publishing the partner/ex-partner.[774]

(iii) Northern Ireland

[19.142] The approach adopted in the Domestic Abuse and Civil Proceeding Act (Northern Ireland) 2021 is similar in many respects to the approach and wording adopted in Scotland. Section 1 of the Act makes it an offence for a person to engage in a course of conduct that is abusive of another person, where the two people are "personally connected to each other at the time".[775] This offence is to be known as the "domestic abuse offence".[776]

[19.143] Abusive behaviour is defined in the same way as is done in the Scottish legislation, with a focus on the same "effects" as listed above, appearing in Northern Ireland legislation. However, in contrast to the approach in Scotland, Northern Ireland does not limit the application of the offence to partners or ex-partners. The offence applies where two people are "personally connected to each other" at the time of the offence. "Personal connection" between two people is defined broadly in the Act as meaning any of the following:

- they are, or have been, married to each other;

[773] Section 2(2) of the Domestic Abuse (Scotland) Act 2018.

[774] Section 2(3) of the Domestic Abuse (Scotland) Act 2018.

[775] As in Scotland, in Northern Ireland, it must be established that a reasonable person would consider that the course of behaviour is likely to cause the other person physical or psychological harm. It must also be established that the perpetrator intended to cause such harm or was reckless as to whether they would cause such harm. Psychological harm includes fear, alarm and distress. See section 1 of the Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021.

[776] Section 1(4) of the Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021.

- they are, or have been civil partners of each other;
- they are living together, or have lived together, as if spouses of each other;
- there are, or have been, otherwise in an intimate personal relationship with each other; or
- they are members of the same family.[777]

[19.144] The perpetrator ("A") and the victim ("B") are members of the same family under the Act :

(a) if B is A's parent, grandparent, child, grandchild, brother or sister, or

(b) if—

(i) one of them is in a relevant relationship with someone else ("C"), and

(ii) the other of them is C's parent, grandparent, child, grandchild, brother or sister.[778]

[19.145] During assembly debates on the legislation, the Justice Minister stated that "the devastating impact of familial abuse on victims should not be underestimated and should be captured by this new offence".[779]

[19.146] McQuigg has commented that Northern Ireland out of all the jurisdictions in the United Kingdom and Ireland has "adopted the most expansive approach to those coming within the ambit of the relevant provisions".[780] He notes that as Northern Ireland was the last jurisdiction in the United Kingdom and Ireland to criminalise coercive and controlling behaviour, its approach was informed by the legislation adopted in other jurisdictions, which enabled "Northern Ireland to 'cherry pick' the best aspects of the approaches of these jurisdictions".[781]

[777] Section 5(2) of the Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021.

[778] Section 5(3), (4) of Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021. There is no distinction made under the Act between full blood or half-blood familial relationships, or biological children and stepchildren.; it provides that they are to be treated equally. A person is in a relevant relationship with someone else if they are married or civil partners, or if they are living together "as if spouses of each other".

[779] Northern Ireland Assembly, Official Report: 28 April 2020.

[780] McQuigg, "Northern Ireland's New Offence of Domestic Violence" 44(1) Statute Law Review 1 at page 1

[781] McQuigg, "Northern Ireland's New Offence of Domestic Violence" 44(1) Statute Law Review 1 at page 1.

(iv) New Zealand

[19.147] The Family Violence Act 2018, which repealed the Domestic Violence Act 1995, came into force on the 1 July 2019.[782] It updated the definition of family violence to better reflect that it can include controlling or coercive behaviour. It also clarified that a carer can be in a close personal relationship with the person they care for. These are relevant in the civil context in that a person who is a victim of family violence can obtain orders to prevent the perpetrator interacting with them. Psychological abuse, or a pattern of controlling behaviour, are not criminal offences in New Zealand,[783] unless the victim obtains a protection order, or some other kind of order and the perpetrator does not comply.[784] A perpetrator of family violence is defined in the Act as a person who has or is inflicting family violence "even if no offence involving the violence is, or is to be, admitted or prosecuted".[785]

[19.148] In its public discussion paper on Strengthening New Zealand's Legislative Response to Family Violence, the Ministry of Justice raised the possibility of introducing a new offence of psychological violence and referred specifically to the United Kingdom's offence of coercive control.[786] This was just one of a number of approaches put forward for discussion on how the criminal law could be changed to better respond to family violence.

[19.149] The Family Violence Act 2018 extends the meaning of "family violence" to include psychological abuse.[787] It provides that violence includes a pattern of behaviour consisting of a number of acts that are either physical, sexual, or psychological in nature, which acts are coercive or controlling or cause or may cause a person cumulative harm.[788] Family violence means violence inflicted by a person on another person with whom they are in a family relationship.[789] The meaning of family relationship extends beyond spouses, partners, relatives, to

[782] Section 2 and section 258 of the Family Violence Act 2018 (New Zealand).

[783] This is despite the fact that the Family Violence Act 2018 (New Zealand) creates three new family violence offences, strangulation, assault on a person in a family relationship and coerced marriage or civil union.

[784] Section 112 of the Family Violence Act 2018 (New Zealand) makes it an offence to breach a protection order or related property order. Every person who is convicted of an offence under the section is liable to imprisonment for a term not exceeding 3 years.

[785] Section 8 of the Family Violence Act 2018 (New Zealand).

[786] Ministry of Justice (New Zealand), *Strengthening New Zealand's legislative response to family violence* (2015) at page 33.

[787] Section 9(2)(c) of the Family Violence Act 2018 (New Zealand).

[788] Section 9(3) of the Family Violence Act 2018 (New Zealand).

[789] Section 9(1) of the Family Violence Act 2018 (New Zealand).

people who ordinarily share a household, or who have a close personal relationship.[790]

[19.150] Two people are not regarded as sharing a household by reason only of the fact that (1) there is landlord-tenant relationship, an employer-employee relationship, or an employee-employee relationship or (2) they share a dwellinghouse.[791] Section 14(2) of the Family Violence Act 2018 provides that "a person (A) is not prevented from having a close personal relationship with another person (B) … by reason only of the fact that A has, with B, a recipient of a care-carer relationship".[792] It is not necessary for there to be a sexual relationship to establish a close personal relationship.[793] In determining whether two people have a close personal relationship, the court must have regard to:

(a) the nature and intensity of the relationship, in particular:

(i) the amount of time … spent together;
(ii) the place or places where that time is ordinarily spent;
(iii) the manner in which that time is ordinarily spent; and

(b) the duration of the relationship.[794]

[19.151] The Cabinet Paper states that the definition of family relationships specifies carer relationships "to signal that recipients of care are particularly vulnerable to family violence".[795] It acknowledges that the "ordinarily share a household" and "close personal relationship" applicability criteria could cause confusion for those in the care sector as to whether carer/recipient of care relationships are included.[796] This is why the Ministry proposed an amendment to the initial Bill to explicitly refer to the relationship between carers and recipients of care in the definition of the family relationship to avoid "misperceptions that such

[790] Section 12 of the Family Violence Act 2018 (New Zealand).

[791] Section 13 of the Family Violence Act 2018 (New Zealand).

[792] Section 14(2) of the Family Violence Act 2018 (New Zealand).

[793] Section 14(4) of the Family Violence Act 2018 (New Zealand).

[794] Section 14(3) of the Family Violence Act 2018 (New Zealand).

[795] Ministry of Justice (New Zealand), *Policy Paper – Family Violence Legislation – A modern Act with a greater focus on victims* at page 1 < https://www.justice.govt.nz/assets/a-modern-and-victim-focussed-act.pdf> accessed 9 April 2024.

[796] Ministry of Justice (New Zealand), *Policy Paper – Family Violence Legislation – A modern Act with a greater focus on victims* at page 15 < https://www.justice.govt.nz/assets/a-modern-and-victim-focussed-act.pdf> accessed 9 April 2024.

behaviour is not family violence" and recognise the relationship of dependence that exists.[797]

(v) Australia (Federal law)

[19.152] In 2021, the House Standing Committee on Social Policy and Legal Affairs published its report on an inquiry into family, domestic and sexual violence.[798] It recommended that the Australian Government work with state and territory governments to establish a uniform definition of family, domestic and sexual violence, which:

- reflects a common understanding of the features and dynamics of such violence and the breadth of relationships in which violence can occur;
- encompasses a broad range of violence, including but not limited to coercive control, reproductive coercion, economic abuse, and complex forms of violence, such as forced marriage, female genital mutilation/cutting and dowry abuse; and
- recognises the diversity of victim-survivors and perpetrators and the particular vulnerability of certain groups.[799]

[19.153] The Committee recommended that the Australian government and state and territory governments develop shared principles to guide any future offences of coercive and controlling behaviour.[800] The purpose of this would be to bring about consistency across jurisdictions, as far as is possible. It recommends that one of these principles should be "the breadth of relationships captured by any new offences".[801]

[19.154] In its response, the federal government committed to developing a national definition of family and domestic violence that includes coercive control, in close

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797 Ministry of Justice (New Zealand), *Policy Paper – Family Violence Legislation – A modern Act with a greater focus on victims* at page 15 < https://www.justice.govt.nz/assets/a-modern-and-victim-focussed-act.pdf> accessed 9 April 2024.

798 House of Representatives Standing Committee on Social Policy and Legal Affairs, *Inquiry into family, domestic and sexual violence* (2021).

799 House of Representatives Standing Committee on Social Policy and Legal Affairs, *Inquiry into family, domestic and sexual violence* (2021) at page 49.

800 Australian Government, *Australian Government Response to the House of Representatives Standing Committee on Social Policy and Legal Affairs Report*: Inquiry into family, domestic and sexual violence (2023) at page 25.

801 House of Representatives Standing Committee on Social Policy and Legal Affairs, *Inquiry into family, domestic and sexual violence* (2021) at page 160.

partnership with the states and territories.[802] It also agreed to develop the shared principles to shape any future offences of coercive and controlling behaviour, which includes the scope of the offence in terms of applicability to a range of relationships.[803] The Commonwealth, states and territories worked together through the Standing Council of Attorney-Generals ("SCAG") to develop the National Principles to Address Coercive Control in Family and Domestic Violence, which were endorsed on the 22 September 2023.[804] The National Principles set out a shared understanding of common features and impacts of coercive control.

[19.155] The National Principles acknowledge that coercive control is not restricted to current and former intimate partner relationships, and that it "can also be perpetrated in broader family relationships, such as against children or young people by parents or relatives, against parents or elders by adult children or grandchildren or between siblings".[805] It provides that broader family relationships can also include "extended family networks, cultural kindship relationships and family of choice relationships".[806] It emphasises that coercive control is particularly prevalent in relationships that involve power imbalances, where the victim is reliant on the perpetrator, due to disability, age or financial circumstances, and that victims can be of all ages.[807] The principles go on to point out that coercive control can occur where the victim is reliant on the perpetrator for care, such as an adult child performing caring duties for an older person who:

> may restrict access to their medical treatment, phones or computers, or limit their social interactions … [or] undermine their autonomy by suggesting to other people that they are

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802 Australian Government, *Australian Government Response to the House of Representatives Standing Committee on Social Policy and Legal Affairs Report: Inquiry into family, domestic and sexual violence* (2023) at page 25.

803 Australian Government, *Australian Government Response to the House of Representatives Standing Committee on Social Policy and Legal Affairs Report: Inquiry into family, domestic and sexual violence* (2023) at page 11.

804 Commonwealth of Australia, *Attorney-General's Department, National Principles to Address Coercive Control in Family and Domestic Violence* (2023).

805 Commonwealth of Australia, *Attorney-General's Department, National Principles to Address Coercive Control in Family and Domestic Violence* (2023) at page 2.

806 Commonwealth of Australia, *Attorney-General's Department, National Principles to Address Coercive Control in Family and Domestic Violence* (2023) at page 2.

807 Commonwealth of Australia, Attorney-General's Department, *National Principles to Address Coercive Control in Family and Domestic Violence* (2023) at page 2.

> experiencing cognitive decline and are unable to make decisions for themselves.[808]

[19.156] While the National Principles do not prescribe how states and territories should implement laws, policies, and initiatives to respond to coercive control within their jurisdictions, it provides:

> a foundation to build wider awareness of coercive control within the community, while providing flexibility to allow governments and non-government organisations to design their own tailored approaches. Approaches should be informed by, and aligned with, these National Principles.[809]

[19.157] As many states and territories identified below are developing legislative approaches or have recently developed legislative approaches to addressing coercive control in their jurisdictions, it will be interesting to see how the National Principles influence changes to thinking in relation to the scope of offences, particularly when it comes to the breadth of relationships covered.

(vi) New South Wales (Australia)

[19.158] New South Wales created a stand-alone offence of coercive control after its parliament passed the Crimes Legislation Amendment (Coercive Control) Act 2022.[810] This legislation has not come into operation yet, but it is expected to be commenced in June 2024.[811] The Act was adopted following a recommendation from the NSW Joint Select Committee on Coercive Control ("the Committee") that a criminal offence of coercive control should be created.[812]

[19.159] The Committee considered the relationships that should be included in the offence. It noted that the provisions of the Crimes (Domestic and Personal Violence) Act 2007 ("the CDPV Act") – which includes provisions on Apprehended Domestic Violence Orders ("ADVOs"), stalking and intimidation –

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[808] Commonwealth of Australia, Attorney-General's Department, *National Principles to Address Coercive Control in Family and Domestic Violence* (2023) at page 11.

[809] Commonwealth of Australia, Attorney-General's Department, *National Principles to Address Coercive Control in Family and Domestic Violence* (2023) at page ii.

[810] Crimes Legislation Amendment (Coercive Control) Act 2022 (NSW) (not yet commenced).

[811] NSW Government, Communities and Justice, Criminalising coercive control in NSW < https://www.dcj.nsw.gov.au/children-and-families/family-domestic-and-sexual-violence/police--legal-help-and-the-law/criminalising-coercive-control-in-nsw.html#:~:text=NSW%20Government%20actions%20on%20coercive%20control,-New%20law%20passed&text=The%20Act%20makes%20coercive%20control,(the%20coercive%20control%20offence)> accessed 9 April 2024.

[812] Joint Select Committee on Coercive Control (NSW), *Coercive control in domestic relationships* (2021), see recommendation 1.

applies to all "domestic relationships".[813] Domestic relationships under that Act are defined broadly to include partners, ex-partners, people living in the same household, relatives, and Indigenous kinship connections.[814] The Committee receives views from many stakeholders, some of whom were in favour of the offence applying more broadly to all domestic relationships, as is the case under the CDPV Act. Others felt it should be restricted to current or former intimate relationships to avoid over-criminalisation.[815] In particular, the NSW Ageing and Disability Commission noted:

> [I]t should not be that if you are subject to coercive control by an intimate partner ... that is recognised as being an offence and you have access to protections. But if you are subject to those exact same behaviours in your home by a family member or other party, you do not.[816]

[19.160] The Crimes Legislation Amendment (Coercive Control) Act 2022 will, if commenced, amend the Crimes Act 1900 to provide for an offence of abusive behaviour towards current or former intimate partners.[817] Intimate partner is defined as (1) two people who are, or have been married, or who are or have been de facto partners, or (2) two people who have an intimate personal relationship, "whether or not the intimate relationships involves or has involved a relationship of a sexual nature".[818]

[19.161] If commenced, the Act will also amend the CPVD Act, to insert section 6A to detail the meaning of "domestic abuse". The Act allows the courts to make a wide range of orders to protect people in domestic and personal relationships. It will amend section 11(c) of the CDPV Act to provide that a domestic violence offence includes an offence in which the conduct that constitutes the offence is

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[813] Joint Select Committee on Coercive Control (NSW), *Coercive control in domestic relationships* (2021) at page 95.

[814] Section 5 of the Crimes (Domestic and Personal Violence) Act 2007 (NSW).

[815] Joint Select Committee on Coercive Control (NSW), *Coercive control in domestic relationships* (2021) at pages 95 and 96. Some of those who were in favour of limiting it to intimate relationships maintained that the law should recognise how third parties like children and pets can often be used as "weapons" to coerce and control victims.

[816] Joint Select Committee on Coercive Control (NSW), Coercive control in domestic relationships (2021), at page 96.

[817] Schedule 1 of the Crimes Legislation Amendment (Coercive Control) Act 2022 (NSW) (not yet commenced) will insert section 54D into the Crimes Act 1990 (NSW).

[818] Schedule 1 of the Crimes Legislation Amendment (Coercive Control) Act 2022 (NSW) (not yet commenced) will insert section 54C into the Crimes Act 1990 (NSW) which deals with definitions. A de facto relationship is defined under the section 21C of the Interpretation Act 1987 (NSW) as meaning two people who are in a relationship as a couple living together and are not married or related by family. Such a relationship can exist even if one person is legally married or in a registered partnership with someone else.

domestic abuse.[819] Domestic abuse will apply to domestic relationships, which are defined more broadly under the 2007 Act, as described above in para 20.159, to include, for example, people living in the same household and family. It includes behaviour that coerces or controls a person with whom the perpetrator is in a domestic relationship. Section 6A outlines a broad list of behaviours that could be considered to constitute domestic abuse, including many that could be said to involve coercive control, such as behaviour that shames, degrades or humiliates, and behaviour that isolates a person and prevents the person from maintaining connections with family, friends, or culture.[820]

(vii) South Australia (Australia)

[19.162] At present, coercive control is not a standalone offence in South Australia, but the Government intends to introduce an offence shortly. The government drafted the Criminal Law Consolidation (Coercive Control) Amendment Bill 2023, which creates a new criminal offence of coercive control, and is currently seeking feedback on the text.[821] If enacted, the Bill would amend the Criminal Law Consolidation Act 1935 to insert a new section 20A outlining the coercive control offence.

[19.163] The Bill envisions that it would be an offence for a person to engage in a course of conduct "that consists of behaviour that has a controlling impact on another person" where the person is or was in a relationship with the other person.[822] Two people are in a relationship with one another if they are married, domestic partners or are in some other form of intimate personal relationship in which their lives are interrelated and the actions of one affects the other".[823] It appears that the focus of the offence of the Bill is coercive control against spouses, domestic partners or intimate partners. The government noted that it is taking this approach "to focus on the area of highest risk", as coercive control in relationships is a risk factor for intimate partner homicide.[824]

[819] Schedule 2 of the Crimes Legislation Amendment (Coercive Control) Act 2022 (NSW) (not yet commenced).

[820] Schedule 2 of the Crime Legislation Amendment (Coercive Control) Act 2022 (SA).

[821] Government of South Australia, Coercive control in South Australia <https://www.agd.sa.gov.au/law-and-justice/legislation/coercive-control-in-south-australia> accessed 9 April 2024.

[822] Section 3 of the Criminal Law Consolidation (Coercive Control) Amendment Bill 2023 (SA).

[823] Section 3 of the Criminal Law Consolidation (Coercive Control) Amendment Bill 2023 (SA).

[824] Government of South Australia, *Criminalising Coercive Control – Community Guide* (2023) at page 5.

(viii) Queensland (Australia)

[19.164] Queensland recently introduced draft legislation to create a stand-alone criminal offence of coercive control.[825] The draft bill proposes to amend the criminal code to insert an offence of coercive control.[826] The proposed offence would apply if the person is in a domestic relationship with another person, and engages in a course of conduct against that person that consists of domestic violence on more than one occasion and they intend for that course of conduct to coerce or control the other person.[827] A domestic relationship means a relevant relationship under section 13 of the Domestic and Family Violence Protection Act 2012 and includes an intimate personal relationship,[828] a family relationship,[829] or an informal care relationship.[830]

(ix) Tasmania (Australia)

[19.165] Tasmania was one of the first Australian states to make coercive controlling behaviours an offence. Under the Family Violence Act 2004, family violence is an offence where specific types of conduct are committed directly or indirectly against a person's spouse or partner.[831] It is defined as including threats, coercion, intimidation or verbal abuse.[832] Section 170A of the Criminal Code Act 1924 provides that a person is guilty of a crime where they commit persistent

[825] Criminal Law (Coercive Control and Affirmative Consent) and Other Legislation Amendment Bill 2023 (Qld). It was introduced into parliament on the 11 October 2023.

[826] Criminal Code Act 1899 (Qld).

[827] Section 20 of the Criminal Law (Coercive Control and Affirmative Consent) and Other Legislation Amendment Bill 2023 (Qld).

[828] An intimate personal relationship is defined in section 14 of the Domestic and Family Violence Protection Act 2012 (Qld) as a spousal, engagement or couple relationship.

[829] A family relationship is defined in section 19(1) of the Domestic and Family Violence Protection Act 2012 (Qld) as meaning the relative of a person, who is ordinarily understood to be or have been connected to the person by blood or marriage. It can also include a person who is regarded as a relative where it may be the case that the community of people have a wider concept of a relative, for example, Aboriginal people.

[830] Section 13 of the Domestic and Family Violence Protection Act 2012 (Qld). An informal care relationship is defined under the aforementioned Act as a relationship between 2 persons where one of them is or was dependent on the other person for help in an activity of daily living. The Act gives examples such as helping someone dress or with person grooming and preparing their meals or assisting them with eating meals. An informal care arrangement cannot exist between a child and a parent of a child, or where the carer is helping the person under a commercial arrangement. See section 20 of the Domestic and Family Violence Protection Act 2012 (Qld).

[831] Section 7 of the Family Violence Act 2004 (Tasmania). A family relationship is defined in section 4 of the Act as meaning a marriage or significant relationship within the meaning of the Relationships Act 2003 and includes a relationship where one or both of the parties is between the ages of 16 and 18 and would otherwise be a significant relationship within the meaning of the Act.

[832] Section 7 of the Family Violence Act 2004 (Tasmania).

family violence in relation to another person with whom they are in a family relationship, as defined under the Family Violence Act 2004.[833] "Family relationship" means a marriage or a significant relationship within the meaning of the Relationships Act 2003.[834] A "significant relationship" is defined as "a relationship between two adult persons –

(a) who have a relationship as a couple; and
(b) who are not married to one another or related by family."[835]

[19.166] The application of the relevant offence is therefore restricted to marital and intimate relationships.

(c) Reform proposals

[19.167] The Commission is persuaded by the arguments put forward by consultees and by commentators generally that the existing offence of coercive control is unduly narrow and limited, when viewed from an adult safeguarding perspective. The existing offence of coercive control in the Domestic Violence Act 2018 only applies where the two people are spouses, civil partners, or previously were in an intimate relationship with one another.[836]

[19.168] The Commission is of the opinion that at-risk adults are also exposed to risk of coercive control given how dependent they may be on family members, and those who care for them. It is not uncommon to hear about at-risk adults being isolated from their support networks, deprived of basic needs, coerced, humiliated, controlled or threatened. Coercive behaviour that is encompassed by the coercive control offence applicable to spouses, civil partners and intimate partners, can be used by those in close contact with at-risk adults and have a serious effect on the victim, in much the same way as it does in intimate relationships.[837]

[19.169] Amendments to the offence in the Domestic Violence Act 2018 to extend its remit to a broader category of familial, caring and cohabiting relationships is beyond the scope of this project as it would have a broader reach beyond the adult safeguarding context. The existing offence applies more broadly than to the coercive control of at-risk adults; it captures the coercive control of all

[833] Section 170A(2) of the Criminal Code Act 1924 (Tasmania).

[834] Section 4 of the Family Violence Act 2004 (Tasmania).

[835] Section 4 of the Relationships Act 2003 (Tasmania).

[836] Section 39(4) of the Domestic Violence Act 2018.

[837] Under section 39(2) of the Domestic Violence Act 2018, coercive behaviour is considered to have a serious effect on another person if the behaviour causes them (a) to fear that violence will be used against him or her, or (b) serious alarm or distress that has a substantial adverse impact on their usual day to day activities.

persons who are in an applicable relationship with the perpetrator. For that reason, the Commission believes that recommending the extension of the applicability of the existing offence would be outside of the scope of this project although there may be merit to amending the existing coercive control offence to benefit a wider section of society. The Government may wish to give consideration to the practicalities and consequences of such an expansion.

[19.170] The Commission recommends that a new offence of coercive control of a relevant person is introduced in the Criminal Law (Adult Safeguarding) Bill 2024, which would apply to a broader range of relationships than the offence in section 39 of the Domestic Violence Act 2018. It recommends that the new coercive control offence should apply to coercive control by all persons in a familial, caring or cohabiting relationship with a relevant person whether or not cohabitation is on a contractual or a non-contractual basis or care is being provided on a paid or unpaid basis. This would cover live-in carers as well as lodgers who may not be related to the relevant person.

[19.171] In England and Wales, section 68 of the Domestic Violence Act 2021 amends section 76 of the Serious Crimes Act 2015 (that contains an offence of controlling or coercive behaviour in an intimate or family relationships) to make it apply to intimate and family relationships. Section 76(6) of the Serious Crimes Act 2015 lists the relationships where a person can be considered "personally connected" to another for the purposes of the offence of controlling or coercive behaviour.[838] The Commission largely recommends adopting the same approach in its proposed offence of coercive control for the purposes of the Criminal Law (Adult Safeguarding) Bill 2024, with the addition of:

- they reside in the same household on a contractual, or non-contractual basis;
- the person provides care to the relevant person on a paid, or unpaid, basis.

[19.172] The Commission considers that the offence of coercive control should be modelled on the offence in section 39 of the Domestic Violence Act 2018. This will ensure that there are not too many differences between the two offences which are trying to criminalise the same behaviour, albeit in different types of relationships.

[838] Section 76(6) of the Serious Crimes Act 2015 (England and Wales).

R. 19.4 **The Commission recommends that** a new offence of coercive control of a relevant person should be enacted in the Criminal Law (Adult Safeguarding) Bill 2024, which would apply to a broader range of relationships than the offence in section 39 of the Domestic Violence Act 2018.

R. 19.5 **The Commission recommends that** the new offence of coercive control in the Criminal Law (Adult Safeguarding) Bill 2024 should apply to all persons in a familial, caring or cohabitating relationship with a relevant person.

6. Coercive exploitation

(a) Exploitation of at-risk adults

[19.173] The Commission considered whether or not there is a need for an additional offence of coercive exploitation to capture behaviour that does not fall within the scope of the coercive control offence and is not caught by existing offences of coercion, making a gain or causing a loss by deception, or theft. Currently, Ireland does not have an offence of coercive exploitation of at-risk adults, as exists in some other jurisdictions. At-risk adults may be targeted and taken advantage of due to their perceived "vulnerability", dependency on others and social isolation.[839] Opportunists may engage in a pattern of behaviour, that is not violent, threatening, intimidating or deceptive, but nevertheless is morally reprehensible and manipulative to such an extent that it should be criminalised. Below, the Commission sets out case studies to demonstrate the gap that it thinks an offence of coercive exploitation of a relevant person could fill.

[19.174] Financial exploitation and behaviour such as "cuckooing",[840] or "mate crimes"[841] are particular adult safeguarding issues that have been frequently reported in

[839] MacDonald, Donovan, Clayton and Husband, "Becoming cuckooed: conceptualising the relationship between disability, home takeovers and criminal exploitation" (2022) Disability & Society 1.

[840] Søgaard, Højlund Bræmer and Mulbjerg Pedersen, *Technical Report - Exploring drug supply, associated violence and exploitation of vulnerable groups in Denmark* (European Monitoring Centre for Drugs and Drug Addiction 2021); Mac Donald, Donovan, Clayton, Husband, "Becoming cuckooed: conceptualising the relationship between disability, home takeovers and criminal exploitation" [2022] Disability and Society 1; Harding, "Cuckooing and Nuanced Dealing Relationships" in County Lines: Exploitation and Drug Dealing among Street Gangs (Policy Press 2020) at pages 179 to 222.

[841] MacDonald, Donovan, Clayton and Husband, "Becoming cuckooed: conceptualising the relationship between disability, home takeovers and criminal exploitation" (2022) Disability & Society 1; Foster and Pearson, "'Bullies Tend to be Obvious': Autistic Adults' Perceptions of Friendship and the Concept of Mate Crime" (2020) 35(7) Disability and Society 1103; Doherty, "Prejudice, friendship and the abuse of disabled people: an exploration into the concept of exploitative familiarity ('mate crime')" (2019) 35(9) Disability & Society 1457; Landman, "'A counterfeit friendship": Mate crime and people with learning disabilities" (2014) 16(6) The Journal of Adult Protection 355.

recent years.[842] An example of a mate crime is where a person befriends an at-risk adult and once they gain the trust of the at-risk adult, begins using their residence to engage in anti-social or criminal behaviour, or asks for a loan of some of their social welfare allowance on the day it gets paid, and never gives it back. Often, the at-risk adult may not realise they are being exploited by the perpetrators, as they see the person as a friend or potential intimate partner.[843]

[19.175] It is important to note that at-risk adults have the right to make friends who others may consider are not suitable for them. They also have the right to spend time with whoever they want, in their house, or elsewhere. They can decide to help their friends and make decisions that others may consider "unwise". This is something that will have to be borne in mind by any authorities who are considering whether an at-risk adult is being, or has been, exploited. In a recent Safeguarding Adult Review in England, it was determined that an at-risk adult was not protected from the risk of abuse, and that issues of self-neglect and the person's capacity to make unwise decisions "clouded agencies' judgment to assess the risk of cuckooing under the appropriate process" which should have

[842] The concept of cuckooing is discussed in Chapter 14, cuckooing involves the hostile takeover of a home, whereby a person may be targeted by virtue of their age or disability or other personal characteristic and pressured into allowing another person to use of their home to carry out illegal activities. See Spicer, Moyle and Coomber, "The variable and evolving nature of 'cuckooing' as a form of criminal exploitation in street level drug markets" (2020) 23 Trends in Organised Crime 301; O'Brien, "Two arrested as part of investigation into man's death in Dublin flat used for drug taking" *The Irish Times* (24 January 2024) https://www.irishtimes.com/crime-law/2024/01/24/two-arrested-as-part-of-investigation-into-mans-death-in-dublin-flat-used-for-drug-taking/ accessed 9 April 2024; Holland, "Man fatally stabbed in Dublin apartment taken over by 'cuckooing' drug users, neighbours say" *The Irish Times* (8 November 2022) < https://www.irishtimes.com/crime-law/2022/11/08/ballyfermot-apartment-stabbing-latest/> accessed 9 April 2024; Power, "Concern over increasing prevalence of drug-related 'cuckooing'" *The Irish Times* (9 November 2022) < https://www.irishtimes.com/ireland/housing-planning/2022/11/09/concern-over-increasing-prevalence-of-drug-related-cuckooing/> accessed 9 April 2024; O'Keefe, "Council secures return of 19 homes subject to 'hostile takeovers' by gangs" *The Irish Examiner* (17 April 2021) < https://www.irishexaminer.com/news/courtandcrime/arid-40267757.html> accessed 9 April 2024; Windle and Sweeney, "How out-of-town drug dealers are exploiting vulnerable people in Ireland" *RTÉ* (15 January 2020) < https://www.rte.ie/brainstorm/2020/0107/1104781-how-out-of-town-drug-dealers-exploit-vulnerable-people-in-ireland/> accessed 9 April 2024. For articles on financial abuse or exploitation, see for example, Boyle, "What is financial abuse" *RTÉ* (2 June 2023) < https://www.rte.ie/brainstorm/2023/0602/1386945-financial-abuse-coercive-control-relationships/> accessed 9 April 2024; Connelly, "Banking staff trained to spot signs of financial abuse" *RTÉ* (4 February 2022)< https://www.rte.ie/news/business/2022/0204/1277688-abuse-banks/> accessed 9 April 2024 and Murphy, "Elderly man had €100,000 taken from his bank account" *The Irish Examiner* (14 May 2019) < https://www.irishexaminer.com/news/arid-30924061.html> accessed 9 April 2024.

[843] Mac Donald, Donovan, Clayton, Husband, "Becoming cuckooed: conceptualising the relationship between disability, home takeovers and criminal exploitation" [2022] Disability and Society 1 at pages 3 to 4.

been to launch a safeguarding enquiry.[844] A briefing on exploitation in Nottinghamshire discussed barriers to safeguarding interventions. It noted that:

> A significant aspect of professionals' inability to intervene was because of the affected individual's capacity to consent. In cases where people did not recognise the exploitation and asserted that their perpetrators were their friends, and they had capacity to consent, professionals could be powerless to act.[845]

[19.176] The briefing report also noted that "tensions were raised between professionals wanting to safeguard potential victims and intervene to end the exploitation, but also acknowledging that such intervention can be harmful to individuals in terms of restricting their liberty and independence".[846] It also considers that many at-risk adults experiencing exploitation do not acknowledge or accept that they were being "groomed or victimised". It stated that:

> people affected by exploitation often saw their perpetrators as their friends – largely because of their desire for social interaction – and even when the relationship was exploitative or inappropriate, it was an improvement on their previous feelings of isolation and loneliness.[847]

[19.177] In an article on autistic adults' perceptions of friendship and the concept of 'mate crime', Forster and Pearson note that it is "essential that we understand the 'mate' aspect of mate crime".[848] The article presents research on the lived

[844] Safeguarding Adults Board Leicestershire & Rutland, *Safeguarding Adults Review (SAR) Executive Summary on the death of Person D* (March 2022) <https://nationalnetwork.org.uk/2022/LRSAB%20Person%20D%20SAR%202022.pdf> accessed 9 April 2024.

[845] University of Nottingham Rights Lab, The intersection between cognitive impairments and exploitation in Nottingham at page 4 <https://www.nottingham.ac.uk/research/beacons-of-excellence/rights-lab/resources/reports-and-briefings/2022/march/briefing-on-the-intersection-between-cognitive-impairments-and-exploitation-in-nottingham.pdf> accessed 9 April 2024.

[846] University of Nottingham Rights Lab, The intersection between cognitive impairments and exploitation in Nottingham at page 4 < https://www.nottingham.ac.uk/research/beacons-of-excellence/rights-lab/resources/reports-and-briefings/2022/march/briefing-on-the-intersection-between-cognitive-impairments-and-exploitation-in-nottingham.pdf> accessed 9 April 2024.

[847] University of Nottingham Rights Lab, The intersection between cognitive impairments and exploitation in Nottingham at page 4< https://www.nottingham.ac.uk/research/beacons-of-excellence/rights-lab/resources/reports-and-briefings/2022/march/briefing-on-the-intersection-between-cognitive-impairments-and-exploitation-in-nottingham.pdf> accessed 9 April 2024.

[848] Forster and Pearson, "'Bullies tend to be obvious': autistic adults perceptions of friendship and the concept of 'mate crime'" (2019) Disability & Society 1103.

experience of autistic adults, their perceptions and experiences of friendship and their awareness of mate crime. The line between typical aspects of friendships and behaviour that signifies the existence of an exploitative relationship is a difficult one to delineate. It requires a full assessment of the circumstances and consideration should always be given to the views of the at-risk adult on the situation.

[19.178] While the method used by the perpetrator may be non-threatening and appear innocent, it can amount to exploitation of at-risk adults who may not be in a position to fully comprehend that they are a victim of a hostile takeover or that they are being taken advantage of. MacDonald and others note that once a person's home is taken over "they can then be trapped in a coercively controlled environment where emotional/ economic abuse and violence can become part of the victim's/ survivor's daily routine".[849] Social isolation and loneliness can often be a factor in at-risk adults being targeted in these cuckooing scenarios by local people who are aware that they live alone or lack support networks and seek to exploit their perceived "vulnerabilities" by offering friendship with the intention of exploiting the person.[850] Research on cognitive impairment and exploitation in Nottinghamshire found that people who were exploited experienced shame and social stigma, and that people who realised they were being exploited sometimes failed to engage with services because they were fearful of the potential for further abuse should their perpetrators find out that they had spoken to authority figures.[851] In these situations, the research found that it was easier for them to remain silent about their exploitation and not risk experiencing further harm.[852]

(b) Coercion, deception and theft

[19.179] Section 9 of the Non-Fatal Offences against the Person Act 1997 provides for an offence of coercion. It provides that a person shall be guilty of an offence where

849 Mac Donald, Donovan, Clayton, Husband, "Becoming cuckooed: conceptualising the relationship between disability, home takeovers and criminal exploitation" [2022] Disability and Society 1 at page 4.

850 Mac Donald, Donovan, Clayton, Husband, "Becoming cuckooed: conceptualising the relationship between disability, home takeovers and criminal exploitation" [2022] Disability and Society 1 at pages 12 to 13.

851 University of Nottingham Rights Lab, The intersection between cognitive impairments and exploitation in Nottingham at page 4< https://www.nottingham.ac.uk/research/beacons-of-excellence/rights-lab/resources/reports-and-briefings/2022/march/briefing-on-the-intersection-between-cognitive-impairments-and-exploitation-in-nottingham.pdf> accessed 9 April 2024.

852 University of Nottingham Rights Lab, The intersection between cognitive impairments and exploitation in Nottingham at page 4< https://www.nottingham.ac.uk/research/beacons-of-excellence/rights-lab/resources/reports-and-briefings/2022/march/briefing-on-the-intersection-between-cognitive-impairments-and-exploitation-in-nottingham.pdf> accessed 9 April 2024.

the accused, "with a view to compel another to abstain from doing or to do any act" that the other person has a lawful right to do or not do, wrongfully and without lawful authority—

> (a) uses violence to or intimidates that other person or a member of the family or the civil partner within the meaning of the Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010 of the other, or
> (b) injures or damages the property of that other, or
> (c) persistently follows that other about from place to place, or
> (d) watches or besets the premises or other place where that other resides, works or carries on business, or happens to be, or the approach to such premises or place, or
> (e) follows that other with one or more other persons in a disorderly manner in or through any public place.[853]

[19.180] This offence often will involve the use of violence, intimidation or other menacing actions to coerce someone into doing or not doing an act. This does not cover every situation where it could be said that an at-risk adult is being exploited, as not all situations will involve violence, intimidation or the other actions described above.

[19.181] Section 6 of the Criminal Justice (Theft and Fraud Offences) Act 2001 establishes an offence of making a gain or causing a loss by deception. It provides that:

> A person who dishonestly, with the intention of making a gain for himself or herself or another, or of causing loss to another, by any deception induces another to do or refrain from doing an act is guilty of an offence.[854]

[19.182] While this offence does not require proof of violence, intimidation or other threatening behaviour, it must be shown that the person acted dishonestly and used deception with the intention or making a gain for themselves or another. The Commission considers that some situations where an at-risk adult may be exploited with detrimental consequences would not be captured by this offence either.

[853] Section 9(1) of the Non-Fatal Offences against the Person Act 1997. Subsection (2) provides that a person who attends at or near the premises or place where a person resides, works carries out business or happens to be, or approaches such premises or place, is not considered to be watching or besetting, if they are there merely to obtain or communicate information.

[854] Section 6(1) of the Criminal Justice (Theft and Fraud Offences) Act 2001.

[19.183] Both the coercion offence and the making a gain or causing loss by deception offence are liable on indictment to a fine or imprisonment for a term not exceeding 5 years or both.[855]

[19.184] Section 4 of the Criminal Justice (Theft and Fraud Offences) Act 2001 provides for an offence of theft, where a person "dishonestly appropriates property without the consent of its owner and with the intention of depriving the owner of it".[856] "Appropriates" in relation to property under the Act means to "usurp or adversely interfere with the proprietary rights of the owner of the property".[857] Depriving someone of their property includes temporary and permanent deprivations.[858]

[19.185] A person does not appropriate the property of another without their consent if the person believed they had the owner's consent, or would have the owner's consent if the owner knew of the appropriation and the circumstances in which it was appropriated.[859] A person does not appropriate the property where they believe that the owner cannot be discovered by taking reasonable steps (unless the property came to the person as trustee or personal representative).[860] However, consent obtained by deception or intimidation cannot be considered consent for those purposes.

[19.186] At trial, the court or the jury must consider whether the accused believed (1) that they had acted dishonestly, (2) that the owner of the property consented or would have consented to its appropriation or (3) that the owner could not be discovered by taking reasonable steps.[861] A person found guilty of the offence is liable on indictment to a fine or imprisonment for a term not exceeding 10 years or both.[862]

[19.187] The Commission considers that while the offences outlined above would be applicable in some cases of exploitation involving at-risk adults, there are some situations that fall outside their scope. In some cases, at-risk adults may be targeted and taken advantage of in a manner that cannot be said to be threatening, intimidating or deceptive, or to have involved actual theft of

[855] Section 9(3) of the Non-Fatal Offences against the Person Act 1997 and section 6 of the Criminal Justice (Theft and Fraud Offences) Act 2001.

[856] Section 4(1) of the Criminal Justice (Theft and Fraud Offences) Act 2001. See the exceptions to the theft offence in section 5 of the Criminal Justice (Theft and Fraud Offences) Act 2001.

[857] Section 5(5) of the Criminal Justice (Theft and Fraud Offences) Act 2001.

[858] Section 5(5) of the Criminal Justice (Theft and Fraud Offences) Act 2001.

[859] Section 4(2)(a) of the Criminal Justice (Theft and Fraud Offences) Act 2001.

[860] Section 4(2)(b) of the Criminal Justice (Theft and Fraud Offences) Act 2001.

[861] Section 4(4) of the Criminal Justice (Theft and Fraud Offences) Act 2001.

[862] Section 4(6) of the Criminal Justice (Theft and Fraud Offences) Act 2001.

property. To illustrate the kinds of behaviour the Commission thinks should be captured by a coercive exploitation offence that are not captured by the offences discussed above, the Commission sets out two fictional case studies below.

(c) Case studies

[19.188] The case studies are included below to illustrate the nuances of the type of behaviour the Commission intends to capture with its coercive exploitation offence, outlined in section 6(e).

> **Case study 1:** Joan has a mild intellectual disability and lives in supported housing. She is befriended by Joe, a local taxi driver, who often brings her to her local day service. Joe befriends her over time. He sometimes calls into her for a cup of tea and once brought her a small bunch of flowers from the local garage. After a short time, Joe tells Joan that he is short of money. He begins to call to Joan weekly on the day that she receives her disability benefit, and she gives him €50. As a result, Joan has been struggling to meet her own expenses, but she is worried about losing Joe's friendship if she refuses to give him the money. Joe has told her that he loves her and indicated that he would like to start a romantic relationship when he has resolved his financial issues with Joan's help. Joe is also receiving regular small sums of money from Nuala and Mary who he has befriended in similar ways. Nuala has an acquired brain injury and Mary is a recently widowed older woman. Joe has brought them to and from hospital appointments and bingo respectively in his role as a taxi driver.

[19.189] This case study illustrates the befriending scenario that the Commission thinks should be criminalised. As Joe has a history of befriending or romancing at-risk adults, and only calls to Joan on the day she receives her disability benefit to borrow money, his actions could be said to be devious and conniving. Joe does not use violence, intimidation or deception to convince Joan to give him money. Joan thinks they are friends and potentially that Joe might be romantically interested in her and his use of affectionate behaviour (bringing her flowers and calling in for a cup of tea) means she does not realise she is being taken advantage of. She is scared of losing his friendship and for that reason, she gives him the money. It cannot necessarily be said or proven that Joe deceived Joan into thinking that they are friends. Maybe they are friends, but that does not mean that his actions are not exploitative, particularly given his pattern of befriending at-risk adults and asking them for money.

[19.190] Of course, people regularly lend or give others money for all sorts of reasons, and the Commission does not think that convincing someone to do so should be more broadly criminalised. Moreover, at-risk adults have the right to lend money to their friends, if they so wish, and the boundary between friendship

and exploitative relationships can be difficult to delineate. However, what makes these actions particularly egregious is the fact that they were committed against a relevant person (a specific category of at-risk adults) who may be more readily exploited by others due to difficulties they might have protecting themselves from harm or exploitation. The Commission does not think that the factual scenario in this case study would be captured by any of the existing offences of coercion, making a gain or causing a loss by deception, or theft, but it is equally deserving of condemnation and criminalisation.

Case study 2: Tom has an intellectual disability. He lives independently in local authority housing. He works 2 days per week in a warehouse and attends a day service on the other 3 days. Derek became aware of Tom as Derek's parents live nearby. Derek knows that Tom has an intellectual disability. Derek is a drug user and has been convicted of theft offences having stolen to fund his drug habit. He calls to Tom weekly after Tom has received his disability benefit and been paid by his employer. Derek has told Tom that he is short of money and needs drugs to help with his nerves. Tom gives Derek money, which Derek uses to buy drugs and alcohol for himself. Derek and his friends often spend time at Tom's flat over weekends using drugs and drinking alcohol. Tom is struggling to meet his expenses and does not like the mess that Derek and his friends leave in his flat each weekend. He is also worried about damage that has been done to the flat by Derek's friends. However, he does not have any other friends and is worried about losing Derek's friendship, as Derek has told him that they are best friends. Derek has previously engaged in similar behaviour with John, who has an acquired brain injury. Derek stopped calling to John's house when John's sister took over the management of John's finances after finding out that John's electricity had been cut off due to arrears. The arrears arose as John struggled to pay his bills due to the money that he was giving Derek on a weekly basis.

[19.191] This case study illustrates the cuckooing or mate crime behaviour that the Commission believes should be criminalised. This is a tactic used by drug users and drug dealers to take over the home of at-risk adults and use the property as a base for criminal activity and anti-social behaviour, without due regard to the effect this will have on the at-risk adult.[863] It also demonstrates financial exploitation and how at-risk adults may be deliberately targeted by opportunists for their own personal gain. In this case study, Derek is not using violence, intimidation or deception to convince Tom to give him money, or to let him and his friends use his house, so these actions would not be captured by the existing

[863] Home Office, *Criminal exploitation of children, young people and vulnerable adults – County Lines* (2017) at page 4.

criminal offences detailed above. However, he is engaging in a pattern of behaviour that clearly takes advantage of Tom, who acts to his detriment, as he does not have enough money to cover his own expenses, and does not like the state Derek and his friends leave his house in. There have been many recent examples of this sort of behaviour in this jurisdiction,[864] and in England, there have been calls for "cuckooing" to be made a criminal offence,[865] potentially by extending the application of the Modern Slavery Act 2015.[866]

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[864] O'Brien, "Two arrested as part of investigation into man's death in Dublin flat used for drug taking" *The Irish Times* (24 January 2024) https://www.irishtimes.com/crime-law/2024/01/24/two-arrested-as-part-of-investigation-into-mans-death-in-dublin-flat-used-for-drug-taking/ accessed 9 April 2024; Southern Star, "Judge notes the trend of vulnerable people being targeted for drug storage" *Southern Star* (27 April 2023) < https://www.southernstar.ie/news/judge-notes-the-trend-of-vulnerable-people-being-targeted-for-drug-storage-4261992> accessed 9 April 2024; Power, "Concern over increasing prevalence of drug-related 'cuckooing' *The Irish Times* (9 November 2022) < https://www.irishtimes.com/ireland/housing-planning/2022/11/09/concern-over-increasing-prevalence-of-drug-related-cuckooing/> accessed 9 April 2024; Heylin, "Dealers forced vulnerable Corkman to hold drugs by taking his Pokemon cards" *The Irish Examiner* (26 October 2023) <https://www.irishexaminer.com/news/courtandcrime/arid-41256436.html> accessed 9 April 2024.

[865] Coyle, "'Cuckooing': Calls for government to introduce new criminal offence" *BBC* (1 February 2024) < https://www.bbc.com/news/uk-england-leeds-68158124> accessed 9 April 2024 and the Centre for Social Justice and Justice Care, Cuckooing – *The case for strengthening the law against slavery in the home* (2021) < https://www.centreforsocialjustice.org.uk/wp-content/uploads/2021/11/CSJ-Report-Cuckooing.pdf> accessed 9 April 2024. See also: London Assembly Labour, Protecting the Vulnerable: Addressing "Cuckooing" in London (2023) < https://www.london.gov.uk/sites/default/files/2023-05/Cuckooing%20Report%20Embargoed.pdf> accessed 9 April 2024; University of Leeds, Understanding and preventing 'cuckoo' victimisation < https://essl.leeds.ac.uk/law-research-centre-criminal-justice-studies/dir-record/research-projects/1221/understanding-and-preventing-cuckoo-victimisation> accessed 9 April 2024; Booth, "Jess Philips and Iain Duncan Smith lead calls to criminalise 'cuckooing'" *The Guardian* (26 February 2023) < https://www.theguardian.com/uk-news/2023/feb/26/jess-phillips-and-iain-duncan-smith-lead-calls-to-criminalise-cuckooing> accessed 9 April 2024; Elgueta, "Cuckooing crimes on rise across London" *BBC* (18 May 2023) https://www.bbc.com/news/uk-england-london-65637307 accessed 9 April 2024; Hassan, "What is cuckooing and why do people want it to be criminalised?" *The Standard* (12 April 2023) < https://www.standard.co.uk/news/uk/what-is-cuckooing-why-criminalise-gangs-criminals-b1063292.html> accessed 9 April 2024; Cotterill, "'I thought they were being kind': 'Cuckooing' victim reveals how drug dealers took over her flat" *Sky News* (3 April 2022) < https://news.sky.com/story/i-thought-they-were-being-kind-cuckooing-victim-reveals-how-drug-dealers-took-over-her-flat-12580191> accessed 9 April 2024; Marsh, "Cuckooing victims: 'They start as friends but end up as bullies" *The Guardian* (18 September 2019) < https://www.theguardian.com/uk-news/2019/sep/18/they-start-as-friends-but-end-as-bullies-the-victims-of-cuckooing> accessed 9 April 2024.

[866] Section 1 of the Modern Slavery Act 2015 criminalises holding another person in slavery or servitude. Section 1(4) provides that in determining whether someone is being held in slavery or servitude, regard must be had to any of the person's circumstances which make them more vulnerable than other persons (including whether there is any mental or physical illness) and to any work or services provided by the person. The Centre for Social Justice reports that the established interpretation of the Crown Prosecution Service is to not charge

(d) Other jurisdictions

[19.192] Not many jurisdictions have criminal offences that specifically target coercive exploitation of at-risk adults such as cuckooing or mate crimes, although depending on the particular factual circumstances, broader criminal offences may be applicable. It is a growing phenomenon in many jurisdictions and therefore may result in more legislative interventions in the future to criminalise such behaviour.

[19.193] Many states in America have legislation that may be used to criminalise this behaviour, and the Commission considered these legislative provisions when considering whether or not to recommend the introduction of a coercive exploitation offence in this jurisdiction. The Commission considered in particular

someone under section 1 of the Act where there is "mere occupation", whereas the Centre for Social Justice considered that the use of the premises should be considered a benefit in kind that should fall into provision of services., see Centre for Social Justice and Justice Care, *Cuckooing – The case for strengthening the law against slavery in the home* (2021) at pages 4 to 5 < https://www.centreforsocialjustice.org.uk/wp-content/uploads/2021/11/CSJ-Report-Cuckooing.pdf> accessed 9 April 2024.

offences in Alabama,[867] Arkansas,[868] Florida,[869] Georgia,[870] Idaho,[871] Indiana,[872] Mississippi,[873] Texas,[874] Virginia,[875] and West Virgina.[876]

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[867] In Alabama, there is an offence of unlawful abuse, neglect, exploitation or emotional abuse of a protected person. Exploitation is defined as "the expenditure, diminution or use of the property, assets, or resources of a protected person without the express voluntary consent" from that person or their authorised representatives. See Code of Alabama, Title 38, Public Welfare, Chapter 9 – Protection of Aged Adults or Adults with a Disability.

[868] In Arkansas, there is an offence of exploitation of an endangered person or impaired person by any person or caregiver. See Arkansas Code – Title 5 – Criminal Offences, Subtitle 3 – Offences Involving Family Dependents, etc, Chapter 28 – Abuse of Adults.

[869] In Florida, there is an offence of exploitation of an elderly person or disabled adult. It is committed where a person who knows or reasonably should know that the person is an elderly person or disabled person "knowingly" obtains the use of funds, assets or property, or attempts to obtain the use of such things, with the intent to temporarily or permanently deprive the person of the use of it or to benefit someone else, or conspiring to do any of these things. See Florida Statutes, Title XLVI – Crimes Chapter 825 – Abuse, Neglect and Financial Exploitation of Elderly Persons and Disabled Adults.

[870] In Georgia, there are various offences including exploitation, unreasonable confinement and deprivation of essential services. Exploitation involves illegally or improperly using a disabled adult or elder person or their resources through, among other things, abuse of access for one's own or another's profit or advantage. See Georgia Code, Title 16 – Crimes and Offences, Chapter 5 – Crimes Against the Person – Art – Protection of Elder Persons.

[871] In Idaho, there is an offence of exploitation which may involve the "unjust or improper use of a vulnerable adult's financial power of attorney, funds, property or resources" by a person for their profit or advantage. See Idaho Statutes, Title 18 – Crimes and Punishment – Chapter 15 – Children and Vulnerable Adults.

[872] In Indiana, there is an offence of exploitation of a dependant or endangered adult which is committed where a person "recklessly uses or exerts control over the personal services or the property" of a dependent or endangered adult for their own profit or advantage, or that of another. See Indiana Code – Title 35 – Criminal Law and Procedure – Article 46 – Miscellaneous Offences – Chapter 1 – Offences Against the Family.

[873] In Mississippi, it is unlawful to exploit any "vulnerable person" as defined. Exploitation is defined as the "illegal or improper use of a vulnerable person or his resources" for another's profit, advantage or unjust enrichment with or without the consent of the vulnerable person. It may only be one incident. See Mississippi Code, Title 43 – Public Welfare – Chapter 47 – Mississippi – Vulnerable Persons Act.

[874] In Texas, there is an offence of exploitation of a child, elderly individual or disabled individual. It is committed where a person knowingly or recklessly causes exploitation, which is defined as the "illegal or improper use of [the person] or of their resources for monetary or personal benefit, profit or gain". There is also an offence of financial abuse of elderly individuals – which includes financial exploitation. See Texas Statutes, Penal Code, Title 7 – Offences Against Property, Chapter 32 – Fraud, Other Deceptive Practices.

[875] In Virgina, there is an offence of larceny or financial exploitation, where a person who knows or should know that someone is a vulnerable adult, takes, obtains, or converts money or other things of value belonging to that person, with the intent to permanently deprive them of it, through the use of the person's impairment. See Code of Virginia, Title 18.2 – Crimes and Offences Generally, Chapter 6 – Crimes involving Fraud.

[876] In West Virgina, there is an offence of financial exploitation of elderly persons or protected persons. It is defined as the "intentional misappropriation or misuse of funds or assets" of the person. It does not apply where the accused made a "good faith effort" to assist the

[19.194] The Commission also considered the offence of financial exploitation of an older individual in Iowa.[877] There, it is an offence to knowingly and by undue influence obtain control over or use the "benefits, property, resources, belongings, or assets" of an older person to their detriment. There is an expansive definition of "undue influence" which is defined as meaning the "excessive persuasion" by a person that causes the older individual to "act or refrain from acting by overcoming [their] free will and results in inequity". In determining whether a result was produced by undue influence, the following elements should be considered:

- the "vulnerability" of the older individual, including their isolation or dependency, and the level of knowledge the perpetrator has of their vulnerability;
- the perpetrator's apparent authority including their status as a family member, or care provider, for example;
- equity of result, including, for example, the economic consequences for the older person, any divergence from their prior intent.

[19.195] The perpetrator's actions or tactics should also be considered, which includes but is not limited to:

(a) controlling necessaries of life, medication, the older individual's interactions with others, access to information, or sleep;
(b) use of affection, intimidation, or coercion;
(c) initiation of changes in personal or property rights, use of haste or secrecy in effecting those changes, effecting changes at inappropriate times and places, and claims of expertise in effecting changes.

[19.196] The Commission considers that the Iowa offence of financial exploitation is helpful in considering how to formulate a coercive exploitation offence in this jurisdiction, particularly in regard to what actions or tactics a perpetrator might take to exploit an at-risk adult.

(e) Reform proposals

[19.197] Coercive exploitation in the adult safeguarding context would not be fully addressed by the introduction of a new offence of coercive control, as the behaviour must have a serious effect on the person, which means they must fear

person with the management of their finances or property. See West Virgina Code, Chapter 61 – Crimes and Their Punishment, Art 2 – Crimes Against the Person.

[877] Iowa Code, Title XVI – Criminal Law and Procedure, Subtitle 1 – Crime Control and Criminal Acts, Chapter 726 – Protection of Family and Dependent Persons. An older individual is defined as someone who is 60 years of age or older.

that violence will be used against them, or they must experience serious alarm or distress that has a substantial impact of their day-to-day activities. This will not always be the case where at-risk adults are being exploited, in some cases they may be friends with the person who is exploiting them and fail to realise that they are being taken advantage of. In addition, the coercive control offence applies only to a limited number of relationships where it must be shown that the perpetrator and the relevant person are "personally connected".

[19.198] As discussed in section 6(a) of this Chapter, cuckooing and mate crime behaviours are frequently reported in this jurisdiction and are being perpetrated against at-risk adults in our communities. While there are existing offences of coercion, theft and making a gain or causing a loss by deception in this jurisdiction, the Commission does not consider that these offences will address all cases where an at-risk adult is being exploited by another, particularly if it cannot be proven that the perpetrator used violence, intimidation or deception to exploit the at-risk adult, or where the at-risk adult ostensibly consents to giving the perpetrator what they are looking for, meaning the *actus reus* for theft cannot be established. In light of the rising number of instances of cuckooing in this jurisdiction, and the detrimental impact this behaviour can have on at-risk adults, the Commission takes the view that a new offence of coercive exploitation of a relevant person, should be included in its Criminal Law (Adult Safeguarding) Bill 2024. Cuckooing and mate crimes pose serious risks to at-risk adults – their health, safety and welfare can be jeopardised by exposure to criminal activity and anti-social behaviour, and where financial exploitation occurs, they may not be able to meet their own expenses as a result of funding others. Additionally, they may encounter problems with the Garda Síochána or the local authority where they are living in social housing if neighbours report anti-social or criminal behaviour in their residence, which could result in criminal charges being brought against them, or their eviction.[878] There is a real risk that without adequate criminalisation, those who intentionally target and take advantage of people who they know are at-risk adults will continue to do so with impunity.

[19.199] Accordingly, the Commission recommends that an offence of coercive exploitation of a relevant person should be enacted in the Criminal Law (Adult Safeguarding) Bill 2024. The coercive exploitation offence should criminalises a person who, without reasonable excuse, engages in controlling or coercive behaviour in relation to a relevant person for the purpose of obtaining or exercising control over any of the property (whether real or personal) or

[878] For example, see London Borough of Camden Safeguarding Adults Partnership Board, *Safeguarding Adult Review Matthew 2023* (2023) <https://www.camden.gov.uk/documents/20142/25239158/Camden+SAR+Matthew+Final+Report+April+2023.pdf/3877de70-00f6-be85-87e5-70fb32245513?t=1686312958207> accessed 9 April 2024.

financial resources of that relevant person in order to gain a benefit or advantage, whether for themselves, or for a third party. For the purposes of the offence, it is irrelevant whether there was any actual gain, benefit or advantage, and it will not be a defence to prove the acquiring of consent of or acquiescence by the relevant person.

[19.200] For the purposes of this offence, the Commission recommends that benefit or advantage be defined to include any form of financial benefit or advantage, including:

(a) the taking, withholding, appropriation, or use of money or assets owned by a relevant person;
(b) the taking, withholding, appropriation, or use of property owned or occupied by a relevant person, including occupying or making use of any property owned or occupied by a relevant person, or any part of such property, or otherwise interfering with the relevant person's enjoyment of such property;
(c) the taking, withholding, appropriation or use of any benefits payable to a relevant person.

[19.201] This is a non-exhaustive list of advantages, and the Commission recommends that any one of them or a combination of them can form the basis for the offence.

[19.202] The introduction of such an offence will make it clear that coercive exploitation is a serious safeguarding concern and a criminal offence with significant penalties. Efforts should be made to increase the public awareness of this criminal behaviour so that instances of cuckooing and other similar tactical and sinister befriending and exploitative behaviours can be detected in the community, and dealt with swiftly so that the perpetrator does not go on to exploit other victims. The Commission hopes that the safeguarding measures it proposes in its proposed regulatory framework for adult safeguarding will mean that instances of coercive exploitation of a particular at-risk adult will be reported to the Garda Síochána and the Safeguarding Body and come to the attention of other agencies and organisations tasked with safeguarding at-risk adults, and they will be able to take action accordingly to protect the victim. While they can put measures in place to safeguard the particular victim, their ability to stop the perpetrator from going on to exploit other at-risk adults in the same way is limited. The Commission considers that criminalising this behaviour reduces the likelihood that the perpetrator will be able to take advantage of multiple at-risk adults with impunity. The Commission believes that its proposed offence of coercive exploitation of at-risk adults achieves that aim.

[19.203] Often, where an at-risk adult is being exploited, the behaviour escalates over time. It is rarely a once-off incident, but rather the exploitation develops as a

result of the increasing familiarity between the perpetrator and the at-risk adult.[879] However, it may not always be the case that a pattern of exploitative behaviour can be established – whether that is repeated instances of the perpetrator taking advantage of a particular at-risk adult, or whether it can be shown that the perpetrator has behaved in the same way with multiple at-risk adults. It is for the Garda Síochána to investigate whether the facts of a particular case meet the criteria for the coercive exploitation offence, and for the Director of Public Prosecutions to determine whether the facts meet the threshold for prosecution. The Commission considers that is highly unlikely that prosecutions will be brought for minor instances of exploitative behaviour between friends.

[19.204] In formulating the offence, the Commission found the Iowa offence of financial exploitation particularly useful, which is discussed earlier in this section. The Commission recommends that the legislation should specify a non-exhaustive list of behaviours that can be considered to be "controlling or coercive behaviour", while leaving open the possibility that other actions may fall within the scope of the offence. This non-exhaustive list should include:

(a) controlling the relevant person's necessaries of life, medication, interactions with others, access to information, or sleep;
(b) use of violence, intimidation or threats, whether directed against a relevant person or any family member of a relevant person;
(c) exercising undue influence over a relevant person; and
(d) making, or threatening to make, changes to the personal or property rights of a relevant person.

[19.205] Undue influence involves a person exploiting a position of power in relation to a relevant person so as to cause that relevant person to act, or to refrain from acting, in a manner detrimental to their own best interests and which confers, or is intended to confer, a benefit or advantage themselves or a third party. A number of examples of the type of benefit or advantage that can be gained are suggested but again, this is a non-exhaustive list.

[879] Landman, "'A counterfeit friendship": Mate crime and people with learning disabilities" (2014) 16(6) The Journal of Adult Protection 355 at page 356.

R. 19.6 **The Commission recommends that** an offence of coercive exploitation of a relevant person should be enacted in the Criminal Law (Adult Safeguarding) Bill 2024.

R. 19.7 **The Commission recommends that** the offence of coercive exploitation should criminalise the actions of a person who, without reasonable excuse, engages in controlling or coercive behaviour in relation to a relevant person for the purpose of obtaining or exercising control over any of the property (whether real or personal) or financial resources of that relevant person in order to gain a benefit or advantage, whether for themselves, or for any third party.

R. 19.8 **The Commission recommends that** for the purposes of the coercive exploitation offence, it is irrelevant whether there was any actual gain, benefit or advantage, and it will not be a defence to prove the acquiring of consent of or acquiescence by the relevant person.

R. 19.9 **The Commission recommends that** the legislation should specify a non-exhaustive list of behaviours that can be considered to be "controlling or coercive behaviour", while leaving open the possibility that other actions may fall within the scope of the offence. This non-exhaustive list should include:

(a) controlling the relevant person's necessaries of life, medication, interactions with others, access to information, or sleep;

(b) use of violence, intimidation or threats, whether directed against a relevant person or any family member of a relevant person;

(c) exercising undue influence over a relevant person; or

(d) making, or threatening to make, changes to the personal or property rights of a relevant person.

R. 19.10 **The Commission recommends that** the definition of benefit or advantage should include, but not be limited to, any form of financial benefit or advantage, including one, or more, of the following:

(a) the taking, withholding, appropriation, or use of money or assets owned by a relevant person;

(b) the taking, withholding, appropriation, or use of property owned or occupied by a relevant person, including occupying or making use of any property owned or occupied by a relevant person, or any part of such property, or otherwise interfering with the relevant person's enjoyment of such property;

(c) the taking, withholding, appropriation or use of any benefits payable to a relevant person.

R. 19.11 **The Commission recommends that** the proposed offence should specify that undue influence involves a person exploiting a position of power in relation to a relevant person so as to cause that relevant person to act, or to refrain from acting, in a manner detrimental to their own best interests and which confers, or is intended to confer, a benefit or advantage on themselves or a third party.

7. Penalties and ancillary orders and provisions

(a) Penalties

[19.206] The Commission's Criminal Law (Adult Safeguarding) Bill 2024 sets out the penalties that should apply where each criminal offence is committed, and it is not proposed to go into detail on the penalties prescribed in this Chapter or in the Report. It is worth noting that in setting the penalties for the criminal offences, where there is an equivalent offence in respect of children, the Commission had regard to the penalties for such offences. In addition, in setting the fine for conviction on indictment, the Commission discussed how the offences in the Criminal Law (Adult Safeguarding) Bill 2024 apply to natural persons as well as bodies corporate and unincorporated bodies who are care providers, and how lower level fines would be insufficient to act as a deterrent for large corporate care providers that are increasingly providing care in this jurisdiction.[880] With this in mind, for each of the offences, the Commission determined that the maximum fine should be €1,000,000. The Commission takes the view that setting the maximum fine high illustrates how serious these offences are and gives the judiciary significant discretion to distinguish between natural persons, smaller care providers and large corporate care providers.

(b) Publicity orders

[19.207] As mentioned in section 3(b) of this Chapter, there is a specific care provider offence of ill-treatment or wilful neglect in England and Wales.[881] The Criminal Justice and Courts Act 2015 that contains the offences provides for the making of ancillary orders where a person is convicted of the offence of ill-treatment or wilful neglect.[882] One of these orders is termed a "publicity order", which is an

[880] Economic and Social Research Institute, *Changes and challenges facing the Irish long-term residential sector since COVID-19* (ESRI 2024) < https://www.esri.ie/news/changes-and-challenges-facing-the-irish-long-term-residential-care-sector-since-covid-19> accessed 9 April 2024. This report noted that large nursing home operators are now the dominant providers in long-term residential care.

[881] Section 21 of the Criminal Justice and Courts Act 2015 (England and Wales)

[882] As well as publicity orders, it makes provision for remedial orders in section 23(3) of the Criminal Justice and Courts Act 2015 (England and Wales). These orders require the care provider to take specified steps to remedy the breach, or any matters arising from the breach, or any deficiency in their policies, systems or practices.

order that requires the care provider to publicise in a specified manner the following:

(a) the fact that the person has been convicted of the offence,
(b) specified particulars of the offence,
(c) the amount of any fine imposed,
(d) the terms of any remedial order made.883

[19.208] A publicity order may be made instead of, or in addition to, imposing a fine (which is the penalty on indictment or summary conviction).[884] A publicity order must specify a period within which the publicity requirements specified in the order must be complied with.[885] For example, the order could provide that the care provider must publicise specified information on its website for 2 months. A person who fails to comply with a publicity order commits an offence.[886]

[19.209] The Commission considers that a publicity order is a useful mechanism to ensure that the general public are made aware of convictions secured against care providers for committing offences. Accordingly, it recommends that where a person who is a care provider is found guilty of certain offences under the Criminal Law (Adult Safeguarding) Bill 2024, a court may make a publicity order.

[19.210] The Commission recommends that, in deciding whether to make a publicity order, the court should have regard to the following:

(a) whether the publicity order is in the public interest;
(b) whether the making of the publicity order risks the identification of the victim;
(c) the potential effect of identification on the victim by the making of the publicity order;
(d) the views of the victim on the making of the publicity order, where they can be ascertained.

[19.211] The Commission recommends that a publicity order should require the person convicted of the offence to publicise one or more of the following:

(a) the fact that the person has been convicted of an offence,
(b) the particulars of the offence concerned,
(c) the amount of fine, or duration of any term of imprisonment, imposed by the court in respect of the offence.

[883] Section 23(4) of the Criminal Justice and Courts Act 2015 (England and Wales).

[884] Section 23(2) of the Criminal Justice and Courts Act 2015 (England and Wales).

[885] Section 23(6) of the Criminal Justice and Courts Act 2015 (England and Wales).

[886] Section 23(7) of the Criminal Justice and Courts Act 2015 (England and Wales).

[19.212] It is useful to detail the form publication may take in the Criminal Law (Adult Safeguarding) Bill 2024. Accordingly, the Commission recommends that the court may specify the manner the matters concerned should be publicised, and a non-exhaustive list of forms of publication should be included in the Criminal Law (Adult Safeguarding) Bill 2024. This should include notification to the regulator where the care provider is an approved centre regulated by the Mental Health Commission or a service or residential centre regulated by HIQA. Where a service is publicly funded, the Minister and the body, organisation or group through which the funds are provided should also be notified.

[19.213] As is the case in the legislation in England and Wales, the publicity order should specify a period within which the requirements specified in the order must be complied with.

R. 19.12 **The Commission recommends that** where a person who is a care provider is found guilty of certain offences under the Criminal Law (Adult Safeguarding) Bill 2024, a court may make a publicity order.

R. 19.13 **The Commission recommends that**, in deciding whether to make a publicity order, the court should have regard to the following:

(a) whether the publicity order is in the public interest;

(b) whether the making of the publicity order risks the identification of the victim;

(c) the potential effect of identification on the victim by the making of the publicity order;

(d) the views of the victim on the making of the publicity order, where they can be ascertained.

R. 19.14 **The Commission recommends that** a publicity order should require the person convicted of the offence to publicise one or more of the following:

(a) the fact that the person has been convicted of an offence,

(b) the particulars of the offence concerned,

(c) the amount of fine, or duration of any term of imprisonment, imposed by the court in respect of the offence.

R. 19.15 **The Commission recommends that** the court may specify the manner of publication, and a non-exhaustive list of forms of publication should be included in the Criminal Law (Adult Safeguarding) Bill 2024. This should include notification to the regulator where the care provider is an approved centre regulated by the Mental Health Commission or a service or designated centre regulated by HIQA. Where a service is publicly funded, the Minister and the body, organisation or group through which the funds are provided should also be notified.

(c) Prohibition orders

[19.214] The Criminal Law (Adult Safeguarding) Bill 2024includes a provision regarding prohibition orders which are orders that can be made to prohibit those who commit offences under the Bill from engaging in prohibited work or activity with relevant persons (a specified category of at-risk adults). The rationale for including prohibition orders in the Criminal Law (Adult Safeguarding) Bill 2024 and the Commission's recommendations in that respect are discussed in detail in Chapter 18 of this Report, which examines regulation of professionals and occupational groups.

(d) Anonymity of the victim

[19.215] The benefit of preserving the anonymity of at-risk adults is discussed in detail in Chapters 10, 11, 12 and 13 in the context of civil interventions where it is known or suspected that there is a risk to the health, safety or welfare of the at-risk adult. The same rationale applies in the criminal context where an offence is committed against a relevant person. Similar provisions to ensure the anonymity of victims of offences or witnesses exist in many pieces of criminal legislation.[887] In certain situations, it is necessary to ensure the anonymity of the offender to preserve the anonymity of the victim of the offence.

[19.216] In certain circumstances, the court may consider that it is in the interests of justice that certain information should be published, distributed or broadcast. In such situations, the court should be permitted to specify in a direction the manner in which information can be published, distributed or broadcast and impose any conditions it considers necessary. Contravening a direction of this sort should be an offence, unless the person is the relevant person the offence was committed against.

[19.217] The Commission recommends that in relation to any proceedings for an offence committed under the Criminal Law (Adult Safeguarding) Bill 2024, it should be

[887] See for example, section 55 of the Criminal Justice (Miscellaneous Provisions) Act 2023; section 5 of the Harassment, Harmful Communications and Related Offences Act 2020; section 30 of the Criminal Law (Sexual Offences) Act 2017 and section 11 of the Criminal Law (Human Trafficking) Act 2008.

an offence for a person, other than a relevant person, to publish, distribute or broadcast any information likely to identify the relevant person, unless the court otherwise directs.

R. 19.16 **The Commission recommends that**, in relation to any proceedings for an offence committed under the Criminal Law (Adult Safeguarding) Bill 2024, it should be an offence for a person, other than a relevant person, to publish, distribute or broadcast any information likely to identify the relevant person, unless the court otherwise directs.

8. Regulatory offences

[19.218] While the Commission is of the view that that the criminal offences it proposes in this Chapter can be committed by care providers, it is important to acknowledge that there are regulatory offences in this jurisdiction that address failures in care by regulated care providers, and the criminal law will not operate in a vacuum. Care providers who run residential centres for people with disabilities and older persons may be prosecuted for regulatory offences by the Health Information and Quality Authority ("HIQA"). Care providers who run approved centres for people with mental disorders may be prosecuted for regulatory offences by the Mental Health Commission. Both regulators also have other regulatory enforcement mechanisms that they can use to ensure that care is being provided in a safe way and that breaches of regulations and non-compliance are addressed.[888] For the sake of completeness, the Commission sets out the regulatory offences under the Health Act 2007 and the Mental Health Act 2001 below. It also details the offences that can be prosecuted by the Care Quality Commission in England and Wales.

[19.219] The existence of regulatory offences under the Health Act 2007 and the Mental Health Act 2001 is the main reason that the Commission opted not to recommend the introduction of care provider specific criminal offences. It considered whether certain obligations in relation to the provision of care should be placed on care providers, and where a care provider failed to comply with these obligations it would be guilty of a criminal offence. The Commission ultimately concluded that there would be a significant overlap with the regulatory offences for regulated care providers. In terms of unregulated care providers, it is unlikely that there would be established standards, procedures and processes for provision of care, against which any failures of care could be assessed. The Commission is satisfied that the combination of the existing regulatory offences and the ability of a care provider to be prosecuted for

[888] For example, they can serve non-compliance notices on care providers, and impose conditions on their registration, or where the care provider cannot be brought back into compliance, they have the power to cancel their registration.

offences in the Commission's Criminal Law (Adult Safeguarding) Bill 2024 would mean that failures in care by a care provider would be sufficiently addressed.

(a) The Health Act 2007 and associated regulations

[19.220] Section 79(2) of the Health Act 2007 provides that it is an offence for a person or a registered provider carrying on the business of a residential centre not to comply with certain duties. Some of the offences that apply to persons relate to registration – it is an offence to run an unregistered residential centre,[889] or to provide false or misleading information in an application for registration.[890] Where a registered provider does not comply with certain duties it can be found guilty of an offence.[891] These duties include: a failure to supply information;[892] failure to "discharge a duty to which the registered provider is subject under a provision of regulations";[893] contravention of provisions in the regulations;[894] and failure to comply with a condition of the registration of a residential centre.[895] These are similar to offences that exist under the English and Welsh legislation. A registered provider of a residential centre is defined in section 2 of the Act as "the person whose name is entered in a register as the person carrying on the business of a designated centre".

[19.221] Regulations such as the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the Health Act 2007 (Care and Support of Residents in Designated Centres for People (Children and Adults) with Disabilities) Regulations 2013 place various duties on registered providers of residential centres and breaching the regulations or failing to discharge a duty is an offence.

[889] Sections 46(1) and 49(1)(b) of the Health Act 2007.

[890] Sections 47 and 49(1)(b) of the Health Act 2007.

[891] Section 79(2) of the Health Act 2007.

[892] Sections 65 and 79(2)9a) of the Health Act 2007.

[893] Section 79(2)(c) of the Health Act 2007.

[894] Section 79(2)(d) of the Health Act 2007.

[895] Section 79(2)(e) of the Health Act 2007.

[19.222] These include duties to have a statement of purpose,[896] written policies and procedures,[897] individualised assessment and personal plans for residents,[898] to provide appropriate health care,[899] and to ensure staff have up to date knowledge and skills and training to support residents in managing their behaviour.[900] Registered providers also have a duty to protect residents from all forms of abuse,[901] or a duty to take all reasonable measures to protect residents from abuse,[902] depending on the regulation.

[19.223] Other duties under the regulations relate to residents' rights, communication with residents, residents' receiving visitors, and residents' personal possessions. The registered provider is also required to have a suitable person in charge and

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[896] Regulation 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013) and regulation 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013).

[897] Regulation 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013) and regulation 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013).

[898] Regulation 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013) and regulation 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013).

[899] Regulation 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013) and regulation 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013).

[900] Regulation 7 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013) and regulation 7 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013).

[901] Regulation 8(2) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013). The registered provider is also required to assist and support each resident to "develop the knowledge, self-awareness, understanding and skills needed for self-care and protection". The registered provider must carry out an investigation where there is "an incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse". Regulation 8 outlines a number of steps the registered provider must take in relation to protection from abuse – including ensuring safeguarding measures are in place where staff provide personal intimate care to residents, and to ensure staff receive appropriate training in relation to "safeguarding residents and the prevention, detection and response to abuse".

[902] Regulation 8 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013). Regulation 8(2) provides that the measures taken must include staff training in relation to the detection and prevention of and responses to abuse. Regulation 8(3) provides that the person in charge of the designated centre must investigate any incident or allegation of abuse, unless they themselves are the subject of the allegation, in which case the registered provider shall investigate the matter or nominate a suitable person to do so.

to have the number and mix of staff necessary to cater to the needs of residents.[903] They must also ensure that staff have access to appropriate training, that they are appropriately supervised, and are informed of the Health Act 2007 and any regulations or standards made under it.[904] They contain similar duties to those in England and Wales regarding the suitability of premises, food and nutrition and the need to keep information and records.

[19.224] The regulations on residential centres for older people also place a duty on the registered provider to have an "accessible and effective procedure for dealing with complaints, which includes a review process".[905] They are obligated to make each resident aware of the complaints procedure and display a copy of the procedure in a prominent position in the residential centre. The regulations set out how the registered provider should offer to assist the complainant in making a complaint and how it should record complaints. The regulations on residential centres for people with disabilities also contain a provision on complaints procedures – but it has not been updated to align with the new provisions on complaints in the regulation on residential centres for older people.

[19.225] It is an offence under section 79(2)(c) and (d) of the Health Act 2007 for a registered person to fail to discharge a duty under the regulations or to contravene a provision of the regulations. The Chief Inspector has the power to prosecute summary offences committed by residential centres and registered providers.

[19.226] Section 80(4) of the Health Act 2007 provides that where an offence under the Act:

> (a) is committed by a body corporate, by a person purporting to act on behalf of a body corporate or by an individual or an unincorporated body of persons, and

[903] Regulations 14 and 15 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013) and Regulations 14 and 15 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013).

[904] Regulation 16 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013) and Regulation 16 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (SI No 367 of 2013).

[905] Regulation 34 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (SI No 415 of 2013) as amended by Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2022 (SI 628 of 2022).

(b) is proved to have been committed with the consent or approval of, or to have been attributable to any neglect on the part of, any person who, when the offence was committed, was—

(i) a director, member of the committee of management or other controlling authority of the body concerned, or

(ii) the manager, secretary or other officer of the body concerned,

that person shall also be deemed to have committed the offence and may be proceeded against and punished accordingly.

[19.227] This means that where an offence is committed by a registered provider of a residential centre, the manager of the registered provider may also be prosecuted if it can be proven that the offence was committed with the manager's consent or approval, or that it occurred due to their neglect. The position under the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014 (England and Wales) is similar in that offences can be committed by registered persons (which includes service providers or registered managers).[906]

[19.228] The Commission understands that HIQA and its Chief Inspector prefer to use other enforcement mechanisms (such as imposing conditions, varying or removing conditions, or cancelling registration) instead of pursuing prosecution of residential centres, as its other enforcement mechanisms are more likely to bring about improvements quickly.[907] In a recent report, HIQA states that the Chief Inspector:

> is of the view that prosecution should be a last resort as its use does not improve the safety and welfare of residents or achieve regulatory compliance.[908]

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[906] Regulations 2 and 22 of Health and Social Care Act 2008 (Regulation Activities) Regulations 2014 (England and Wales).

[907] Where HIQA's Chief Inspector has brought prosecutions in the past, this concerned unregistered designated centres, as opposed to registered designated centres who breach the regulations. See Gallagher, "HIQA Chief Inspector has issued proceedings against Western Care" *Mayo News* (1 November 2023) <https://www.mayonews.ie/news/home/1337733/hiqa-chief-inspector-has-issued-proceedings-against-western-care.html> accessed 9 April 2024.

[908] Health Information and Quality Authority, *The Need for Regulatory Reform – A Summary of HIQA reports and publications examining the case for reforming the regulatory framework for social care services* (HIQA February 2021) at page 24. The Chief Inspector suggests that it would be helpful for there to be some provision in the Health Act 2007 for the Chief Inspector to issue designated centres with compliance or improvement notices in order to (1) improve the safety and welfare of residents, and (2) for the designated centre to come into compliance with the regulations. HIQA and the Chief Inspector believe that this is a

(b) The Mental Health Act 2001 and associated regulations

[19.229] The Mental Health Act 2001 and associated regulations set out various duties that registered proprietors[909] of approved centres must comply with and failure to comply with these duties is an offence. The Mental Health Act 2001 contains offences of making false or misleading statements when applying for someone to be admitted involuntarily,[910] failure to disclose a previous refused application,[911] and obstructing or interfering with a consultant psychiatrist directed to examine the patient.[912] There are also offences related to not attending at a mental health tribunal, refusing to answer questions, failing or refusing to provide documents and giving false evidence.[913] It is also an offence to obstruct or interfere with an Inspector.[914] It is an offence to carry on a centre unless it is registered as an approved centre under the Act and to provide false or misleading information in making an application for registration.[915] If a condition of registration is contravened, the registered provider is guilty of an offence.[916]

[19.230] The Mental Health Act 2001 (Approved Centres) Regulations 2006 places certain obligations on registered proprietors.[917] For example, the registered proprietor must ensure that residents are readily identifiable by staff when receiving medication, health care or other services. They must ensure food is provided safely and that residents are provided with clothing where necessary. They must have policies and procedures in place regarding residents' personal property and possessions and maintain a record of each resident's personal property and possessions.[918]

[19.231] Residents in approved centres must be able to access appropriate recreational activities insofar as is practicable and they must be facilitated to practice their

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more "efficient, appropriate and proportionate response in many instances of non-compliance with the regulations".

[909] Registered proprietors are defined in section 62 of the Mental Health Act 2001 as the person whose name is entered in the register as the person carrying on the centre.

[910] Section 9(6) of the Mental Health Act 2001.

[911] Section 11 of the Mental Health Act 2001.

[912] Section 17(4) of the Mental Health Act 2001.

[913] Section 49(4) and (5) of the Mental Health Act 2001.

[914] Section 53 of the Mental Health Act 2001.

[915] Sections 63 and 64(8)(b) of the Mental Health Act 2001.

[916] Section 64(13) of the Mental Health Act 2001.

[917] Registered proprietors are defined in section 62 of the Mental Health Act 2001 as the person whose name is entered in the register as the person carrying on the centre.

[918] Regulation 8 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 (SI No 551 of 2006).

religion, insofar as is reasonably practicable.[919] There are also provisions about the registered proprietor's duty to enable residents to receive visitors, communicate and provisions regarding searches of residents, their belongings and their environment. There must be written operational policies and procedures on these matters. There is a duty on the registered proprietor to ensure each resident has an individual care plan and access to therapeutic services and programmes.[920] There are also duties on the registered proprietor where a resident is transferred from one approved centre to another, and a duty to have adequate arrangement in place for residents to access general health services and to undergo regular assessments. Residents must be provided with information in an understandable form and language and their privacy and dignity must be appropriately respected.

[19.232] Like in England and Wales, there are duties on registered proprietors to ensure premises are clean and maintained, among other requirements. The registered proprietor must ensure the approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.[921] Regulation 24(2) provides that this regulation is "without prejudice to the provisions of the Health and Safety Act 1989 [sic] the Health and Safety at Work Act 2005 and any regulations made thereunder". There are further obligations on the registered proprietor in relation to staffing, maintenance of records, register of residents and cooperation with Mental Health Tribunals.

[19.233] Regulation 31 provides that the approved centre must have written operational policies and procedures for complaints, and each resident must be made aware of the procedure as soon as practicable after they are admitted. Like under the Health Act 2007, the complaints procedure must be displayed in a prominent position in the approved centre. Complaints must be investigated promptly, and records must be kept.

[19.234] Regulation 32 provides that the registered proprietor must have a "comprehensive written risk management policy in place" and this must be implemented. The registered proprietor must ensure that the risk management policy covers the following:

(a) the identification and assessment of risks throughout the approved centre,

(b) the precautions in place to control the risks identified

[919] Regulations 9 and 10 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 (SI No 551 of 2006).

[920] Regulations 15 and 16 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 (SI No 551 of 2006).

[921] Regulation 24(1) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 (SI No 551 of 2006).

(c) the precautions in place to control the following specified risks:

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;

(e) arrangements for responding to emergencies;

(f) arrangements for the protection of children and vulnerable adults from abuse.[922]

[19.235] The registered proprietor must keep a record of all incidents and notify the Mental Health Commission of incidents that occur in the approved centre.[923]

[19.236] Section 66(3) of the Mental Health Act 2001 provides that where a centre fails or refuses to comply with a provision of the regulations, the registered proprietor is guilty of an offence.[924] It also provides that a person who fails or refuses to comply with a provision of the regulations is guilty of an offence.[925] Therefore, if the registered proprietor of an approved centre fails or refuses to comply with one of the duties outlined above, they are guilty of an offence under the Act. Summary offences can be prosecuted by the Commission.[926]

[19.237] The Mental Health Commission has pursued a small number of prosecutions in recent years, see for example the prosecution it brought against the HSE due to failures that occurred in the Department of Psychiatry in St. Luke's Hospital in Kilkenny.[927] The Chief Executive of the Mental Health Commission noted that "the improvements that have occurred at St Luke's since 2018 clearly demonstrate that our decision to initiate legal proceedings was undoubtedly the

[922] Regulation 32(2) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 (SI No 551 of 2006).

[923] Regulation 32(3) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 (SI No 551 of 2006).

[924] Section 66(3)(a) of the Mental Health Act 2001.

[925] Section 66(3)(b) of the Mental Health Act 2001.

[926] Section 74(1) of the Mental Health Act 2001.

[927] Burke and Uger, "Mental Health Commission takes first prosecution of its kind against the HSE under the Mental Health Act 2001" *Fieldfisher* (23 March 2019) https://www.fieldfisher.com/en-ie/locations/ireland/ireland-blog/mental-health-commission-takes-first-prosecution-of-its-kind-against-the-hse-under-the-mental-health-act-2001 accessed 9 April 2024; Bowers, "HSE fined over failures at Kilkenny psychiatric unit" *RTÉ* (25 February 2019) <https://www.rte.ie/news/health/2019/0225/1032710-mental-health/> accessed 9 April 2024.

right call to make".[928] The Mental Health Commission also brought a case against St. Stephen's Hospital in Cork,[929] however the prosecution was withdrawn following assurances from the HSE.[930]

[19.238] Much like the Health Act 2007, section 74(3) of the Mental Health Act 2001 provides that where an offence has been committed by a body corporate and is proved to have been committed "with the consent or connivance of or be attributable to any neglect on the part of" a director, manager, secretary or other officer of the body corporate, or a person purporting to act in such capacity, that person along with the body corporate shall be guilty of an offence.[931]

(c) Care Quality Commission governing legislation

[19.239] In England, the Health and Social Care Act 2008 established the Care Quality Commission. The Care Quality Commission is responsible for the registration, inspection and monitoring of health and adult social care providers who carry out "regulated activities". Its remit includes monitoring the exercise of powers and discharge of duties by services registered to assess, treat and care for people under the Mental Health Act 1983. It carries out similar functions to those carried out by both HIQA and the Mental Health Commission.[932]

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[928] Kilkenny Now, "Kilkenny psychiatry unit shows 'extraordinary improvement' since embarrassment of court prosecution – report" *Kilkenny Now* (19 February 2021) < https://kilkennynow.ie/kilkenny-psychiatry-unit-shows-extraordinary-improvement-since-embarrassment-of-court-prosecution-report/> accessed 9 April 2024. See also Shanahan, "'We will intervene robustly' – Mental Health Commission issue warning that substandard service won't be tolerated" *The Irish Examiner* (21 February 2019) < https://www.irishexaminer.com/news/arid-30906208.html> accessed 9 April 2024. This article was written in 2019 before the Mental Health Commission had brought any prosecutions. The Chief Executive is quoted as saying that while no prosecutions were brought to date, "that will change" and "where there is a risk to service users, [the Mental Health Commission] will intervene robustly, without fear of favour".

[929] Mental Health Commission, Mental Health Commission issues proceedings against Cork HSE centre <https://www.mhcirl.ie/news/mental-health-commission-issues-proceedings-against-cork-hse-centre> accessed 9 April 2024.

[930] Heylin, "Mental Health Commission drops court action against Cork psychiatric hospital" *The Irish Examiner* (30 November 2022) https://www.irishexaminer.com/news/munster/arid-41018318.html accessed 9 April 2024.

[931] Section 74(4) of the Mental Health Act 2001 provides that where the affairs of a body corporate are managed by its members, subsection 3 "shall apply in relation to the acts and defaults of a member in connection with his or her functions of management as if he or she were a director or manager of the body corporate.

[932] It has no role to investigate individual complaints made against a specific service (except for certain complaints made under the Mental Health Act 1983). See Care Quality Commission, Complain about the use of the Mental Health Act < https://www.cqc.org.uk/contact-us/how-complain/complain-about-use-mental-health-act> accessed 11 December 2023.

[19.240] The Health and Social Care Act 2008 (Regulation Activities) Regulations 2014 sets out regulatory offences that can be prosecuted by the Care Quality Commission. The regulations place certain duties on service providers or registered managers that are regulated by the Care Quality Commission (known as "registered persons") and makes it an offence to fail to comply with these duties.[933]

[19.241] The regulations provide, among other things, that:

- care and treatment must be provided in a safe way for service users,[934]
- service users must be protected from abuse and improper treatment,[935]
- any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation,[936]
- the registered person must establish and operate an effective and accessible complaints system, and
- systems or processes must be established and operated effectively to ensure compliance with good governance to enable the registered person to assess, monitor and improve the quality and safety of services provided and to assess, monitor and mitigate the risks to health, safety and welfare of service users who may be at risk.[937]

[19.242] Regulation 22(1) provides that it is an offence for a registered person to fail to comply with any of the requirements under regulations 11, 16(3), 17(3), 20(2)(a) and (3) or 20A. Regulation 22(2) provides that a registered person commits an

[933] Regulation 12, 13, 22 and 23 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014 (England and Wales).

[934] Regulation 12(1) of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014 (England and Wales). It provides a list of things that a registered person must do to comply with this regulation. These include, for example: (a) assessing the risks to health and safety of service users of receiving the care or treatment, (b) doing all that is reasonably practicable to mitigate any such risks, (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely, (d) ensuring that the premises used by the service provider are safe to use for intended purpose and are used in a safe way …

[935] Regulation 13(1) of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014 (England and Wales).

[936] Regulation 16 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014 (England and Wales).

[937] Regulation 17 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014 (England and Wales).

offence if it fails to comply with a requirement under regulation 12, 13(1) to (4), or 14 if such failures result in:

> (a) avoidable harm (whether of a physical or psychological nature) to a service user,
> (b) a service user being exposed to a significant risk of such harm occurring, or
> (c) in the case of theft, misuse or misappropriation of money or property, any loss by a service user of the money or property concerned.

[19.243] The offences under regulation 22(1) and (2) all must be read with the general proviso that the requirement to comply with the regulations "does not require a person to do something to the extent that what is required to be done to comply with regulations 9 to 20A has already been done by another person who is a registered person in relation to the regulated activity concerned".[938] Regulation 22(4) provides that it is a defence for a registered person to prove that "they took all reasonable steps and exercised all due diligence to prevent any breach of any of those regulations that has occurred".

[19.244] Breaches of the regulations are frequently prosecuted by the Care Quality Commission, and a spreadsheet detailing the prosecutions it has brought can be found on its website.[939] It has other ways of addressing breaches of regulations and these mechanisms such as warning notices are outlined in its enforcement policy.

(d) Conclusion

[19.245] As detailed above, HIQA and the Mental Health Commission have prosecutorial powers where offences are committed under the Health Act 2007 and the Mental Health Act 2001 for breaches in regulations, or failures to discharge duties. Having engaged with consultees, the Commission does not believe that amendments to the existing regulatory offences are required. The Commission is also aware that the Government is engaged in ongoing work to review the

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[938] Regulation 8 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014 (England and Wales).

[939] Care Quality Commission, Prosecutions <https://www.cqc.org.uk/about-us/how-we-do-our-job/prosecutions> accessed 15 February 2024. See excel sheet: List of prosecutions brought by CQC (last updated 6 February 2024). For a recent example, see Flash, "Ex-care home boss admits failing to stop sex abuse" BBC (16 February 2024) <https://www.bbc.com/news/articles/c3ge3j7w0lpo> accessed 9 April 2024.

Health Act 2007[940] and the Mental Health Act 2001.[941] The Care Quality Commission in England and Wales appears to prosecute far more frequently than HIQA and the Mental Health Commission, who prefer to use other enforcement tools at their disposal to address non-compliance with regulations to improve the quality and safety of services. The decision to prosecute or not is a matter for the regulator, but the Commission considers that as both HIQA and the Mental Health Commission have the powers to pursue prosecutions for offences where required, there is no need for an offence specific to care providers in the Commission's Criminal Law (Adult Safeguarding) Bill 2024. The offences in that Bill apply equally to care providers who run residential centres and approved centres and to natural persons where the criteria for the offence are met.

[19.246] In terms of unregulated care providers, the Commission recommends in Chapter 7 that the Government should carefully consider whether relevant services, which are not currently subject to statutory regulatory regimes including statutory inspections, should be brought within such regulatory regimes. If the Government decides to regulate such services, presumably similar regulatory offences to those that exist under the Health Act 2007 and the Mental Health Act 2001 could be extended to providers of relevant services as part of any regulatory regime. Separately, where the criteria for an offence under the Criminal Law (Adult Safeguarding) Bill 2024 are met, an unregulated care provider could be prosecuted for that offence.

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[940] See the Government's General Scheme of the Health (Amendment) Bill 2022 <https://assets.gov.ie/237826/520c746e-ed5f-4711-9df7-a993dce6cdd0.pdf> accessed 15 February 2024. If enacted, Head 6 would provide for amendment of the Health Act 2007 to expand the regulator's toolkit to include advance notices, non-compliance notices and urgent orders, which the General Scheme states would allow for more immediate and proportionate interventions in response to regulatory breaches.

[941] See the Sub-Committee on Mental Health's Report on Pre-Legislative Scrutiny of the Draft Heads of Bill to Amend the Mental Health Act 2001 published in October 2022 <https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/joint_sub_committee_on_mental_health/reports/2022/2022-10-12_report-on-pre-legislative-scrutiny-of-the-draft-heads-of-bill-to-amend-the-mental-health-act-2001_en.pdf> accessed 9 April 2024. The Government's Spring Legislation Programme 2024 states that drafting is ongoing.

CHAPTER 20
A REGULATORY FRAMEWORK FOR ADULT SAFEGUARDING – IMPLEMENTATION AND A WHOLE OF GOVERNMENT APPROACH

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1. Introduction

[20.1] It is important to note that legal reforms are not a panacea – legislation must be underpinned by policy, structural, governance and procedural changes, adequate resourcing and funding. Cultural change, awareness building and training are also required to ensure that adult safeguarding practices are embedded in the provision of care to at-risk adults, or adults who may become at-risk adults.

[20.2] It is important that an adult safeguarding framework is preventative as well as responsive. It should aim to minimise the risk of harm to at-risk adults, or adults who may become at-risk adults, and strive to prevent harm occurring in the first place. Intervention at an early stage can prevent adult safeguarding concerns from escalating or arising in the future. Where adult safeguarding concerns do arise – it is important that everyone knows how to identify and respond to such concerns by intervening to help the at-risk adult protect themselves. The Commission believes that its proposed adult safeguarding statutory framework would achieve both these aims.

[20.3] Throughout the Report, the Commission makes various civil and criminal law recommendations with the primary objective of putting measures in place to safeguard at-risk adults in this jurisdiction. The Commission endeavoured to ensure that the regime it proposes is centred on the views and preferences of at-risk adults, respects their autonomy, and promotes their right to make their own decisions. The guiding principles outlined in Chapter 3, informed the making of all the recommendations contained in the Report, and the Commission believes they should guide all actions taken under adult safeguarding legislation, if the proposed legislation is enacted.

[20.4] The Commission's recommendations and draft legislation are intended to be cross-sectoral, and do not apply exclusively to the health and social care sector. While it is true that the vast majority of at-risk adults in Ireland will be engaging with health and social care services, some at-risk adults, or adults who may become at-risk adults, may be availing of services outside of the health and social care sector or no services at all. It is important that at-risk adults in receipt of those services and those living in the community who are not in receipt of services are adequately supported and safeguarded by any reforms to adult safeguarding on foot of this Report.

[20.5] The Commission believes that a cross-sectoral Safeguarding Body needs to be established. It recommends in Chapter 6 that the Safeguarding Body would be a social work-led adult safeguarding agency. It would have statutory functions, duties and powers to receive and respond to reports of actual or suspected abuse or neglect arising in relation to at-risk adults living in the community who are not in receipt of any services and at-risk adults who are in receipt of health, social care, accommodation, refuge and financial services across multiple sectors. This

would capture public, private and voluntary services in the health and social care sector and services in other sectors including for example:

(a) refuge accommodation services for victims of domestic, sexual or gender-based violence;
(b) reception or accommodation centres which provide residential accommodation services to adults in the international protection process under contract to the Department of Children, Equality, Disability, Integration and Youth;
(c) centres which provide residential accommodation services to adults experiencing homelessness.

[20.6] It is important to note that the application of the existing HSE National Policy and Procedures on adult safeguarding is limited to:

(a) health and social care services for older people and adults with disabilities provided or funded by the HSE; and
(b) adults with disabilities or older people who are living in the community and not in receipt of formal services.[942]

[20.7] The HSE National Policy and Procedures do not apply to other HSE managed or funded services including mental health services or to private health or social care services.

[20.8] In the late stages of finalising this report, the Government published and consulted on its Policy Proposals on Adult Safeguarding in the Health and Social Care Sector.[943] The Government's policy proposals are intended to apply to the entire health and social care sector.[944] The Commission refers to the Government's policy proposals on various topics throughout this report. In its public consultation document, the Government notes that the Commission is preparing its report on a Regulatory Framework for Adult Safeguarding, along

[942] Health Service Executive, Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures (HSE 2014) at page 6<https://assets.hse.ie/media/documents/ncr/personsatriskofabuse.pdf> accessed 2 April 2024.

[943] The Policy Proposals were prepared by the Department of Health. See Government of Ireland, *Public Consultation Policy Proposals on Adult Safeguarding in the Health and Social Care Sector* (Department of Health 2024) < https://assets.gov.ie/282259/c941dc0c-c220-4a3a-8da5-460ba6af51bd.pdf> accessed 2 April 2024.

[944] If this new overarching policy is adopted, it would have a broader scope than the HSE National Policy and Procedures and apply to the entire health and social care sector including public, voluntary and private health and social care services and all staff and volunteers working within those services. See Government of Ireland, *Public Consultation Policy Proposals on Adult Safeguarding in the Health and Social Care Sector* (Department of Health 2024) at page 9 < https://assets.gov.ie/282259/c941dc0c-c220-4a3a-8da5-460ba6af51bd.pdf> accessed 2 April 2024.

with draft legislation that will apply to all sectors.[945] In relation to the safeguarding structures for the health and social care sector, it states that consideration on the most appropriate location for these structures "will need to take account of broader cross-Government considerations on adult safeguarding" such as the recommendations in the Commission's report.[946]

[20.9] The Commission understands that adult safeguarding is an important priority for the Government. The publication of the Commission's report is timely considering the recent publication of the Government's policy proposals for the health and social care sector, and the ongoing review of the HSE's safeguarding policy, procedures and structures which is expected to be published shortly.[947] The Commission believes that this presents a major opportunity to bring about change in adult safeguarding in Ireland, which is desperately needed to minimise harm to at-risk adults and promote their health, safety and welfare. Recently, the Áras Attracta, 'Brandon', 'Grace' and 'Emily' reviews have highlighted the need for a more formalised, practical and robust cross-sectoral regulatory framework on a statutory basis. The Commission believes that its proposed regulatory framework for adult safeguarding, outlined in its recommendations and its draft legislation, provide a comprehensive, clear, cohesive framework for adult safeguarding. It hopes that it will be useful to Government and policymakers in determining the road ahead.

[20.10] As the concluding chapter of this report, this Chapter aims to tie together the Commission's recommendations throughout the Report and identify what is required in order for its proposed regulatory framework to operate effectively. This chapter will:

(a) identify the need for cross-sectoral adult safeguarding legislation;

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[945] Government of Ireland, *Public Consultation Policy Proposals on Adult Safeguarding in the Health and Social Care Sector* (Department of Health 2024) at page 7 <https://assets.gov.ie/282259/c941dc0c-c220-4a3a-8da5-460ba6af51bd.pdf> accessed 2 April 2024.

[946] Government of Ireland, *Public Consultation Policy Proposals on Adult Safeguarding in the Health and Social Care Sector* (Department of Health 2024) at page 14 <https://assets.gov.ie/282259/c941dc0c-c220-4a3a-8da5-460ba6af51bd.pdf> accessed 2 April 2024.

[947] Jackie McIlroy was commissioned by the HSE to undertake a two-part review in July 2023, following the 'Emily' case. The first part of the review was published in August 2023 and it examined the specifics of the Emily case. See McIlroy, Adult Safeguarding Review Professional Advice to the CEO the Health Service Executive (HSE 2023) <https://www.hse.ie/eng/services/news/newsfeatures/adult-safeguarding/adult-safeguarding-review-2023-ms-jackie-mcilroy.pdf> accessed 2 April 2024. The report related to the second part of the review, which will focus on HSE safeguarding policy, procedures, structures, was not published at the time of writing.

(b) identify the need for a lead department and briefly outline the perspectives of consultees and other stakeholders on this issue;

(c) propose the establishment of an inter-departmental group and preparation of sectoral implementation plans by relevant departments to ensure a whole of government approach to adult safeguarding;

(d) recommend the introduction of statutory guidance through guidelines and codes of practice; and

(e) discuss the Commission's perspective on the interaction of the Commission's proposed legislation with other relevant legislation such as the Assisted Decision-Making (Capacity) Act 2015.

2. The need for cross-sectoral legislation

[20.11] As briefly outlined above, the Commission's recommendations in this report, and its draft legislation apply across multiple sectors, and do not just apply to the health and social care sector. The Commission believes that any adult safeguarding legislation introduced in the future should be cross-sectoral. If adult safeguarding legislation related only to the health and social care sector, there would be a significant gap in support and protection for at-risk adults outside those sectors. One of the Commission's main objectives when developing the recommendations in this Report is that they would apply across multiple sectors. The Commission believes that it is necessary to capture public, private and voluntary services in the health and social care sector and services in other sectors including, for example:

(a) refuge accommodation services for victims of domestic, sexual or gender-based violence;
(b) reception or accommodation centres which provide residential accommodation services to adults in the international protection process under management by, or contract to, the Department of Children, Equality, Disability, Integration and Youth;
(c) centres which provide residential accommodation services to adults experiencing homelessness.

[20.12] These services will come into frequent contact with adults who are or may become at-risk adults. For that reason, in Chapter 7, the Commission recommends that safeguarding duties (to prevent harm, to undertake and document a risk assessment, and to prepare an adult safeguarding statement) should be placed on providers of a "relevant service". The list of relevant services is cross-sectoral, it applies to health and social care services, for example, residential centres for older people and people with disabilities, but it also

includes services outside the health and social care sector, such as those listed above, among others. These are preventative duties that aim to prevent adult safeguarding concerns from arising by having procedures in place to minimise the risk of harm to at-risk adults and promote their health, safety and welfare.

[20.13] Chapter 14 discusses one of the most prevalent forms of abuse against at-risk adults – financial abuse. The Commission sets out a number of proposals on how to prevent and address such abuse and strengthen Irish law to address this increasingly significant issue. It recommends that the Safeguarding Body's remit to receive and respond to reports of actual or suspected abuse or neglect of at-risk adults should include actual or suspected financial abuse of at-risk adults. It also makes a number of law reform recommendations, which it believes would help to keep at-risk adults safe from financial abuse.

[20.14] The Safeguarding Body which is proposed by the Commission would have a major role to play in promoting awareness of adult safeguarding issues, and the need for those who come into contact with at-risk adults, whether individuals, service providers or public service bodies, to respond effectively to any safeguarding concerns. Cooperation and the sharing of information between the Safeguarding Body, service providers and public service bodies across sectors is vital to ensure that there is a joined-up approach, and that timely and comprehensive actions are taken to safeguard at-risk adults. Chapter 15 suggests reforms to ensure that the Safeguarding Body, certain public service bodies and providers of relevant services cooperate with one another to prevent and address safeguarding concerns. This should ensure cooperation across sectors. In a similar vein, Chapter 16 contains the Commission's recommendations on information sharing, which it hopes will improve the sharing of information between "relevant bodies" whose functions relate, in whole or in part, to safeguarding the health, safety or welfare of at-risk adults.

[20.15] Where adult safeguarding measures are currently in place, they exist primarily on a policy or administrative basis and are sector-specific, meaning that the approach across sectors is somewhat fragmented and siloed. The Commission recommends that proposed cross-sectoral adult safeguarding legislation, applicable across all relevant sectors rather than specific legislation being introduced for individual sectors.

R. 20.1 **The Commission recommends that** proposed adult safeguarding legislation should be cross-sectoral legislation that applies across all relevant sectors rather than specific legislation being introduced for individual sectors.

3. Lead department and a whole of government approach

(a) Lead department for adult safeguarding

[20.16] The question of which department should be the lead department in the adult safeguarding context is a complex policy matter – given that there are many relevant departments, and responsibilities for functions are frequently re-allocated and transferred. Consultees, including relevant departments,[948] expressed various different views on which department should be the lead department for adult safeguarding. For example, HIQA suggested that primary responsibility for adult safeguarding legislation should lie with the Department of Health.[949] Other stakeholders also expressed diverging views in their own reports on adult safeguarding. For example, Safeguarding Ireland considers that the Department of Justice should be the lead department.[950] In contrast, the Irish Association of Social Workers believes that the lead department should be the Department of Children, Equality, Disability, Integration and Youth ("DCEDIY") given its expertise in disability, human rights, inequality, marginalisation and childhood adversity, abuse, and safeguarding (which it considers are "inextricably linked with experiences of abuse in adulthood").[951] In 2017, the Joint Oireachtas Committee on Health said that responsibility for an "adult safeguarding

[948] For example, see Department of Health, *Law Reform Commission Issues Paper: A Regulatory Framework for Adult Safeguarding – A response from the Department of Health (Department of Health 2020)* at pages 18 to 19 <https://assets.gov.ie/83566/8594f084-fe09-4e55-80a9-ccbeac1075cd.pdf> accessed 3 April 2024.

[949] Health Information and Quality Authority, *Law Reform Commission Issues Paper 'A Regulatory Framework for Adult Safeguarding' – Response by the Health Information and Quality Authority (HIQA)* (HIQA 2020) at page 54 < https://www.hiqa.ie/sites/default/files/2020-06/HIQA-Response-LRC-Issues-Paper.pdf> accessed 3 April 2024.

[950] Safeguarding Ireland, *Identifying RISKS Sharing RESPONSIBILITIES – The Case for a Comprehensive Approach to Safeguarding Vulnerable Adults* (Safeguarding Ireland 2022) at pages 22, 23, 207, 213, 215 < https://safeguardingireland.org/wp-content/uploads/2022/05/6439-Safeguarding-Risks-Resp-Report-FA4_lowres.pdf> accessed 3 April 2024. See also Safeguarding Ireland, Safeguarding Ireland presents 'safeguarding roadmap' to the Oireachtas < https://safeguardingireland.org/safeguarding-ireland-presents-safeguarding-roadmap-to-the-oireachtas/> accessed 3 April 2024.

[951] Irish Association of Social Workers, *Position Paper on Adult Safeguarding: Legislation, Policy and Practice* (IASW 2022) at pages 22 to 23 < https://www.iasw.ie/download/1076/IASW%20Adult%20Safeguarding%20Position%20Paper%202022%20%282%29.pdf> accessed 3 April 2024.

authority" and any new legislation would need to be shared between a number of departments.[952]

[20.17] Undoubtedly, a range of departments need to have some responsibility for adult safeguarding. The work of many departments or the work of public service bodies acting under their aegis relate, or will relate (if the Commission's recommendations are implemented), to safeguarding at-risk adults or providing services to people who are at-risk adults or may become at-risk adults. The Commission considers that the following departments are particularly relevant to adult safeguarding:

(a) the **Department of Health**: it has responsibility for the HSE (and by extension the HSE National Safeguarding Office, its Safeguarding and Protection Teams and the National Independent Review Panel), HIQA, the Mental Health Commission and the Director of the Decision Support Service. It also has responsibility for developing adult safeguarding policy for the health and social care sector;

(b) the **Department of Children, Equality, Disability, Integration and Youth**: it has responsibility for disability, equality, children (including children transitioning into adulthood) and integration including international protection. It has particular expertise in child protection and safeguarding as it is responsible for the Child and Family Agency;

(c) the **Department of Justice**: It has responsibility for the Garda Síochána, the DSGBV Agency (Cuan),953 and the Policing and Community Safety Authority.954 It is responsible for Garda Vetting, data protection legislation and the Domestic Violence Act 2018 which are the subject of a number of recommendations in the report. It would have responsibility for the criminal legislation related to adult safeguarding proposed in this Report;

(d) the **Department of Social Protection**: it has responsibility for the Citizens Information Board (which provides the National Advocacy Service for people with disabilities and the Patient Advocacy Service – services providing independent advocacy services). It also has a Safeguarding Unit which responds to reports it receives of actual or suspected financial abuse of at-risk adults where the at-risk adult is

[952] Houses of the Oireachtas, *Joint Committee on Health Report on Adult Safeguarding* (Houses of the Oireachtas 2017) at page 22 <https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_health/reports/2017/2017-12-13_report-adult-safeguarding_en.pdf> accessed 3 April 2024.

[953] The legal name for this agency is An Ghníomhaireacht um Fhoréigean Baile, Gnéasach agus Inscnebhunaithe, which means Domestic, Sexual and Gender Based Violence Agency in the Irish language.

[954] The legal name for this authority is An tÚdarás Póilíneachta agus Sábháilteachta Pobail.

in receipt of pensions or benefits.[955] It also established a working group to examine and make recommendations on the adequacy of procedures and processes in the Department to protect at-risk adults, particularly in terms of financial abuse;[956]

(e) the **Department of Housing, Local Government and Heritage**: it has responsibility for housing people with disabilities, homelessness (including emergency accommodation) and supported living schemes.

[20.18] Other departments may have more limited remits in respect of adult safeguarding. This could include the Department of Transport in respect of amendments to regulations under the Taxi Regulation Act 2013 to introduce a requirement on holders of licences to drive small public vehicles to undertake adult safeguarding training on how to detect, prevent and respond to abuse, as recommended by the Commission in Chapter 7.

[20.19] The Commission believes that it is essential that a lead department, and by extension, a lead minister is appointed to coordinate the introduction and implementation of adult safeguarding legislation and consult and engage with other relevant departments where necessary. The Commission believes that the decision about which department should be the lead department is a decision that would most appropriately be made by the Government – particularly as the functions of the departments at the time of writing may not be the functions of the departments at the time of implementation of the Commission's recommendations, or the enactment of any future adult safeguarding legislation. Furthermore, the identity of the Safeguarding Body – whether it would be established as a new independent statutory adult safeguarding body, or as a statutory office in an existing statutory body – is a relevant consideration in determining which department should be the lead department, and as discussed in Chapter 6, the Commission believes the Government is better placed to determine this question. The Commission therefore recommends that one Department should be identified by Government as the appropriate Department to lead on the introduction, and implementation, of the proposed cross-sectoral adult safeguarding legislation.

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[955] The Safeguarding Unit consults and involves other relevant agencies as appropriate including the HSE and the Garda Síochána. Department of Social Protection, Safeguarding Vulnerable Adults < https://www.gov.ie/en/publication/3f6bc5-safeguarding-vulnerable-adults/> accessed 3 April 2024.

[956] Joint Committee on Health Debates 4 October 2017 < https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2017-10-04/2/> accessed 3 April 2024.

R. 20.2 **The Commission recommends that** one Department should be identified by Government as the appropriate Department to lead on the introduction, and implementation, of the proposed cross-sectoral adult safeguarding legislation.

(b) Whole of government approach

(i) Inter-departmental implementation group

[20.20] The appointment of a lead department does not mean that it will be solely responsible for adult safeguarding in Ireland – as discussed above, the Commission intends for its recommendations and draft legislation to be cross-sectoral. That requires each relevant department taking responsibility for adult safeguarding. The Commission believes that an inter-departmental implementation group is an effective mechanism to ensure inter-departmental cooperation and collaboration when implementing cross-sectoral legislation, and that such a group is necessary to ensure synergies are realised and that every relevant department plays its part to strengthen adult safeguarding measures across relevant sectors.

[20.21] The Commission notes that an inter-departmental implementation group was established in accordance with the Children First Act 2015.[957] Its functions include promoting compliance by departments with their obligations under the Act, monitoring the implementation by departments of any guidelines and providing support to departments on preparation of sectoral implementation plans, and ensuring a consistent approach by the departments in that respect.[958] The inter-departmental implementation group also reports, where requested, to the lead minister on the implementation of the 2015 Act and of any guidelines, and it can provide information and advice, and make proposals to the lead minister on matters related to its functions.[959] In addition to the departments, there are ordinary members such as a member of the Garda Síochána, a member of the Child and Family Agency and an employee of the HSE.[960]

[20.22] The Commission takes the view that an inter-departmental implementation group is an appropriate mechanism to ensure that all relevant departments of government fulfil their responsibilities for adult safeguarding. This is necessary with cross-sectoral legislation to ensure seamless and efficient cooperation and collaboration between departments, and the various public service bodies under their aegis, and other relevant partners such as the proposed Safeguarding Body, the Garda Síochána and the HSE. It promotes the idea that "safeguarding is

[957] Section 20 of the Children First Act 2015.

[958] Section 22(a), (b), (c), (d) of the Children First Act 2015.

[959] Section 22(e) and (f) of the Children First Act 2015.

[960] Section 21 of the Children First Act 2015.

everyone's business" and not just the responsibility of the lead department, or the health or social care sector. The Commission considers that the Government should designate the departments which should be members of the inter-departmental implementation group. It should give particular consideration to the departments listed above, as these are the departments that, in the Commission's view, have particular responsibilities towards at-risk adults. If an inter-departmental implementation group is established, it should also consist of ordinary members, including members from the Garda Síochána, the Safeguarding Body and the HSE, if the Government decides that the Safeguarding Body should not be established within the HSE. The inter-departmental implementation group should have the following functions in respect of adult safeguarding legislation:

(a) promote compliance by departments with their obligations under the Act;
(b) monitor compliance by public service bodies with their obligations to cooperation under the Act;
(c) monitor the implementation by departments with any guidelines issued by the lead minister;
(d) provide support to relevant departments to assist them with preparing and publishing sectoral implementation plans (discussed further below);
(e) ensure consistency between departments in relation to sectoral implementation plans;
(f) report to the lead minister when requested on progress to implement the Act and any guidelines issued in accordance with the Act;
(g) provide information or advice and make proposals to the lead minister on matters related to the functions of the inter-departmental implementation group.

R. 20.3 **The Commission recommends that** an interdepartmental implementation group should be established on a statutory basis in the proposed adult safeguarding legislation to provide oversight of the introduction and implementation of the proposed legislation.

R. 20.4 **The Commission recommends that** the inter-departmental implementation group should have the following functions in respect of adult safeguarding legislation:

(a) promote compliance by departments with their obligations under the Act;

(b) monitor compliance by public service bodies with their obligations to cooperation under the Act;

(c) monitor the implementation by departments with any guidelines issued by the lead minister;

(d) provide support to relevant departments to assist them with preparing and publishing sectoral implementation plans (discussed further below);

(e) ensure consistency between departments in relation to sectoral implementation plans;

(f) report to the lead minister when requested on progress to implement the Act and any guidelines issued in accordance with the Act;

(g) provide information or advice and make proposals to the lead minister on matters related to the functions of the inter-departmental implementation group.

(ii) Sectoral plans

[20.23] Sectoral plans or sectoral implementation plans are another useful feature for inclusion in cross-sectoral legislation. The Children First Act 2015 and the Disability Act 2005 require certain Ministers to produce sectoral plans or sectoral implementation plans.[961] These plans typically outline the measures that will be put in place and actions that the Minister, its department and public service bodies under its aegis will take to comply with the provisions of an Act. This ensures that all relevant Ministers are accountable under the relevant Act and that each department sets out a plan on how exactly it intends to implement the Act and comply with its obligations.

[20.24] The Commission therefore recommends that the Government should designate the relevant Ministers who are required to prepare and publish a sectoral implementation plan under adult safeguarding legislation. This plan should outline the measures taken or proposed to be taken by or on behalf of each Minister concerned to ensure that their department, any public service bodies under the aegis of their department and any organisation that provides a relevant service for and receives funding from the department comply with their obligations under the Act and any guidelines issued by the lead Minister.

[961] Section 27 of the Children First Act 2015 and section 31 to 37 of the Disability Act 2005.

R. 20.5 **The Commission recommends that** the Government should designate the relevant Ministers who are required to prepare and publish a sectoral implementation plan under adult safeguarding legislation. This plan should outline the measures taken or proposed to be taken by or on behalf of the Minister concerned to ensure that their department, any public service bodies under the aegis of their department and any organisation that provides a relevant service for and receives funding from the department comply with their obligations under the Act and any guidelines issued by the lead minister.

4. Statutory guidance in the form of guidelines and codes of practice

[20.25] The Commission's draft legislation is comprehensive, but there is still a need for statutory guidance in the form of guidelines and codes of practices, as is often the case with large pieces of legislation. If the Commission's proposed adult safeguarding legislation is implemented, it would introduce a statutory and regulatory framework for adult safeguarding in Ireland for the first time. It is of paramount importance that all those with obligations, functions and powers under the Act understand what is expected of them and this can be achieved through statutory guidance.

[20.26] Throughout the Report, the Commission suggests on a number of occasions that statutory guidance in the form of guidelines or codes of practice would be useful in respect of a particular area. For example, in Chapter 17, the Commission suggests that guidelines should be issued by the lead minister to provide practical guidance to the reviewing body on adult safeguarding reviews. In a similar vein, the Commission recommends in Chapter 8 that adult safeguarding legislation should include a provision to allow the relevant Minister or the Safeguarding Body to publish a code of practice for independent advocates providing support to adults who are at-risk adults, or adults who may become at-risk adults.[962]

[20.27] The Commission believes that the proposed civil adult safeguarding legislation should provide for the lead Minister to introduce statutory guidance in the form of guidelines or codes of practice to provide practical guidance to any person or organisation in respect of the performance of their functions under the Act or on the application and interpretation of the legislation.

[962] See recommendation 8.10 in Chapter 8.

R. 20.6 **The Commission recommends that** the proposed civil adult safeguarding legislation should provide for the lead minister to introduce statutory guidance in the form of guidelines or codes of practice to provide practical guidance to any person or organisation in respect of the performance of their functions under the Act or on the application and interpretation of the legislation.

5. Interaction between adult safeguarding legislation and existing and future legislation

[20.28] As evident throughout the Report, adult safeguarding legislation will interface with many other pieces of legislation and various regulations, including, in particular:

(a) the Assisted Decision-Making Capacity Act 2015;
(b) the Mental Health Act 2001;
(c) the Health Act 2007;
(d) the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (when commenced);
(e) the Domestic Violence Act 2018.

[20.29] The Commission endeavoured to align its recommendations with existing legislation including regulations, so that adult safeguarding legislation could fit seamlessly alongside existing legislation. For example, its recommendations on guiding principles governing adult safeguarding legislation were informed by the guiding principles in the Assisted Decision-Making Capacity Act 2015. It also makes numerous recommendations on how the regulations made under the Health Act 2007 and the Mental Health Act 2001 should be amended to account for specific adult safeguarding requirements.

[20.30] Significant reforms of the Mental Health Act 2001 are also expected in the near future. It therefore remains to be determined how future mental health legislation will relate to the Commission's proposed civil adult safeguarding legislation. The Assisted Decision-Making (Capacity) Act 2015 was commenced in April 2023, and therefore, its full impact has not been realised in practice yet.

[20.31] The Commission's proposed adult safeguarding legislation would likely interface with the Protection of Liberty Safeguards Bill (if enacted) which is currently being developed by the Department of Health, which appointed an Expert Advisory Group to assist it with this work in early 2023.[963] The provisions of the Protection of Liberty Safeguards Bill would need to be aligned with the Commission's proposed adult safeguarding legislation, if both are enacted. In particular, the Commission's recommendations in Chapters 10, 11 and 12, which are reflected in

[963] See the background section of this Report for more details.

its draft civil legislation, would be relevant if a Protection of Liberty Safeguards Bill is introduced in the future. This would ensure a joined-up approach to adult safeguarding. The Commission has anticipated such interaction. In Chapter 12, the Commission recommends a removal and transfer order, but does not recommend a power to detain an at-risk adult in a particular place, in light of the ongoing work by the Department of Health on the Protection of Liberty Safeguards Bill. The Commission is of the view that it would be preferable for detention of at-risk adults (for example, for the purposes of medical assessment or treatment) to be dealt with comprehensively under an overarching legislative framework. The precise interaction between the Commission's proposed interventions and the Protection of Liberty Safeguards Bill cannot be determined until the draft legislation is finalised and enacted.

[20.32] Given the anticipated legislative changes, the Commission believes that the Government should consider, by way of regulatory impact analysis, how the proposed adult safeguarding legislation would interact with existing legislation at the time of implementation, in particular the Assisted Decision-Making (Capacity) Act 2015, Health Act 2007 and the Mental Health Act 2001, and any future legislation.

The Law Reform Commission is an independent statutory body established by the Law Reform Commission Act 1975. The Commission's principal role is to keep the law under review and to make proposals for reform, in particular by recommending the enactment of legislation to clarify and modernise the law.

The Commission's law reform role is carried out primarily under a Programme of Law Reform. Its Fifth Programme of Law Reform was prepared by the Commission following broad consultation and discussion. In accordance with the 1975 Act it was approved by the Government in March 2019 and placed before both Houses of the Oireachtas. The Commission also works on specific matters referred to it by the Attorney General under the 1975 Act.

The Commission's Access to Legislation work makes legislation more accessible online to the public. This includes the Legislation Directory (an electronically searchable index of amendments to Acts and statutory instruments), a selection of Revised Acts (Acts in their amended form rather than as enacted) and the Classified List of Legislation in Ireland (a list of Acts in force organised under 36 subject matter headings).

ADDRESS
Styne House, Upper Hatch St, Dublin D02 DY27, Ireland
TELEPHONE
+353 1 6377600
EMAIL
info@lawreform.ie
WEBSITE
lawreform.ie