Adult Protection Bill

September 26, 2025

Considerations for the Assembly Health Committee

Families Involved Northern Ireland (FINI) is a regional network of families acting as informal advocates on behalf of our family members with learning disability and complex needs, who are assessed to lack the capacity to make decisions for themselves. My sister has learning disabilities, complex health needs and limited verbal communication. She no longer lives in the family home.

My comments on the Adult Protection Bill reflect my concerns on its actual ability to improve the safeguarding and protection of our people across Northern Ireland.

I believe that this legislation should not proceed until the recommendations from the Muckamore Abbey Hospital Inquiry on the largest safeguarding investigation in British history are published.

It should also be noted that this legislation was originally triggered by the events in Dunmurry Manor by an independent provider on older people and following various CPEA reviews.

The full implications of the failures by a **statutory body** in a **statutory facility** for people with **learning disabilities** are still to be fully understood and this legislation should not be expedited until the findings of the Muckamore Public Inquiry are published.

Public Communication

Notwithstanding the limitations noted above, some of the questions that families are asking is:

'Where else is harm actually happening today across the region that we don't yet know about?'

'What is the position of Adult Safeguarding and Protection across Northern Ireland today?'

'What in this legislation would have prevented the abuse at Muckamore Abbey Hospital and Dunmurry Manor happening?'

'This Bill introduces a duty to report harm but what about a duty to do no harm and keep adults at risk of harm safe?'

'How can a statutory body investigate itself when abuse has been reported and uphold any Public Trust?'

'Safeguarding and Protection are a continuum, how can they be separated and why isn't safeguarding a statutory duty as much as protection? Surely preventing this harm is where the focus needs to be and not when the horse has bolted?'

What are the key messages to the Public that this legislation is adequate and where is the assurance and evidence that present practices of safeguarding and protection in Northern Ireland are working?

Family role in Safeguarding and Protection

The right to be kept safe is the fundamental right that every family member, who has a vulnerable adult living in some form of institution or attending a public service, is fighting for daily. Families are the bedrock for ensuring that their loved ones are kept safe and should be recognised and respected by the Health & Social Care System. A major cultural change across the whole system needs to happen if families are to be acknowledged as the people who know their vulnerable adult best and should be listened to. They have safety at the top of their agenda and are probably the first people to identify neglect. Families need to be recognised as a full partner in safeguarding and protection. When adults at risk of harm can no longer live in the family home, they still need to be living close to their families with full accessibility.

Who are the Adults at Risk of Harm? – need clear definitions of who these people are.

I would like to see specific recognition of the people and the environments noted below as evidence would suggest that these are the most vulnerable and the environments most likely to reflect institutionalised living.

- Those with a DoLS (Deprivation of Liberty Safeguards) and/or subject to restrictive practices
- Those with learning disabilities and/or autism and complex needs. Many who are deemed to lack mental capacity and have limited oral communication.
- Those living in any congregated living settings with locked doors (long term hospitals, some day centres, community nursing or residential or supported living set up) with other people with similar clinical disabilities and deemed to have no mental capacity.
- Those known to the Office of Care and Protection.

What is Harm?

The definitions of harm should be laid out legally. Why has this not yet been done?

Many of our people with learning disability and/or autism with limited verbal communication may be unable to tell anyone when they have been abused. What in this bill will make sure they are protected in the future? How do we determine if they suffered harm, serious harm or trauma?

How will the police determine if harm has happened to these people?

Exclusion of Self Harm

What if self-harm, in the case of people with learning disability and/or autism, is due to neglect, inappropriate environment, or a lack of appropriate training for staff to communicate with the person? What if those care workers knowingly or unknowingly are causing harm? What are the implications for the exclusion of harm to this group of people and what kind of protection will be available to them?

Before the Bill is Implemented – the reporting of Harm

What exactly are Trusts doing today when harm or neglect is reported? Are we to believe that they are not reporting or investigating because there is no present duty? It was concerning a remark made at the last briefing of the Health Committee by the DoH that reporting could not begin until they had resources to investigate. This needs further challenge.What level of risk is

presently being carried by our Health and Social Care System in reports of harm or neglect that are not being investigated? We would like to see some evidence that could help understand the present gap in concerns that are not investigated.

Staff

This legislation includes criminal liabilities for care workers and care organisations. What responsibility will be laid at the door of the commissioners i.e. Trusts who develop the contracts and care packages for individuals with these care organisations?

What protections will be available to frontline workers who are part of inadequate staffing teams and who have not been provided with appropriate training to ensure they can meet the needs of the people they are caring for?

What consideration has been made that this type of employment is going to be made even more unattractive with the launch of this bill and recruitment could be even more difficult?

What evidence to we have that there has been an improvement in the working culture of these organisations with leadership that values these employees?

The Reform of Adult Social Care is reviewing the remuneration, terms of employment and progression of frontline workers within the Care System.

Will recommendations be available before the introductions of this legislation?

This sector relies on agency staff. How will organisations ensure that agency staff are appropriately trained and informed of individual client requirements to ensure their safety?

Independence of Investigations

Families remain concerned about Trusts charged with investigating harm reported within their own statutory services. Some families have remarked on this as marking your own homework and do not have the confidence or trust that individual Trusts will carry this out with integrity.

There is a need to have an independent investigation mechanism to hold Trusts accountable.

Governance

What evidence is presently available in the public domain to give an overview by Trust of the present situation on safeguarding and protection across Northern Ireland?

NIASP was stood down in August 2020, what data has/is presently being collected and by who on Adult Safeguarding & Protection to demonstrate that there are appropriate control and accountability across Northern Ireland?

What is the present role of the Interim Adult Protection Board?

What will be the differences in future between the role of the new Adult Protection Board and any other safeguarding oversight within the Department of Health/SPPG?

Where will ultimate accountability lie for safeguarding and protection?

What are the implications for the Adult Protection Bill without full implementation of the 2016 MCA?

Families need reassurance that those tasked with screening in or out a safeguarding incident can be challenged by an independent authority.

Serious Case Review

SCR (Serious Case Reviews) requirements. How will these be different from the present SAI process (Serious Adverse Incidents)? Can thresholds be properly communicated to the public on what exactly the purpose and outcomes of SCRs will be?

RQIA did a review of the SAI process in 2022. Have the recommendations been adopted and implemented by the DoH? How will these recommendations also be incorporated into this new SCR process? Will families and the public be consulted on this new process when established?

Independent Advocacy

It has been identified that independent advocacy is required to support the 2016 MCA (Mental Capacity Act), the new restrictive practices policy 2022 (which has not been implemented and as a side should be in legislation and not just a policy) and now the Adult Protection Bill.

Who is charged with developing the profile of advocacy required and commissioning it across Northern Ireland?

Why has there been no advocacy provided to people under DoLS within the MCA?

Where is the business case for independent advocacy in the Adult Protection Bill? Or is this another piece of legislation that will disregard the rights of adults at risk of harm.

The System has been delinquent in commissioning the calibre of expertise and independence needed to support individuals who fall under the various pieces legislation/policy and this needs rectified if the rights of individuals are going to be upheld.

Families as the best advocates for people with complex needs but have no legislative rights to have their voices heard. This should be considered to be added to the legislation.

Statutory Guidance

Why is the Bill being rushed through when issues like thresholds of harm have not been detailed?

Training – how will the safeguarding and protection training improve culture and understanding of how to safely look after adults at risk of harm?

How far has the system got in standardising thresholds, processes and procedures across the region on present safeguarding?

Will there be consultations on specific content of the Bill?

- CCTV policy
- Statutory Guidance including detail of adults at risk of harm and thresholds of harm?
- SCR? What is the difference between SAI (Serious Adverse Incident) and SCR (Serious Case Review)?

- Changes to 2016 Adult Safeguarding Operational Procedures?
- New data reporting?
- Changes to training and development?
- Independent Advocacy?

RQIA Role

Do RQIA recognise the 'high risk' settings that adults at risk of harm live? How do they enhance their inspections of these places and assure themselves that they are safe? (People with DoLs and subject to restrictive practices)

Do they ensure they speak with family members of those with learning disabilities and/or autism and limited verbal communication when they are carrying out inspections? Should this be made mandatory?

Do RQIA acknowledge the additional training required by staff working with people with complex needs and distressed behaviours?

Do RQIA monitor staffing both training and numbers across all shifts? Do RQIA check how organisations cope with using bank and agency workers to understand the needs of complex people?

Protection of Frontline Staff

Families have mentioned that they have seen situations where a lack of adequate staffing levels and limited training of these staff has allowed harm and neglect to occur to their loved ones. Staff cannot physically be in two places at the one time and in settings where people with learning disabilities who can be unpredictable are living together it is essential that there are enough staff to support them at all times (including night shift). There is a duty on the commissioners (Trusts) and management of the institution to ensure that there are adequate staffing levels and training to protect these frontline workers.

There are key risks for organisations in the use of agency staff if they have inadequate training and lack of knowledge of the care plans for individual residents/patients.

It will have a detrimental impact on hiring staff in an already difficult field of work if they are exposed to a high level of risk for prosecution for failings in management to provide adequate staffing and training.

Financial Overview

Although this Bill is now proceeding through the approval process, there has not been a detailed business case presented, and money made available for implementation.

What is the incremental cost by Trust for introducing this bill? What are the details of these costs by category of cost? (personnel, training, independent advocacy etc)

It would also be useful to see what the present baseline of expenditure is by Trust to cover safeguarding and protection.

What is the present social work headcount by Trust working on safeguarding and protection and the associated costs?

What explains the differences between Trusts?

Are levels of safeguarding and protection cases different in each Trust?

What is the level of training carried out annually in each Trust?

What is the cost to the C&V and Independent sector of this Bill?

Will commissioners change contracts with C&V and Independent sector to reflect safeguarding and protection duties?

Will commissioners provide extra funding to C&V and Independent sector to deliver on the Bill?

How much of the investment proposed is so fix identified failings on safeguarding?

What is the present deficit in adult safeguarding training by Trust?

How much money is for independent advocacy?

Thank you in advance for the opportunity to share by concerns about this Bill as a family member.

I also attach a letter I directed to the Health Committee last year with regards to the present oversight of Adult Safeguarding and Protection and a lack of transparent data and reporting in the public domain.

Best wishes

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Emailed to Health Committee members **June 6th, 2024**

Questions on Interim Adult Protection Board and Health Committee Meeting on Adult Protection Bill

Interim Adult Protection Board

A website https://online.hscni.net/partnerships/interim-apb/ has been established to inform the public of the work of the Interim Adult Protection Board.

Below is an extract from this website, describing the function of the IAPB.

'About the Interim Adult Protection Board

The Interim Adult Protection Board (IAPB) was established in 2019 by then Minister for Health, Mr Robin Swann. He undertook to bring forward an Adult Protection Bill for Northern Ireland and stood down the Northern Ireland Adult Safeguarding Partnership (NIASP). It was anticipated the legislation would be enacted within two years. As this has not been possible the Interim Board will remain in place until the Bill has become law.

Our Role

The objective of the IAPB will be to protect and safeguard adults at risk of harm or in need of protection in Northern Ireland by co-ordinating the work and ensuring the effectiveness of each person or body represented on the Board.

Mission, Vision and Values

The Interim Adult Protection Board (IAPB) is the key statutory mechanism for agreeing how relevant partners will co-operate and work together to protect and safeguard adults at risk of harm in Northern Ireland. The Board is committed to developing its trauma informed approach to how we work and practice.'

There are no minutes from the IAPB meetings in the five years that it has been in operation, so no public information or oversight of the work undertaken by this group to assure us that Adult Safeguarding is under control across the Region. The IAPB is not solely a strategic body looking at the future structure required to support the Bill but the also the oversight of present Adult Safeguarding practices and concerns across the Region. What is the present state of safeguarding in Northern Ireland? Who can the public hold accountable for this?

Work on the structures to support the implementation of the Adult Protection Bill is in progress but there is again limited information on this website to inform the public on the status of this and without sight of the final Bill content, work has been restricted. As a member of the public with a specific interest in Learning Disabled people, I have participated as a member of two of the four workstreams to support the Bill. As part of these

workstreams, I have repeatedly asked to have the minutes of the Interim Adult Protection Board Meetings, and although promised on numerous occasions, these have never materialised. It was recently mentioned that the IAPB had not met since last October. Is this level of governance of something as important as Adult Safeguarding, and in light of the recent scandals, acceptable practice by the Health & Social Care System?

While Protection is an important element of Safeguarding, prevention for family members of people at risk of harm, is paramount.

While work proceeds on the Adult Protection Bill, many families are unsure on what is happening across the region on safeguarding today and now.

What is the present status of safeguarding across the Region?

What is the process for reporting, screening and further investigation of any incident?

Who is responsible for the different steps in these processes?

What are the criteria for investigating?

How quickly do these incidents get investigated and necessary protections plans put in place for people?

How are families informed about these events and how are they involved in the processes?

How many referrals have been made by Program of Care and what type of incidents have been investigated and by whom?

Are there consistencies in processes, protocols and reporting in each Trust?

How many adults by PoC have a protection plan?

Can we see the evidence of this?

The recent presentation given by Mr Mark McGuicken and Ms Kerry Loveland-Morrison from the Department of Health to the Committee for Health (16th May 2024), gave rise to several questions which I would be grateful for your consideration.

The Adult Protection Bill was initiated on the back of the Dunmurry Manor Care Home scandal and the subsequent reports of the CPEA and the Older People's Commissioner. This was a non-statutory service commissioned for Older People by several Trusts.

Although at the time, the scandal at Muckamore Abbey Hospital was already known, it will not be until the recommendations of the public inquiry into Muckamore are published that we will have the full insight of how a Statutory Body has caused so much harm to people with Learning Disabilities.

Are we rushing an Adult Protection Bill before adequate consideration and reflection has been given to the outcomes of the MAHI and to understand if additional independent oversight and independent investigation of statutory bodies should be included in this Bill?

Is there a place for the Department of Justice to oversee this Bill?

Resources

The Department of Health gave details of the incremental costs associated with the introduction of this Bill. Can we see the baseline information of what is being spent now on Adult Safeguarding and Protection? Can you provide details of the resources, including numbers of people by Trust and Program of Care that are presently involved in this work?

What is the full breakdown (by type of cost) for each Trust and program of care for the projected £16 million per annum increase to deliver the Adult Protection Bill?

Has there been any work carried out on how much it would cost to improve the prevention aspect of adult safeguarding and protection?

Has there been any analysis of the costs associated with delivering unsafe care? E.g.:

- Suspensions on full pay for staff at Muckamore
- Incremental cost of agency staff
- Legal costs of handling individual abuse claims
- Damage settlements to people
- Public Inquiry costs
- Legal costs of all represented Health & Social Care bodies

What are the similar costs associated with Dunmurry Manor, Neurology, Urology and other patient safety reviews?

CCTV

If CCTV is not made mandatory, how will we ever establish the evidence needed to demonstrate abuse, harm and/or neglect have occurred?

If CCTV had not been operational in Muckamore Abbey Hospital, unknown to staff, we would still not know what was happening there. What is the legal advice about CCTV being used in Muckamore?

It begs the question where else is this happening that we are still unaware of.

We are families of people with learning disabilities, who have limited or no verbal communication. Without CCTV to verify the cause of any harm that happens, an adult protection bill is meaningless. We will be no better off post Bill than we were before.

It has been said that investigators see people with learning disabilities who lack capacity as 'unreliable' witnesses even when they can speak. We need to have their rights respected to live free from harm like every other citizen and if CCTV is one key tool to do this then we need to state that.

Independence

Trust in statutory bodies is at an all-time low and the revelations from the witness statements/transcripts at the Muckamore Inquiry would suggest a Health Service culture that is not encouraging or rewarding of candour.

Are there any plans to bring the Duty of Candour to the Executive for approval?

How can families be assured that their safeguarding concerns are properly investigated if a particular Trust has responsibility for investigating itself? How would this not be a conflict of interest?

We have grave concerns that making it a statutory duty to investigate an incident will make any difference to what happens, unless an external body outside Health & Social Care can oversee this process. There is also considerable work that needs to happen to ensure that Health & Social Care is open and transparent to families with any concerns that the family has about the care of their loved one.

The reassurances from the Department of Health of the genuine support and goodwill of the Trusts for this new legislation and driving forward change is not enough to assure families that real change will come about and accountability will be attainable.

Although the mantra that 'lessons will be learnt' is part of the Health & Social Care brief, evidence that learning is applied within Trusts never mind across the region is not apparent. How and who will hold Trusts accountable for the implementation of key learning outcomes?

The Draft Bill has emphasis on the introduction of new offences like care worker offence and care provider offence, does this include Statutory Body offence and statutory worker

offence? Again, it seems that the reality of what has happened in Muckamore is not being adequately addressed in the overall content of the Bill.

The minimisation/elimination of the use of restrictive practices whether that is physical or chemical is a key element of the new Regional Restrictive Practices policy. This will require substantial training for staff in new ways of working with older people with dementia, people with mental health concerns and people with learning disabilities and/or autism. Restrictive practices lead to people being harmed and traumatised and these need to be seen as part of the overall implementation of this Bill. When will the new Restrictive Practices Policy be implemented in each Trust? How will the use of restrictive practices be considered in the implementation of the Adult Protection Bill and subsequent reporting?

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Deprivation of Liberties Safeguarding (DoLS), part of the MCA 2016 can lead to restrictions and restrictive practices being used on people who are assessed as not having capacity. Some people with learning disabilities have a Nominated Person who in many cases will be a family member who can be consulted on these restrictions. There are many however who no longer have family and do not presently have independent advocacy to support the decision making on these restrictions. We need to protect people at risk of harm from having restrictions placed on them that could be in the 'best interests' of organisations rather than the individual themselves. Lack of adequate numbers and training of staff can lead to restrictive practices that are harmful to people. Will the Bill make special provision for particular groups of people who are at higher risk of harm?

Thank you for your consideration of these questions.

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Families Involved NI