Northern Ireland Assembly

# Committee for Health, Social Services and Public Safety

# OFFICIAL REPORT (Hansard)

## Adult Safeguarding Policy: Ms Claire Keatinge (Commissioner for Older People for Northern Ireland) and Professor John Williams (Aberystwyth University)

15 October 2014

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Adult Safeguarding Policy:
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and Professor John Williams (Aberystwyth University)

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**Members present for all or part of the proceedings:**
Ms Maeve McLaughlin (Chairperson)
Ms Paula Bradley (Deputy Chairperson)
Mr Mickey Brady
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Gordon Dunne
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Michael McGimpsey
Mr Fearghal McKinney
Mr George Robinson

**Witnesses:**

| | |
|---|---|
| Professor John Williams | Aberystwyth University |
| Ms Claire Keatinge | Commissioner for Older People |

**The Chairperson (Ms Maeve McLaughlin):** Welcome to the Committee. It is good to see you again. I invite you to make a 10-minute presentation, and then we will open up the meeting to questions from members.

**Ms Claire Keatinge (Commissioner for Older People):** Thank you very much. Good afternoon to Committee members whom I have had the pleasure of meeting before, and I welcome the new members. It is nice to see you.
First, thank you very much for agreeing to hear directly from Professor Williams and me on this most significant issue of abuse of older people. It is absolutely imperative that our legislation, policy, practice and guidance prevent such abuse and protect older people who experience abuse. It should also be clear what interventions are available in the event that abuse is suspected or detected.

In my first corporate plan, 'Hope, Confidence, Certainty', I committed to undertaking a review of the legislation and the adequacy and effectiveness of law and policy in relation to older people so that they are better protected from a range of abuse, including physical abuse, emotional abuse, sexual abuse, financial abuse and neglect. That priority focus for my work followed extensive engagement with older people, older people's organisations and professionals working with older people. They expressed considerable anger and, indeed, revulsion about the increasing number of reports of alleged abuse. On examination, and after further consideration, I was convinced that the legal framework to protect older people from abuse and to assist older people who experienced abuse also

required specialist review. So, I commissioned research from Queen's and the University of Ulster to review the legislation in Northern Ireland.

Make no mistake about it: abuse against older people is universally condemned in our society, but it causes incredible fear and distress to older people who are at risk, as well as to those who experience abuse. It can take many forms, including physical abuse, emotional abuse, sexual abuse, financial abuse and neglect. The impact can have absolutely devastating consequences for older people. Sadly, every year, thousands and thousands of older people across Northern Ireland are being abused, often — usually — by somebody with whom they have a relationship of trust and on whom they ought to be able to depend. The number of reports of such abuse is increasing.

We have to have a better situation, one in which older people can have confidence that, if they experience abuse or are at risk of abuse, the law can adequately protect them, and it can punish adequately those who carry out abuse. As it stands now, there is no single piece of legislation to protect older people from abuse, which means that those who are vulnerable or at risk of abuse are not afforded the same legal protections as their counterparts in England, Scotland and Wales, or Cymru, all of which have dedicated laws in place to protect all older people from abuse. So, I am calling for legislation to protect all older people from abuse and recommending that such legislation include clear definitions of abuse and who is at risk, and clearly outline the responsibilities of those who work with older people.

There are clear gaps in the current legislation, which means that there are some areas where older people are not protected from abuse. The legislation is disjointed, and it draws on a very wide range of laws. The current position offers different protections to individuals who lack mental capacity from those who have mental capacity: those with mental capacity are not afforded the same protections from abuse.

There was a conversation in the earlier session about protections as well as rights. To ensure the best possible safeguarding of older people who are at risk or experience harm, any new legislation must strike a balance between the protection from and prevention of abuse, and between human rights and the law.

There is, I think, a wide misunderstanding of what constitutes abuse. The World Health Organization's definition is that it is a single or repeated act or a lack of appropriate action, which occurs in any relationship where there is an expectation of trust, which causes harm or distress to an older person or violates their human and civil rights. So, it is an act of commission or omission. Of course, in reality, older people can be abused in many ways. The five most common forms of abuse, as stated by the campaigning charity Action on Elder Abuse, are physical, psychological, financial, sexual abuse and neglect. Those abuses are carried out in very different ways. They may be carried out by different people, but the impact is absolutely devastating. The abuse can be carried out by family members, friends, volunteers, neighbours, Health and Social Care employees, any other statutory sector employee, community volunteers, or anybody who would get close to and lean on an older person who is vulnerable. That is who commits abuse.

There are questions about the prevalence of abuse. In a 2007 UK-wide study of abuse and neglect, the only available suggested prevalence data on abuse against older people in Northern Ireland, it is estimated at 3% of the older population. However, that is extrapolated data and not specifically related to Northern Ireland. The Northern Ireland Adult Safeguarding Partnership has reported over 3,000 adult safeguarding referrals, with 39% of the regional total to the older people's programmes. That, I am afraid, is a 43% increase in reports of older people safeguarding cases on the previous year, which was 2011-12. Last year, the most common types of abuse against older people were physical and financial. In 2013-14, almost half of all of the adult safeguarding investigations commenced, and almost half of the care and protection plans implemented, concerned older people. Yet our existing legislation is complex, and practitioners have to draw on a wide range of legislation to carry out their duties, including the Family Homes and Domestic Violence (Northern Ireland) Order 1998, the Criminal Law Act (Northern Ireland) 1967 and the Terrorism Act 2000. While safeguarding professionals can make effective use of existing legislation, the legislative intent of two of those pieces of legislation was not to safeguard older people, and practitioners say that the complexity and disjointed nature of the law is unhelpful to them.

As the Commissioner for Older People, my authority is to advise Government on, and in the context of, safeguarding and promoting the interests of older people, which is defined as those aged over 60 and, in exceptional circumstances, those aged over 50. However, I recognise that my proposals would

offer improved legal protection to all adults at risk of harm or abuse. All people should be protected from harm or abuse, and new adult safeguarding legislation would assist in providing that protection.

There is currently a disparity of protection in existing legislation between people who have mental capacity and those assessed as having a lack of mental capacity. For older people with mental illnesses, including dementia, there is a higher level of protection afforded through the Mental Health (Northern Ireland) Order 1986, and the emerging mental capacity Bill will provide increased protection for older people who lack mental capacity. However, there is currently no specific legal protection for older people in Northern Ireland who have the mental capacity to make decisions. Colleagues referred earlier to the question of cooperation with social services and the right of people who have mental capacity to make their own decisions. However, there is no specific legal protection for people who have the mental capacity to make decisions but who may be under coercion, threat, pressure or intimidation from people with whom they have a relationship of trust or dependence. The recommendations in my report focus on addressing this gap and improving the protection to all older people at risk of harm.

I commissioned a team of academics from Queen's University and the University of Ulster to make recommendations, and they identified a very disjointed array of legislation. Then, I engaged with a wide range of older people's organisations and professionals in all sorts of adult safeguarding and other organisations who work with older people to test how useful new legislation would be and to explore some of the specific detail of powers and duties that new legislation could bring. That told me very clearly that professionals working in the field — people trying to build therapeutic relationships with older people, people trying to protect them from abuse and people trying to intervene effectively without making things more difficult or making the situation worse — are calling for better and clearer protection for older people and absolute clarity in a number of areas including statutory definitions, people's legal duties and the legal powers that people have.

My call today is for a new single adult safeguarding Bill. It should provide clarity, as I said, on the definitions, duties and legal powers that would apply to all employees and organisations listed under the specified, relevant organisations, which should also be outlined in future legislation. Change is required to definitions. We need a definition of what constitutes a person at risk. Members already picked up those points in questions to the Department. There should be a clear and easy to understand definition of a person at risk of harm or abuse. What the abuse or harm is should be clear. What is it that the person is at risk of and what constitutes harm or abuse? In particular, we need a clear legislative definition of financial abuse. With reports of allegations of financial abuse rising, we need specific legislative reference to financial abuse. I would seek an adult safeguarding board to be created to act as an oversight body to protect older people.

We should place statutory duties on those who work with older people. It is quite shocking that these are not already in place. We need a statutory duty to report any suspected cases of suspected abuse or harm to all identified relevant organisations. We need a duty for the most appropriate organisation to make enquiries or conduct investigations when a referral is received.

All relevant organisations working with older people who are at risk of harm or abuse should be bound by a duty to provide appropriate services for that older person, including advocacy support. Throughout the safeguarding process — and it is quite shocking that this is not in place — all relevant organisations should be bound by a legislative duty to cooperate with one another to best protect the older person who is at risk of harm or abuse.

To deliver this, we need specific new powers to protect older people. They would be used only with the appropriate safeguards in place, but there should be the power to access a private home or residence for the purposes of conducting a private interview with the person who is believed to be at risk of abuse or abuse taking place and where access is not being granted.

Reasonable cause could be tested through application to a district judge and would be implemented only if it was not going to result in the older person being at greater risk. The private interview has to be able to take place without the person suspected of committing the abuse being present. It is nonsense not to have that in place.

I also recommend that there should be protection from civil liability for anybody who makes a report of suspected abuse. There should also be further support for whistle-blowers. Again and again we see that whistle-blowers do not feel protected or safe and are discouraged from reporting their concerns.

There are a number of additional considerations that I, in my role, believe should be included in legislation but warrant considerable further discussion and consideration. The first is a power of removal of the person at risk and the power to ban a suspected abuser from the home. Remember, much of the abuse of older people is taking place in their own homes by family, friends and neighbours — people with whom they have a relationship and who they should be able to depend on and trust.

England and Wales have considered those powers, and Scotland has implemented them. Further consideration of the powers for Northern Ireland at this time would be very important.

I am requesting further consideration of the power to access financial records, which is available in Scotland but not in England and Wales, as a clear indicator to collect evidence in the event of allegations of financial abuse. Nonetheless, I advise the immediate implementation of a campaign across all our financial institutions to highlight the signs of financial abuse and the impact it has on older people, so that reporting and investigations of complaints of alleged financial abuse are actively encouraged.

I also request consideration of the introduction of a specific criminal charge of elder abuse, where someone commits a crime against an older person by way of their action or neglect. It is not available at this point in England, Scotland or Wales but we have an opportunity in Northern Ireland to lead on that important consideration.

I would ask for consideration of a specific criminal charge of corporate neglect. This charge would mean that any organisation whose employees, directors, managers or owners are found to have committed neglect or abuse of an older person could be held liable for the actions of those employees.

A single adult safeguarding Bill would ensure that we have a clear and defined legislative position in Northern Ireland on which to develop further good practice. You are absolutely right and you have all said it at different times when I have been to the Committee: legislation by itself will not comprehensively protect older people from abuse. Our attitudes and awareness need to change. Our respect for older people and their rights needs to change. Detailed guidance, training, resources and public awareness, with the commitment of the public and all relevant organisations, need also to be in place. Together, those will ensure protection for older people. I urge this Committee to support the introduction of a single adult safeguarding Bill to be enacted at the earliest possible opportunity and without delay. I encourage you to have that conversation and implement that legislation as a matter of urgency.

**The Chairperson (Ms Maeve McLaughlin):** Thank you, Claire, for that concise and direct ask. I had the opportunity to attend the launch of your recent report. I am looking to yourself, Professor Williams, because part of the discussion at the report launch was around models and legislation outside the North of Ireland, and you had some examples of that. I want to tease that out. We ask you the direct question: what has been the correct fit? What have England, Scotland and Wales done well, and what have they done not so well? What are the lessons for us?

**Professor John Williams (Aberystwyth University):** OK. Many thanks for inviting me to attend the Committee. It is a great pleasure and privilege to be here.

I am an advocate of legislation, or a legislative framework, to support adults at risk. There is clearly a human rights issue, and I hear the argument that much of what might be proposed looks as though it violates the article 8 right to autonomy, which in fact is why legislation is important. One thing you will get with legislation, which you will not necessarily get with just policy and guidance, are adequate safeguards and protections against the misuse or abuse of any statutory powers. Also, we have to look at the article 8 right to autonomy, if I can put it that way, and balance that against the article 3 right in the European Convention not to be subjected to "inhuman and degrading treatment". So, within any legislation, there has to be a tension between those two rights, and a calculation as to whether intervention, in that particular case, is appropriate.

I think it is very interesting to look at the Scottish legislation. Really, we can put England, Wales and Scotland into three bands. We can have England as the minimalist approach, Scotland as the maximum, and Wales somewhere in between. The Scottish legislation provides significant powers of intervention. However, the lesson from Scotland is that that has led not necessarily to a use of those powers but rather to more preventative work. There is something about having the power and telling an alleged perpetrator, "We can do this", that makes that person think and enables preventative work to take place. So, that is a kind of maybe unexpected consequence, but a very helpful one. The

Scottish legislation has a range of powers including, in extremis, the removal of the person at risk or a banning order, banning the perpetrator. Now, that really does have to be packed with safeguards but, as I say, in extreme cases, that can happen. The one very useful thing about the Scottish legislation is that you have a set of general principles that must be considered when you are contemplating using any of the powers, and that is about involving the person, minimising risk and respecting their decisions.

The English model is the minimalist one, which is basically the new Care Act 2014. It provides for a duty to make enquiries. I said that this is minimalist, but it is actually a very valuable power because, until now, unlike child protection, there has been no clear and unambiguous duty on local authorities in England and Wales to investigate cases of suspected abuse of adults at risk. This is useful. That is as far as the English model goes, other than providing for the important duty to cooperate.

The legislation in Wales includes a duty to make enquiries. It also introduced adult safeguarding and protection orders. Wales considered going down the path of Scotland, but rejected it. What the adult safeguarding and protection orders involve is the right to apply to a court for an order allowing you to enter premises in order to interview the person in private, see whether they are an adult at risk, whether they are acting of their own free will — and I will come to that in a moment — and, if the answer to both is yes, decide what action should be taken.

If I might say, and coming from Wales perhaps I should not, my concern with this model is that you may go in and find an adult at risk, that they are not acting of their own free will, and that you may say that there are things that need to be done — but all you can do then is leave. That, of course, runs the risk of exposing the person to even greater harm because the abuser now knows that the statutory services are involved and that, with their powers, they cannot do any more. So, that is a problem we are wrestling with in Wales: how to address that limited form of intervention. There are no powers of removal, banning or just taking the person out to have them assessed. If Northern Ireland decides to go down the route of legislation, I think that that is an important thing to consider. You need to go further than the Welsh model, otherwise you will run the risk of exposing the person to greater danger.

The other issues that all three nations have wrestled with are the ideas of consent and autonomy. I agree entirely that consent and autonomy are critical. The question is this: to give a valid consent, you need capacity. Claire mentioned the Mental Capacity Bill that is proposed for Northern Ireland; we have our Mental Capacity Act 2005. So, first, there is a capacity issue. Secondly, there is the importance of making an informed decision — what the options are. Critically, the third element of legal consent is that the decision is made by the person of their own free will; and we know that, in abusive relationships, it is power. Yes, you are absolutely controlling the person every moment of their waking day. If you are controlling them, then their ability to make decisions freely is seriously inhibited. That is a factor that we have to bear in mind, a crucial factor; because, if free will is not present, it is not a valid consent. That is a huge problem for all three of the other nations to wrestle with. I do not actually think that Wales and England have really addressed that one.

So, basically, we have a spectrum: the English, Welsh and Scottish models. As I said, the very interesting thing about the Scottish model is that it has led to more preventative work rather than to greater use of statutory powers. I like the idea of one piece of legislation because I think the safeguards are critical, and they need to be in one place. I do not think that you should shoehorn the issue of adults at risk into other bits of legislation that were not really designed to deal with the issue.

**The Chairperson (Ms Maeve McLaughlin):** Thank you for that. A number of members have indicated that they want to speak.

**Mr McCarthy:** Thank you very much for your presentation. It is good to see you back with us, Claire.

**Ms Keatinge:** Nice to see you, too.

**Mr McCarthy:** I will ask you the same questions I asked the previous witnesses. I think that you were in the room then. Do you have any idea of the scale of abuse that is taking place in Northern Ireland? What sort of exploitation is involved? Also, who do you regard as the best partners in Northern Ireland to help overcome, prevent and detect abuse of the elderly?

**Ms Keatinge:** The best answer I can give you on the suspected prevalence of abuse is 3% of the older population, which is considerably more than the number of reported allegations of abuse. As to the kinds of exploitation that take place, they are everything that you can imagine and some things,

frankly, that you cannot. They include sexual abuse, involving everything from rape, sodomy, violence, unwanted touching and a deeply unpleasant variety of assaults; financial abuse, which is everything from taking the change out of a £10 note when somebody has gone to the shop to separating people from their home, their independence and their opportunity to spend every penny that they ever had; and physical abuse, involving hitting, slapping, pushing, shoving, broken bones, pushing downstairs, threatening people and threats of abuse — all those things. There is also neglect. There is the neglect where somebody does not get taken to the toilet, does not get assistance with eating or does not get food put near enough to them. They do not get taken anywhere, they do not get out or they do not get the company they need. They do not get the things that make their lives full and rich. All those kinds of exploitation take place, in people's homes, in care settings and in hospitals. They take place everywhere where somebody chooses to exploit an older person who is vulnerable.

Kieran, your last question was about the best partners for addressing this. I do not mean this to sound insignificant, but it is all of us. The best partnership for older people to be safer is that we recognise the gravity and prevalence of the abuse of older people. In the first instance, we must stop just condemning it and do much more, practically, to prevent it, protect older people, and respect and value them. Secondly, we must have legislation and practice in place, which places duties and powers on the relevant organisations that work with older people to intervene directly, with absolute clarity about what they can do, and be decisive. Finally, there are the other organisations that work with older people — the best partners that you talk about — and they are all the organisations that work with older people. It includes all of them, every single one. And they all have to be the best partners in that, by legislative requirement, policy and practice. They have to be; it is not optional, they have to be able to deliver.

**Mr McCarthy:** Thank you very much. Finally, you mentioned whistle-blowers. You are probably aware that our former Health Minister was very supportive of whistle-blowers.

**Ms Keatinge:** Indeed.

**Mr McCarthy:** I do not know whether our present Minister will carry that on; but there is always the fear that the whistle-blower will lose their job or that something will happen to them. Do you think that the Department is big enough to overcome this and get the message out that whistle-blowing is acceptable and is to be encouraged?

**Ms Keatinge:** We need more support for whistle-blowers, those working in organisations who see something going wrong, where the safety and security of older people is at risk. We need better protection for them. The former Minister was indeed very supportive and encouraging of whistle-blowing. However, I am absolutely convinced that whistle-blowers and potential whistle-blowers still feel very vulnerable, that a large number of people who would otherwise report, do not do so, and that those who whistle-blow very often feel intimidated and are squeezed out of their roles. I think that the people who work in care settings absolutely have to be encouraged, not only by ministerial requirement and encouragement, but also by better protection, advice, information and support for them as they are going through that whistle-blowing process. We also need redress for them, if they are victimised.

**Mr McCarthy:** Finally, do you think that the finger could be pointed at the Department of Health itself? You mentioned that one of the criteria for abuse is neglect. In some circumstances, the Department is neglecting people, by refusing to provide community meals, for instance. We all know community meetings, meals on wheels. You will be aware that the number of recipients of community meals has gone down dramatically, which means that people are being neglected because they are not getting one decent meal a day. That would seem to be done, probably, for financial reasons.

**Ms Keatinge:** I think that legislation can assist us greatly by providing clarity on what is harm, what is abuse, and what the definitions are. We absolutely have to also use underpinning legislation, matched up with our care standards in every aspect, so that it is quite clear, going forward, what is abusive and what is not. We should stop setting minimum care standards, raise our expectations and look with pride and confidence at excellence in all our care standards; because neglect is cruel, degrading and inhuman. It should not happen.

**Mr McCarthy:** That includes those people who are not getting community meals because they do not meet criteria that have been raised in order to exclude them.

**Ms Keatinge:** Anything that means that an older person does not receive the services and support that they are assessed as needing has to be challenged, absolutely. I encourage members round the table to get on smartly with implementing and putting out to consultation legislation on age, goods, facilities and services. It is unacceptable that our older people, in particular, experience discrimination on the grounds of their age.

**The Chairperson (Ms Maeve McLaughlin):** The definitions are critical in relation to all that as well. Maybe we can come back to that. You referred to the World Health Organization definition: do England, Scotland and Wales use that agreed definition?

**Professor Williams:** Yes, that is very much the touchstone for the definition. I think that all three have specific definitions of harm, abuse and neglect. In the World Health Organization definition, the important part is that it is abuse by someone in a position of trust. That set the parameters of the legislation. It is someone you would trust: a professional or, indeed, a member of the family, a friend, neighbour or whatever.

**Mr McKinney:** You were in the room earlier when I was talking to the officials about this, and you have now touched on it as well. This legislation may have a preventative effect but it is after the fact. How much is it diminished by the fact that we do not have legislation as you have described it, in terms of goods, services and facilities? In other words, it is important that people understand that they cannot do things, but if somebody has the right — what Kieran is talking about — to a service or facility, that gives them extra power, if you like, in themselves, because the state recognises that person's right as the individual. This is important. I am trying to work out cart and horse here. Where does this fit in that scenario?

**Professor Williams:** It is interesting that, both in Wales and England, the safeguarding and protection provisions are part of broader social care provisions. They are part of the Social Care Act (Self-directed Support) (Scotland) Act 2013 and the Social Services and Well-being Act (Wales) 2014. I think that we have to see it in that context. There is the issue of registration and inspection. Certainly, in Wales, we need to raise our game on that, because it is no good going in and measuring curtains and carpets and saying that all is well, when the feel for the home may be pointing towards some concerns.

In terms of the right to services, yes, absolutely; there comes a point where the state has to assume responsibility for violating the person's human rights. I think that denial of medication was used. There has been litigation on that, certainly in England and Wales. Answers from the courts have varied. The courts always say that they recognise that there is a resource allocation issue, but it is having the principled underpinning for those cases that you get from the Human Rights Act 1998, and also from the general principles that you get in the Social Care Act and the Welsh equivalent. You mentioned the Equality Act 2010 earlier, which is interesting. I do not know quite how to put it, but maybe I will say that it is not all that it is cracked up to be. It is good and useful; but whether it actually gives a firm enough basis for the type of case or challenge that you envisage — on the basis, say, of age or disability — is questionable. It is what the courts make of it that is important. However, it is there and it is a framework.

**Mr McKinney:** And Claire, you have thrown out a challenge to us, to lobby etc. What work are you doing to promote that and improve it, vis-à-vis the 2010 Act?

**Ms Keatinge:** I am sorry, do you mean improving and promoting age, goods, facilities and services? I do not think that I can be very much clearer. We need protection from discrimination on the grounds of age, so that our older people are not subjected to discrimination, and so that they have redress in the event that they are. I do not think that I can make it very much clearer.

In answer to your earlier question, about measuring the impact of the lack of that legislation on abuse; so many factors conspire to create the abuse of older people, tolerate it, prevent interventions and stop protections. We are a deeply ageist society and we need to place the abuse of older people with the same gravity as the abuse of children. Let us be absolutely clear: this is unacceptable. It is abuse which is intolerable in our society. And because we diminish older people as a society, we reduce their rights; we regard them as not able or as somehow not worthy of the same levels of protection. That question of equality, redress, protection and prevention is absolutely imperative. We need to challenge ourselves on our ageist attitudes because, too often, allegations of the abuse of older people get somehow passed off, amid issues to do with carer pressures, issues that other people face. It is difficult. Ms McCorley referred to cases where professional carers coming in and

allegations of theft, for example, are made. There are issues to do with how we care for our older people.

Let us put the rights of older people first. In doing so, let us make sure that any investigation into an allegation is straightforward, honest, open and transparent, so that the rights of care workers are protected, the matter is investigated quickly and decisively, and they can move on smartly with their reputation intact, if that is the right thing, and, if not, action can be taken quickly. The absence of legislation to protect on the grounds of age is immeasurable. It is imperative that we have that in place as swiftly as possible.

**Mr McKinney:** Thank you very much for that fulsome answer. That is exactly the position of our party and we would like to see it extended to children. It is locked now in OFMDFM, and we need to be able to ensure that it is furthered.

There is some difference between the Department and you in relation to how we move forward, specifically on this issue. If I heard the officials rightly, the Department would not approve of or support the concept of a safeguarding board. What is your view on that?

**Ms Keatinge:** I think that we should have a safeguarding board on a statutory footing. The current Northern Ireland Adult Safeguarding Partnership is good and works well. However, it is very often described as a coalition of the willing. It does not have a statutory underpinning and requirement to participate and attend is not as clear as it should be. There is, of course, the Safeguarding Board for children, which, as I understand it, has not been evaluated, but could usefully be evaluated to inform what should go into an adult safeguarding board. A statutory footing is the way forward with that without question.

**Professor Williams:** Both Wales and England have statutory safeguarding boards in their legislation.

**Mr McKinney:** I want to return to one specific point that was touched on earlier. You refer a lot to abuse, and the Department refers to harm as a result of abuse. Is a distinction being made that I am maybe right or wrong to focus on?

**Professor Williams:** To some extent, it is playing with words. There is the basic idea of abuse, and Claire has listed the forms of abuse. Then, in individual cases, one needs to see what the effect of that is. To come back to your question about what harm is, it will vary. Some may cope with overbearing or controlling treatment, but for others it may lead to isolation, which is a form of harm. The key is whether abuse — physical, psychological, sexual and the rest of the list — has harmed the individual and affected the way they function, their physical health or their mental health. If so, yes, we need to intervene.

**Mr McKinney:** I am sorry to home in on it, but I think it is worthwhile. I can remove the word harm from the sentences. For example, it says, "promote zero tolerance of harm to all adults from abuse, exploitation and neglect". However, you could say, "promote zero tolerance to adults of abuse, exploitation or neglect". I am trying to work out the purpose of using both words. Maybe it is not the right time to interrogate this so deeply, but is there a distinction?

**Professor Williams:** No. One is a consequence of the other.

**Ms Keatinge:** If we did not have abuse, we would not have harm.

**Mr McKinney:** But that is what I am saying. Surely, if we want to strengthen this, we would simply say zero tolerance to these things, assuming the effect that those things have.

**Ms Keatinge:** John and I are on the same page. It is zero tolerance of abuse.

**Professor Williams:** That is the key message. They are not interchangeable.

**Mrs Dobson:** I apologise for missing the start of your briefing. What I have heard is quite alarming. I have scribbled down the words "neglect", "exploitation" and "ageist society". It is very alarming to hear that.

You mentioned in your introduction a criminal charge for elder abuse. I would like to hear a wee bit more — apologies if you have already covered it — about how you feel that would work and whether the Department would be supportive.

**Ms Keatinge:** I will start from the bottom end of your question, if I may, Jo-Anne. I do not know whether the Department would be supportive at this point in the matter. The recommendations are all going to be part, as I understand it, of the consultation exercise on new policy and guidance. A specific criminal charge of elder abuse would make it very clear what is meant by abuse and harm, what is unacceptable and what is prosecutable. Maybe John can help us.

**Professor Williams:** I can give you an example of a very disturbing case we have had in Wales concerning the owner of eight care homes. There were 110 victims of very serious abuse and neglect. People were vomiting faeces. Sixty people died in suspicious circumstances. There was a five-year police investigation. There was a garage load of information and evidence, and the Crown Prosecution Service refused to prosecute because, it said, there were evidential problems in proving wilful neglect. In anybody's books, there were any number of criminal offences. If you can wriggle out of a criminal offence or criminal prosecution in that case, we need to clearly define the offence of elder abuse. We need to do that to enable us to capture that sort of offence. It so happens that the victims and their families are without any form of justice. That is the type of case that underlines the importance of being clear that most forms of abuse are criminal offences. It is interesting that we use the term "abuse" when, in fact, we are talking about rape, murder, GBH, assault and all the other things. "Abuse" tends to soften it a little bit. I do not know what happens at the age of 60 — well, I do — but something happens. We cease to be victims of a criminal offence and become victims of abuse, which is still a criminal offence.

**Mrs Dobson:** It is pretty horrific. Sometimes, a strong deterrent can be an effective way of reducing abuse. As you said, the proceedings had not worked in that situation, even though the evidence appeared to be there. I am interested in what you propose. How do you see a charge of corporate neglect working in practice?

**Professor Williams:** Corporate neglect is a challenging concept, because you are attributing a mindset to an organisation, but it is not beyond the wit and wisdom of draftspeople to come up with an offence of corporate neglect. I will go back to the case in Wales. I think you could quite easily attribute responsibility to that organisation. It failed to ensure that proper care was given; it failed to ensure that doctors were called when needed; it failed to hydrate; and it failed to feed. They cannot say, "It wasn't me; it was the other person". An organisation is making large sums of money out of this, and that organisation must have some kind of responsibility. If it goes to the person in charge, fair enough. We have done it with banks; we should do it with care homes. Otherwise, it will be somebody else's fault.

**Ms Keatinge:** Another thing I would add to that in relation to corporate neglect is that it is not good enough to blame the individual care worker. It is not good enough to blame the individual in a care setting, which is very often what happens. It is important that the provider of the care services, whether statutory, private, independent, community or voluntary, is corporately accountable for the services that they deliver. That can only be done with a specific criminal charge of corporate neglect and in the context of a specific criminal charge of elder abuse. In the absence of that, there is too much wriggle room and no real accountability for the organisations. It would be a very, very decisive and effective move in relation to improving standards.

**Professor Williams:** There was a wonderful expression in the Stephen Lawrence inquiry about the Metropolitan Police being "institutionally racist". Many organisations providing care for older people are institutionally ageist. It is in the DNA of the organisation, and it is about lack of dignity and respect and going on to cruelty and neglect.

**Mrs Dobson:** Thank you for your frank answers.

**Mr McGimpsey:** Thank you for the presentation. It is very sobering to hear it. You are clearly looking at the issue, and you have said that you need dedicated laws. You gave the examples of England, Scotland and Wales, and you appear to be saying that Scotland is the model to follow.

**Professor Williams:** Not necessarily. Some may argue that Scotland goes too far. We have to bear it in mind that we have to balance, for good human rights reasons, the rights of the alleged victim and

the rights of the alleged perpetrator, because the person might not be an abuser. I am not saying that Scotland is necessarily the ideal model, although it is interesting that it has led to more preventative work. We have this range of powers, and we will use them, if we have to. I certainly would not go for the English model, and I have reservations about the Welsh model. Perhaps the Scottish model is the nearest to perfection that I can see.

**Mr McGimpsey:** How effective has it been? How long has it been in place now? Bearing it in mind that you are looking for proof — you said that abusers are primarily family, friends and neighbours — it must be very hard to get evidence and very hard to prove a case.

**Professor Williams:** Very hard indeed, because a lot of it goes on. The figures that we have of 3% are a gross underestimation of the extent of the abuse that goes on. That is a problem, and we only see it in the home when we come across it. That is a silly thing to say, but it is only when there is some kind of intervention through the statutory services or reports from neighbours that we get to hear about it.

I am not sure what the answer is there. We need to raise public awareness, because, as with domestic abuse, a lot of people just turn their back and think that it does not happen.

**Mr McGimpsey:** I am thinking about the fact that Scotland has the legislation: how effective do they think it has been?

**Professor Williams:** On the whole, the interesting thing about Scotland is that they have the legislation, but the various authorities have not been very good at collecting data. The data is a wee bit on the soft side, I think, but, as I said, the report that Stirling University did provided evidence that, although the powers have not been used that much, the threat of the power can be a sobering influence on those involved and can lead to more intervention through extra social care. We have to recognise that there are some forms of abuse that are the result of carer stress. The carer is totally at their wits' end, they have not had any support and, facing those circumstances 24/7, they snap. We can do something there in providing support for the carers and recognising their problem.

As I said, a lot of the data from Scotland is soft, but we know that the powers have not been used as much as some people thought that they would be used. We had — I think that you have the equivalent here — the old National Assistance Act 1948, which meant that you could remove people living in insanitary conditions who were aged, infirm and all sorts of other unpleasant language. It had not been used for around 30 years, but I came across it being used as a threat on many occasions: "Unless you come along with us, we will use this power". The key thing is for us to change attitudes, and the law can play a role in changing attitudes. We just need to raise awareness among people, both abusers and the general public, that this goes on and we need to stop it.

**Ms Keatinge:** If I can just pick up on your point, Michael, they are quite strong powers. The power to ban somebody who is a suspected perpetrator from a home or to access financial records or a power to remove somebody who is believed to be at risk of abuse are strong legal powers and must absolutely be tempered with a balance to see whether it is necessary or whether anything else could be done. If they are introduced — I believe that they should be — they must not be used instead of prevention. They must not be used instead of building good, therapeutic relationships with professional staff and people believed to be at risk of abuse. They must not be a bull at a gate or the first point of call. They should be there as a power in the event that cooperation cannot be obtained and there is strong enough suspicion, information or evidence that the older person is at risk of abuse or being abused and nothing else will work. It must not be "instead of".

The pressure on budgets often means that preventative work is less invested in than action to protect or intervene. It is important to bear it in mind, as you consider it, that prevention often does not come up in statistics as clearly as actions taken to protect. It is absolutely imperative that we respect and value good community work, good social work, good psychiatric work and good engagement with older people who may be vulnerable. We must assist them to come to a conclusion themselves about what is best in their circumstances, as well as having the power to intervene to remove the perpetrator, the alleged perpetrator or the person deemed to be at risk in the event that there is such a degree of vulnerability that nothing else can be used effectively.

**Mr McGimpsey:** The point is that if you decided you needed this legislation and it is going to work, you can go bespoke and we will be at it for a long time, whereas, if you have something in Scotland

that you can see clearly is working, you take if off the shelf, dust it down, go to consultation and you can legislate.

**Professor Williams:** A critical part of the Scottish legislation is the general principles, one of which is along the lines of the least restrictive intervention. Those are statutory principles. You can go back and argue for those that have got to be the least restrictive. If you go down the route of legislation, it is important to have those principles in place.

**Ms P Bradley:** Thank you. As Michael said, this certainly is sobering. What I find even more powerful about the debate we are having today is the number of people sitting in their home day and daily who have no contact with social services or anybody else because they have not needed contact for various reasons and are being abused every day, 24/7, by family members or people whom they have been groomed by and have come to trust. That needs to be addressed.

I very much welcome the raising of awareness. Gordon brought this up in the last presentation. Whenever we talk about child abuse or domestic violence, we have so many awareness measures out there in the public domain telling people, "If this is happening to you, this is what you can do or who you can call".

As Jo-Anne said, some of the words that were being used are the same words as I heard only two days ago in another meeting. I chair the sexual health committee and we had Brook in talking about children and child sex exploitation. That is all to do with power, control and vulnerability. This happens day and daily in our country, let's not kid ourselves. It happens in the streets where we live, where elder abuse is taking place.

How would the legislation work for people who are at home and have not got all those other people involved in their life? I would say that a lot of those who are involved with the social services and other agencies are the lucky ones because they have outside agencies coming in. There at people at home today who might see a bit of this on the news at some stage and think, "That's me. That's what happening to me every day. I am being abused no matter what because every one of them is bad". They are bad. They are not abusing. As you say, it should not be called abuse: it should be called GBH, ABH, attempted murder, rape, depravity — all those things. That is the hard line. That is what we should call it because that is what we call it when we look at other age groups.

**Professor Williams:** Absolutely.

**Ms Keatinge:** You raise important questions: awareness of abuse, what is abuse and what can be done in the general public. I have been out with Women's Aid a number of times, and a lot of older women who have experienced abuse say, "Yes, well, I didn't think those posters referred to me. I thought that was about young married women with kids. I didn't think it meant just being given the silent treatment, not being talked to or him just keeping the money. I didn't think it meant me". I hear that again and again. Awareness of your rights as an individual and of what abuse is and is not is very important. We are not sufficiently clear about it in the public arena. If you ask around the population, "What is abuse against older people?", you will get a lot of puzzled looks about what it is and is not. Clarity and awareness are important.

You also raise the question that long before people are in need of domiciliary or residential care or those sorts of services, what kind of community support is out there? Invest in our community organisations and our good community infrastructure so that older people can continue to go to their social clubs and to events and activities where they remain engaged and in contact with people whom they know and trust and are not forced into isolation. Good community organisations will come and collect you at your door and bring you to the activity. Those sorts of things are too often not seen as cost-effective, and we cannot measure terribly easily the preventative impact they have. They are critical in keeping older people connected long before they need that kind of social care, so thank you for raising that.

It is also important to look at awareness not only of what abuse is but of what happens when you report it. I hear quite a lot of anxiety about what will happen if people tell someone that they are worried about something. In the main, my understanding is that people have absolutely no idea of what happens if you make an allegation of abuse of an older person. We need to be very transparent about what happens, whether it is an allegation about a care worker, a family member or anybody else. With respect, I think that, even round this table, there would probably be a variety of levels of understanding about what happens. It is not as clear as it should be.

**Ms P Bradley:** There is great sadness because, every day, we hear stories about people who have been abused in institutions or in their own home by people whom they trusted. We hear about it 20 years, 40 years or 50 years down the line. Here, we have people whom we may never hear from, because they will not have those 20 years, 40 years or 50 years. It is so sad that that whole section of our community is not being given that outlet to say that it is happening to them and they need someone to help.

**Professor Williams:** You certainly raise a lot of points. I think that the time for soft pedalling on a public awareness campaign has gone. It needs to be a pretty hard-hitting, almost the kind of NSPCC "Full stop" approach, and people need to be shocked into thinking that it happens.

It is also important to consider the definition of adults at risk. One concern I have is that we link it too much to people who need social care services. It needs to be liberated from that. There are older people who are millionaires who are being abused and —

**Ms P Bradley:** As there are wives, husbands and children.

**Professor Williams:** Absolutely, and we need to be aware of that. It is a resource issue, and that is the argument that comes back. That needs to be thought about quite a lot in any future legislation.

**Ms P Bradley:** As part of prevention and protection, we need to raise the bar and say, "Abuse is abuse is abuse, no matter what age you are or what sex you are. Abuse is abuse".

**Ms Keatinge:** Colleagues around the table have raised the issue of carer stress. Carers can get very stressed, and it can be very difficult, but that is absolutely no excuse for abuse. The fact that family carers are present is no excuse whatsoever for the state to step away from its responsibilities. We need much better support for older carers. There must be absolute certainty that, when their carer needs are assessed, they are met in full, without question, in a way that is flexible and meets their needs to enable them to continue to care for their relative or loved one in a way that allows them to lead a dignified and fulfilled life. Those are all parts of the same joined-up process: early intervention; better respect for older people; less ageist attitudes; equality in terms of goods, facilities and services; better support for carers; and, please, decisive intervention when somebody is being abused. Let us not leave it, let us not wait and let us not leave it to later and hope that it goes away. As you say, older people do not have so long in front of them, and they deserve to live their later years without being vulnerable, exploited, bullied, intimidated and assaulted.

**Mr Dunne:** Thank you very much for your presentation, both of you. I mentioned the institutional abuse. We all share the shock and horror about how much of it has been discovered and how it was allowed to go on. We all need an assurance that we will not see a repeat of that in forthcoming years. What procedures need to be put in place to ensure that it does not happen again? Is it down to RQIA, which we hear so much about? Members of the Committee met RQIA representatives recently in Stormont and were impressed with what they are doing. However, I do not feel that they have the resources in place and, perhaps, all the necessary skills to manage all the institutions and the individuals outside the institutions, which was covered earlier. How can we get an assurance that there is compliance with health care standards?

**Ms Keatinge:** It is a significant question that warrants longer investigation, but, in principle, our standards of care, whether domiciliary, residential, nursing or other, need to be aspirational. There needs to be high standards, and there needs not to be things called minimum standards. The regulation and inspection is to look at the lived experience of people who live in that facility or receive services; how they experience it; whether they are treated with dignity and respect; whether it assists and supports them to lead full, dignified and engaged lives; as well as all the more matter-of-fact matters to do with medicine management, cleanliness and so on. It is about what it is like for the older person. We need to see decisive actions. Whether that is prosecutions for corporate neglect, the deregistration of owners who are unfit or action against individual care workers or improvement plans, they must be decisive and be followed through. Whistle-blowers must be better protected. I am sure that you will have seen the independent review of the situation in a home in Carrickfergus called Cherry Tree House. There are a couple of lines in that report that indicate that, for eight years, that home failed to meet even the minimum standards. That is deeply shocking.

**Mr Dunne:** Yet they were highlighted.

**Ms Keatinge:** In spite of —

**Mr Dunne:** They have been raised.

**Ms Keatinge:** They have, but, in spite of whistle-blowers, families, care workers and members of the public raising issues and in spite of it being investigated by a number of bodies over time, that home, for eight years, failed to meet the minimum standards. That is shocking. I imagine that a large number of older people lived out their entire end of life in a care setting that failed to meet even minimum standards. We need more decisive action, and we need to be clear about what we expect.

**Mr Dunne:** We need to be firm on regulation.

**Professor Williams:** If it is the same as in England and Wales, it is about professionalising the workforce. It is a casual workforce. It is poorly paid. There is minimal investment in training. You are taught how to feed and clean, and that is it. You are not taught anything about treating people with dignity. The person may be there for a month and then move on to something else. That is not an appropriate level of professional input.

**Mr Dunne:** You have identified a considerable risk that needs to be addressed.

**Professor Williams:** It is about decasualising and professionalising the workforce, because it does a crucial job.

**Ms Keatinge:** John is absolutely right: it is about improved status, respect and investment in the workforce. A lot of care workers do an incredibly good job. They deliver dedication, commitment, hard work and real care and love for a lot of the older people they care for and provide that care for. They deserve better support, and they deserve to be properly paid, trained and supported. They also deserve to be challenged when things go wrong, as do their managers and the owners of businesses. Our older people are the people in that setting who are least able to speak up for themselves.

**Mr Dunne:** Do you feel that there needs to be an emphasis on audit and review of organisations and institutions to assure the public that the businesses and organisations are working to the standards and providing the care that they say they do? A lot of things are found out by audit and review, when someone independently walks into an organisation or institution. Why do we wait until something happens? It should be done on an ongoing basis. Feedback should be given to the management and those in authority, rather than waiting until an event happens. We have all been told about the sad cases in the institutions. Why is it not being done on a planned progressive basis? That would give assurance to everyone — those who are in there, their families and the general public — that what is being done is actually being done and they are working in compliance with procedures.

**Professor Williams:** As Claire said, it is not necessarily all about measuring the infrastructure; it is about measuring quality and the experience for older people. Across the UK, we need to rethink the way in which we assess the quality of care that people are given. Dignity is one thing that we need to factor into that.

**Mr Dunne:** Correct.

**Professor Williams:** It is a word that we —

**Mr Dunne:** How do you measure it?

**Professor Williams:** That is interesting. You might not be able to measure it in a scientific way before you can feel it when you are in there. You know a good care home when you go into one. You know a bad one, too.

**Mr Dunne:** You can smell it.

**Professor Williams:** Absolutely, yes.

**Ms Keatinge:** It is a very interesting question from Gordon as to what we extent we look at things like audit and overall assessment. There are individual reviews. You can go on to the RQIA's website and

see the inspection reports of any registered facility, but it would be useful to have an overall sense through, for example, a rating system for care homes that we could have in place. Is there absolute certainty that, if issues are raised at one inspection or by a whistle-blower or through complaints at some point, they are automatically revisited at the next inspection? We need to get some sense of how well our care sector is doing overall.

**Mr Dunne:** Some measures.

**Ms Keatinge:** Some measures. I think that we underestimate the extent of good care and do not act decisively and quickly enough sometimes in the event of poor care. Both of those will create more confidence in the sector.

**Professor Williams:** And what do residents think?

**Mr Dunne:** Correct. Thanks very much.

**The Chairperson (Ms Maeve McLaughlin):** I am conscious, Professor Williams, of time, and there are three more members who want to speak. Are you OK at this point? *[Interruption.]* OK. We will be as concise as we can, because I know that you have a flight to get.

**Ms McCorley:** Go raibh maith agat, a Cathaoirleach. The issues that I was going to ask about have been covered. I appreciate the presentation and think that it is a really valuable discussion. I will not take up any more time.

**Mrs Cameron:** Thank you very much for a very good presentation, and thank you both for being so clear and concise on all the issues. I was first presented with elder abuse in the context of domestic violence and abuse by Women's Aid in my initial years as a councillor in Antrim, and I heard many stories that day. One was about an 80-year-old woman in a home with her husband sharing a double room. She had dementia, and he was just frail and elderly. They discovered bruises and could not understand where they were coming from. When it was raised with the GP they went to see, the answer was that there was a 60-year history of abuse with that couple, and the reaction was to remove the wife and put her in a single room. They did not even — they made up the excuse that she had to be moved because she was disturbing the husband's sleep. John, you talked about the legislation and the maximum level in the extreme legislation in Scotland. Would that have safeguarded that lady? Would it have led to her being — you know?

**Professor Williams:** One of the disturbing things in what you say is that it had been going on for so many years and had not been addressed. Yes, there are things that could have been done. The assessment order might have been useful. The removal order might have been useful. The banning order might have been useful. Clearly, there are sensitivities that you need to address in each case.

It is interesting that, when you reach whatever age is older age, we do not think of it any more as domestic abuse or domestic violence. One of the challenges that we are having in Wales is that we are talking about legislation for domestic abuse and about the safeguarding legislation, but we are not talking to each other. There are clear overlaps. The other example that I come across more and more now is where it has been an abusive relationship throughout the marriage and he has maybe been abusing her, and then he suddenly becomes vulnerable and frail and gets Alzheimer's and it turns round. That is a very difficult one to deal with. The simple answer to your question is, yes, there would be a power of entry that might be helpful. There could be assessments. We also have to look at what support we can give to her, and maybe to him. I do not know. It is all part of the total package of not just the safeguarding, but the type and quality of care that we can provide people in that situation. As I said, the really disturbing thing is that there had been a long history of abuse.

**Mrs Cameron:** Claire, on the same scenario, at the time it was also said that there was a 60-year history of abuse with the couple. That was known not just by the GP but by the family. Obviously, it was not dealt with in any way. You mentioned several times in your presentation the fact that this is happening and that very often the perpetrators are people that we know, such as family members and carers. How badly do we need a new campaign to raise awareness, make it socially unacceptable and reiterate how unacceptable it should and must be?

Given the kind of figures we heard about from the Department of Health, as a result of Kieran's question, about 7,500 referrals to those services — a 36% increase on the previous year — and your

estimate that it should be much more, if we had a very successful campaign would we actually be able to cope with the fallout?

**Ms Keatinge:** That is an interesting question. It has to be the case. If we raise awareness, which we have to do, you have to have in place —

**The Chairperson (Ms Maeve McLaughlin):** Thank you, John. I know you have to leave. Maybe we could direct the question to Claire. Are you OK to stay for a few minutes?

**Ms Keatinge:** I am quite happy to stay.

**The Chairperson (Ms Maeve McLaughlin):** Thank you very much, Professor Williams. I appreciate it, and we will continue the conversation as the policies develop. My view is that the policy needs to be underpinned by some sort of legislative framework. Thank you for taking the time.

**Professor Williams:** Thank you for a very interesting discussion.

**Ms Keatinge:** I also extend my thanks to Professor Williams. He has been enormously helpful and he is an internationally credible and renowned expert on elder abuse. His time has been absolutely invaluable to me and my colleagues.

**Mr G Robinson:** I thank Claire for her presentation. I have a couple of questions, and the first one is more an observation. I was part of the team in OFMDFM that set up the historical abuse inquiry. We are seeing the outworkings of that, and some of the stories that are coming out of it are horrific.

Moving on from that, there is one area where I feel we need to do more. I have been lobbied by several relatives of very elderly people who were in hospital. On occasions, those people have had to step in and speak to the management because of clear cases of neglect involving their elderly relatives. Some of those have nearly ended up as discrimination cases: they were shunned, left to the one side, may have wet themselves and been left there for quite a long time. I am not saying for one minute that it is all medical staff or all hospitals, but there is the odd isolated occasion, so we need to be keeping a closer watch, particularly from very elderly people's point of view.

**Ms Keatinge:** Without question. As Professor Williams said, we are institutionally ageist. Older people get set aside too easily, they get disregarded too easily and their concerns, anxieties and fears, and neglect of them, are set aside too easily. We need to step up to make sure that older people's rights to proper, fair and decent treatment are always actioned and that we set aspirational standards for care and treatment and invest properly in what looks like really excellent care services and excellent hospital treatment.

What does an older person with dementia need when they are admitted to hospital and are already confused and have had a fall and have waited a long time in A&E and they go on to a medical assessment unit or a ward and they are confused? They are not being a nuisance if they are crying out for help, they are not being a nuisance if they need assistance to go to the toilet: they have distinct needs and they must be regarded as people who have enhanced and additional needs. They have the right to have those needs met, rather than something which is a trouble.

**Mr G Robinson:** That is my point: we need the medical problems they have to be more closely scrutinised.

**Ms Keatinge:** Absolutely. What level of staffing is required on hospital wards? What do people with dementia really need? What do frail older people who are waiting in accident and emergency need by way of assistance and support? Let us put it in place with pride and confidence. I encourage you to say, "Invest confidently and proudly in what older people need". That way, we can look around us and say, "It is not that there is quite a lot of good care, and some that isn't, but that we always have excellence in care." When that care falls short — things can always go wrong — we can deal with it swiftly and decisively.

**Mr G Robinson:** My point is that they are nearly discriminated against because of their age. They are pushed to the one side and are neglected.

**Ms Keatinge:** Indeed.

**The Chairperson (Ms Maeve McLaughlin):** Claire, I thank you and Professor Williams. This has been an extremely useful discussion. Obviously, as a Committee, we will track the consultation on the policy, particularly in relation to question 28, which is specifically on the need for legislation, and reflecting on the responses that come in there.

As I said, my view, which has been enforced today, is that we need a legislative framework. There is an opportunity for the North to lead the way in relation to this and get the right fit. I thank you. Today has been very informative, and I look forward to continuing engagement on this.

**Ms Keatinge:** Thank you, Chair. Again, my thanks to Professor Williams and colleagues around the table. If I can be of any further assistance, please ask. We have a relatively small population here, so we have the opportunity to be decisive and show considerable leadership by preventing abuse and protecting our older people. We need to do it. Thank you very much for your time.