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Adult Protection Bill 2025

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This research paper provides an analysis of the Adult Protection Bill (Northern Ireland) 2025, currently at Committee Stage in the Northern Ireland Assembly. The paper examines the Bill's background, scope and key provisions, including statutory duties, protective powers and the establishment of an Independent Adult Protection Board. The paper also explores stakeholder views, implementation challenges and the Bill's interaction with existing legislation and policy frameworks to support scrutiny by members of the Northern Ireland Assembly Committee for Health.

Paper 81/25 October 2025

Contents

1 Executive Summary

This Executive Summary provides an overview of the key themes emerging from the analysis of the Adult Protection Bill. It is intended to support the Health Committee's scrutiny by identifying strategic issues, potential implementation challenges and areas where further clarification may be required through regulations or statutory guidance. Each section highlights cross cutting themes, reflecting how individual provisions within the Adult Protection Bill relate to one another and to broader policy aims such as protecting an adult's rights and ensuring consistency in safeguarding practice.

The Bill's practical effect depends on the timing and quality of statutory guidance

Much of the Bill's impact will depend on the content and timing of statutory guidance issued under Clause 22. While placing operational detail in guidance allows the Department to adapt procedures as practice evolves, it also means that key elements, such as thresholds for intervention, evidentiary standards and multi-agency coordination are not yet defined in the legislation itself.

The Department has stated that statutory guidance will be developed alongside the Bill, however, there is no further indication of its progress, or the timetable for consultation and completion.

The guidance will ultimately determine how duties are interpreted and applied across HSC Trusts, shaping professional judgment, legal compliance and cross sector collaboration. Until this guidance is available, it remains difficult to comment fully on how many provisions of the Bill will operate in practice or how consistently they will be applied across regions

- **Members may wish to seek an update on the progress of the statutory guidance, including any timetable for its completion and consultation process.**
- **Members may wish to consider how stakeholders, including service users and practitioners, are being involved in the drafting and consultation process.**

Principles and rights based approach

The Department has established a set of key principles that underpin the Safeguarding functions set out in Part One of the Bill. The principles are intended to ensure that protection measures are delivered in a way that respects the rights, dignity and autonomy of the adult.

Clause one of the Adult Protection Bill sets out that any actions taken under the Bill must benefit the adult, are the least restrictive option, respect the adult's wishes and feelings and involve them as fully as possible in decisions that affect them. The principles aim to balance protection with personal liberty which reflects contemporary approaches to Adult Safeguarding.

May stakeholders are supportive of the principles set out in the Bill, seeing them as key to creating a fair and empowering approach to adult protection. However, several organisations, including the Northern Ireland Human Rights Commission (NIHRC) noted that the Bill does not include a clear legal duty for public bodies to act in line with human rights frameworks.

Instead, the principles are designed to guide decision making when undertaking the safeguarding duties set out in part one of the Bill. The NICHR and the Commission for Older People in Northern Ireland (COPNI) have suggested that adding an explicit duty to act in accordance with human rights would strengthen

the Bill and provide clearer accountability for public bodies when making safeguarding decisions.

- **Members may wish to consider whether an explicit human rights duty should be added to the Bill.**
- **Members may wish to enquire how the Department will ensure that these principles are embedded across HSC Trusts through guidance, training and inspection.**
- **Members may wish to seek clarity on whether the Adult Protection Board will have a monitoring role in assessing adherence to the principles and reporting on their implementation.**

Clarity and consistency of definitions

This theme considers the importance of clarity and consistency in defining key terms such as ‘harm’, ‘adult at risk’ and ‘undue pressure’.

Clear and consistent definitions are described as fundamental to the Bill’s operation. Terms such as ‘adult at risk,’ ‘harm’ and ‘undue pressure’ underpin every duty and power within the legislation, from reporting and investigation to the use of protection orders. However, stakeholders have highlighted that many of these definitions remain broad or open to interpretation, which may lead to variability in practice.

Stakeholders have noted that ambiguity around definitions carries significant operational and legal implications. For example, inconsistent understanding of ‘harm’ could result in different thresholds for intervention across Trusts, while uncertainty around ‘undue pressure’ may create difficulties in assessing whether consent by the adult has been freely given.

Other terms worth noting include ‘ serious harm’ in relation to production orders (clause 9), ‘gross breach’ in relation to a care provider offence of ill treatment (clause 39), ‘connivance’ in relation to offences by bodies corporate (clause 24) among others.

- **Members may wish to seek assurance that statutory guidance will include practical case examples and illustrative scenarios to support consistent interpretation.**
- **Members may wish to consider how the Bill’s key definitions will align with existing legislation, such as the Mental Capacity Act (NI) 2016, domestic violence and human rights frameworks.**
- **Members may wish to ask whether the Department intends to develop a regional glossary or shared terminology framework to ensure consistent practice and comparable data collection.**

Ensuring consistency and harmonisation across trusts

The challenge of consistent definitions directly connects to broader concerns about harmonisation across HSC Trusts. Even with strong guidance, effective implementation will depend on whether local systems interpret and apply the Bill’s provisions uniformly across Northern Ireland. A recurring concern among stakeholders is the potential for inconsistent implementation of the Bill’s duties, citing that variations in local practice, resources and thresholds for intervention risk creating a ‘postcode lottery’ in adult protection. Research from Queen’s University Belfast found variances in how safeguarding referrals were screened

and escalated between Trusts, possibly as a result of local capacity and practice culture. The study also identified a clear social gradient in adult safeguarding activity, with safeguarding plans more frequently recorded in areas of higher deprivation. This may reflect both a greater underlying need and differences in local resourcing.

While the Bill aims to promote consistency, these findings suggest that equitable protection may require proportionate, rather than identical, resource allocation to ensure that areas with higher levels of risk or deprivation are not disadvantaged.

The same consideration may also need to be given to rural versus urban populations. Experience from Scotland's Adult Support and Protection (Scotland) Act 2007 and Wales Social Services and Wellbeing (Wales) Act 2014 demonstrates that national data collection and performance frameworks are essential to be able to identify variation, inform equitable resource distribution and support consistent standards across agencies.

- **Members may wish to ask how the Department will monitor and evaluate consistency of implementation across Trusts once the Bill is enacted.**
- **Members may wish to consider whether a single regional data framework will be established to track safeguarding outcomes and identify social or geographic disparities.**
- **Members may wish to consider the experience of other UK jurisdictions to understand how they addressed regional variation and whether the Department is engaging with counterparts in these jurisdictions to learn from their implementation and data monitoring models.**

Data collection and evaluation are central to accountability and learning

The Bill gives the Adult Protection Board powers to collect and analyse information from public bodies and care providers to monitor trends and support system learning (Clause 32). However, the Bill itself does not specify how this data will be collected, standardised or reported across HSC Trusts. Stakeholders, including the Information Commissioner's Office (ICO), have emphasised that any sharing or analysis of data must comply with UK GDPR and data protection law, supported by clear protocols and data sharing agreements.

Evidence from Scotland demonstrates both the potential and the challenges of consistent adult protection data collection. Under the Adult Support and Protection (Scotland) Act 2007, the Scottish Government maintains a national minimum dataset designed to provide consistent information across local authorities. While this dataset has strengthened national oversight and transparency, recent technical reports note that differences in how local areas define and categorise adults at risk continue to affect comparability and data quality. This experience underscores the importance of clear definitions, governance arrangements and shared reporting standards when designing regional data systems.

- **Members may wish to ask the Department how they intend to standardise data collection and reporting across HSC Trusts.**
- **Members may wish to ask how specialist adult protection social workers will be recruited, trained and supported without having a negative effect on other parts of the system.**

Workforce capacity and professional confidence are central to implementation

Effective data collection and system learning will only translate into improved protection outcomes if supported by a skilled and adequately resourced workforce.

The Bill places a range of new duties on HSC Trusts, including reporting, investigation and multi-agency coordination. It's success will therefore depend on workforce capacity, competence and training. Clause 27 introduces a statutory requirement for each Trust to employ sufficient qualified staff and to designate specialist adult protection social workers for key statutory functions.

Evidence from across the UK shows that legislation alone does not deliver effective protection without parallel investment in workforce development. Implementation has been strongest where multi-agency training, clear protocols and specialist supervision were embedded, while reviews of safeguarding cases continue to highlight gaps in professional confidence and understanding of intervention thresholds.

Stakeholders in Northern Ireland have similarly emphasised that the Bill's effectiveness will depend on a funded, regionally coordinated workforce strategy. Without additional capacity, there is a risk that new statutory duties will stretch an already under-resourced system, leading to delays, inconsistent practice and practitioner burnout. Trusts have stated that there is limited 'slack in the system' and that introducing new specialist roles could further deplete the social work workforce in other high need areas such as child protection.

- **Members may wish to seek assurance that a dedicated workforce strategy and training plan will accompany the Bill's implementation.**
- **Members may wish to ask how specialist adult protection social workers will be recruited, trained**

and supported without having a negative effect on other parts of the system. Members may wish to ask how specialist adult protection social workers will be recruited, trained and supported without having a negative effect on other parts of the system.

- **Members may wish to ask whether cross sector training (involving health, social care and justice partners) will be mandated to promote consistent understanding of duties and threshold.**

Independent advocacy and participation are essential to rights based protection

Clause 26 places a statutory duty on each HSC Trust to ensure that an independent advocate is available to support adults at risk. Evidence from other jurisdictions shows that advocacy improves engagement, understanding and trust but only when it is well resourced, timely and consistently offered.

Experience in England and Scotland highlights that gaps in advocacy provision often stem from unclear referral processes, late involvement or inadequate commissioning. Stakeholders in Northern Ireland emphasise that advocacy needs to be accessible across all Trusts, with robust oversight to ensure equitable access and quality.

In addition, stakeholders have raised queries about the practicalities of delivering advocacy in real world scenarios. For example, whether advocacy will be available on a 24 hour basis in situations where an emergency protection order is emerging. These concerns highlight the need for clear operational guidance and sufficient resourcing to ensure advocacy is not only available in principle but reliably accessible in practice.

- **Members may wish to ask whether the Department will set clear standards for the timing, referral and independence of advocacy provision**
- **Members may wish to seek assurance that advocacy services will be accessible to adults with disabilities and additional communication needs.**
- **Members may wish to consider whether the Adult Protection Board will have a role in reviewing the accessibility and quality of advocacy provision.**

Engaging families enhances transparency but requires careful balancing

Clause 28 recognises that families and carers also play a role in identifying and preventing harm. The Bill requires Trusts, where practical, to seek and consider their views and to keep them informed of safeguarding actions. Stakeholders supported this duty, noting that relatives often detect early signs of risk and can provide important reassurance when consulted transparently and safely.

However, lessons from safeguarding reviews in Northern Ireland show that families' concerns have often gone unheard until after serious incidents occurred. Evidence from Wales also indicates that reviews frequently fail to capture the perspectives of adults and relatives, limiting system learning. Clear guidance will therefore be essential to ensure that family engagement enhances protection without undermining confidentiality or the autonomy of the adult concerned.

- **Members may wish to ask how the Department will ensure that families' concerns are taken seriously and responded to in a timely and transparent way.**

- **Members may wish to seek assurance that guidance will provide clear parameters for involving families while maintaining confidentiality and respect for consent.**
- **Members may wish to consider whether learning from family experiences will feed into post incident reviews and broader system improvement.**

Use of CCTV in care settings: balancing transparency, privacy and proportionality

The Bill introduces powers for the Department to regulate the use of CCTV in specified care settings. While prompted by evidence from Muckamore Abbey Hospital, where CCTV footage proved critical in exposing abuse, research and consultation responses emphasise that surveillance is not a substitute for good care or professional vigilance.

Stakeholders are divided: advocacy groups and families view CCTV as a tool for transparency and reassurance, while unions highlight concerns about privacy and its potential to undermine trust. Evidence indicates that the effectiveness of CCTV depends on clear regulation, proportionate use and robust data protection safeguards.

The Committee may therefore wish to examine how regulations will define when and where CCTV can be used, how consent will be obtained, particularly for residents who lack capacity, as well as how oversight by RQIA will operate in practice. The balance between accountability, dignity and autonomy will be central to public confidence in this provision.

- **Members may wish to ask how forthcoming regulations will balance the need for transparency with residents' privacy and dignity.**
- **Members may wish to consider how consent will be sought, recorded and revisited, especially for adults lacking capacity.**
- **Members may wish to seek assurance that RQIA will have clear powers and adequate resources to monitor compliance and enforce standards.**

Conclusion

The Adult Protection Bill represents a move towards establishing a statutory framework for safeguarding adults at risk in Northern Ireland. It replaces a policy based system with enforceable legal duties, strengthening accountability and bringing Northern Ireland broadly into line with neighbouring jurisdictions.

Across the evidence base, there is strong consensus on the need for this legislation but equal recognition that its success will depend on implementation quality rather than legislative design alone. Key factors include the clarity and timing of statutory guidance, the availability of resources, workforce capacity and the consistency of interpretation across HSC Trusts.

The analysis also identifies recurring themes likely to influence how effectively the Bill operates in practice: clear definitions, proportionate thresholds for intervention, structured data collection to support system learning and a rights based approach to professional decision making.

Effective cooperation between statutory bodies and continued evaluation of implementation will be essential to achieving consistency and accountability. Finally, the provisions on CCTV illustrate the wider balance the Bill seeks to achieve between safeguarding and respect for privacy and dignity. The

effectiveness of this balance, as with other aspects of the Bill, will depend on clear secondary legislation, transparent oversight and consistent application across settings

2 Background and rationale for legislative reform

This section sets out the historical context, major incidents and policy developments that created the case for legislative intervention, culminating in the introduction of the Adult Protection Bill 2025.

2.1 The pre-legislation context

Before the safeguarding failures at Dunmurry Manor and Muckamore Abbey came to light, adult social care in Northern Ireland was already recognised as an area in need of major reform. Two major strategic initiatives - Transforming Your Care (2011) and Power to People (2017) - sought to modernise services, improve outcomes and better support individuals with complex needs.

Transforming Your Care

Transforming your care focused on shifting care closer to home, promoting person-centred approaches and integrating services. While it acknowledged the importance of safeguarding vulnerable adults, it did not introduce statutory duties or mechanisms for responding to abuse and neglect. Progress was uneven, with critics citing slow implementation, workforce pressures and resource constraints. [1]

Cherry Tree House

The 2014 Cherry Tree House case became a significant moment in the evolving conversation around adult safeguarding in Northern Ireland. Located in Carrickfergus, the private care home was the subject of an independent review following serious concerns raised by a whistleblower. The review found that the home had consistently failed to meet care standards over several years, with issues including poor hygiene, inadequate nutrition and failures in continence care. The Regulation Quality and Inspection Authority (RQIA), the agency responsible for monitoring and inspecting availability and quality of health and social care services in Northern Ireland, was also criticised for not acting on

[1] Transforming your care | Department of Health

repeated warnings and for shortcomings in its inspection and enforcement processes.[2]

In the aftermath, the Commissioner for Older People for Northern Ireland (COPNI) and other stakeholders began publicly calling for dedicated adult protection legislation.[3] They argued that the absence of enforceable duties left adults at risk without a clear system of accountability. While these early calls did not result in immediate legislative change, they helped shape subsequent policy discussions and laid the groundwork for renewed scrutiny following later high-profile safeguarding failures.

Power to People

The 2017 independent review commissioned by the Department of Health (The Department), called for a fundamental rethinking of adult social care. It emphasised dignity, rights, sustainability and accountability. Although not prompted by a specific scandal, many of its recommendations, such as stronger oversight and protections for those unable to speak for themselves, anticipated reforms that would later be demanded in response to safeguarding failures. [4]

Together, these initiatives demonstrated that reform was already on the agenda. Yet despite this strategic momentum, their emphasis on system transformation did not extend to statutory safeguarding. Values such as prevention, integration and person-centred care were promoted, but without a legal framework for intervention when harm occurred. The absence of enforceable duties and limited regulatory reach meant that warning signs could be missed or not acted upon - weaknesses that were exposed by subsequent investigations at Dunmurry Manor and Muckamore Abbey Hospital.

[2] Cherry Tree House nursing home owner failed to report abuse claims - BBC News
[3] March-2020-Adult-Safeguarding-in-Northern-Ireland-Submitted-John-Williams.pdf
[4] Power to People | Department of Health

2.2 Institutional failures and the case for statutory reform

A series of high-profile investigations and reviews, most notably into Dunmurry Manor Care Home and Muckamore Abbey Hospital, revealed significant issues across adult health and social care services in Northern Ireland. These included:

- Unclear responsibilities between agencies;
- Inconsistent responses to abuse and neglect;
- Weak regulatory oversight; and
- Gaps in staff training, supervision and advocacy support.

In many instances, safeguarding concerns were missed, mishandled or insufficiently escalated, with serious consequences for those affected.

At Dunmurry Manor, residents experienced serious safeguarding failures, neglect and loss of dignity. Harm included inadequate personal care and poor management of aggression between residents. Families described distressing incidents such as unexplained injuries, poor hygiene, food deprivation and individuals repeatedly left in urine-soaked clothing and bedding without proper care plans in place. Despite these warning signs, the RQIA conducted 23 inspections over 39 months and consistently reported that the home met minimum standards.

The 'Home Truths' report, published by the Commissioner for Older People in 2018, concluded that both the care provider and the regulator failed to act on evident risks. It made 59 recommendations covering oversight, regulation, family engagement and statutory powers, reinforcing the need for fundamental legal reform.[5]

At Muckamore Abbey Hospital, CCTV footage revealed widespread abuse of non-verbal patients by staff, triggering what has been described as the largest criminal safeguarding investigation in Northern Ireland's history. CCTV footage revealed 1,500 crimes in the psychiatric intensive care unit over the course of

[5] Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home

six months in 2017-2018.[6] The police also revealed the existence of over 300,000 hours of video footage. Reviews exposed systemic failures in supervision, training, whistleblowing protections and governance. Crucially, the RQIA's limited enforcement powers meant that even when risks were identified, no binding action could be taken. [7]

The Department commissioned an Independent Whole Systems Review (2018–2020), which also found that adult protection arrangements were fragmented, lacked statutory coherence and failed to ensure accountability. It recommended the creation of a statutory Adult Protection Bill and an independent safeguarding board, recommendations accepted by the Department.[8] [9]

The public inquiry into Muckamore Abbey Hospital, which began in October 2021, has now concluded its oral hearings and is currently preparing its final report.[10]

2.3 Where are we now

In response to the systemic failures identified at Dunmurry Manor and Muckamore Abbey, the Department initiated a comprehensive adult safeguarding change programme. Central to this effort is the Adult Safeguarding Transformation Board, which was established to drive strategic reform across the Health and Social Care (HSC) system.

The Board's work includes:

- Providing strategic leadership for the safeguarding reform programme;
- Implementing recommendations from the Home Truths report and the Independent Review;
- Replacing the NI Adult Safeguarding Partnership (NIASP) with an interim governance structure under the Strategic Planning and Performance

[6] Muckamore Abbey: CCTV reveals 1,500 crimes at hospital - BBC News
[7] Muckamore Abbey: Nature and extent of abuse at heart of inquiry - BBC News
[8] Independent Whole Systems Review into Safeguarding Care at Dunmurry Manor Care Home
[9] Give Me a Crash Course in ... the Muckamore scandal – The Irish Times
[10] Muckamore Abbey Hospital Inquiry

Group (SPPG), as a precursor to a new Independent Adult Safeguarding Board;

- Assessing regulatory, equality and human rights impacts, alongside financial and resource implications;
- Engaging stakeholders through co-production and co-design principles;
- Aligning safeguarding reforms with broader initiatives, including adult social care reform and the Mental Capacity Act (NI) 2016; and
- Commissioning project teams to deliver specific strands of work.

The Board reports directly to the Department of Health Permanent Secretary and the Health Minister and serves as the main mechanism for regional reporting on adult safeguarding practice.[11]

2.4 Legislative progress

In September 2020, then Health Minister Robin Swann, announced a public consultation on proposed legislation, explicitly referencing Dunmurry Manor as a key driver. The consultation received strong support for placing adult protection duties and powers on a statutory footing:

> 'The failings at Dunmurry Manor demonstrated that existing safeguards were insufficient. We need a legal framework that ensures consistent protection and accountability for adults at risk.' Minister Robin Swann, September 2020[12]

The Adult Protection Bill was formally introduced to the Northern Ireland Assembly on 17 June 2025. It passed its Second Stage on 30 June 2025 and is currently at Committee Stage, where the Committee for Health is reviewing the Bill and gathering evidence from stakeholders.

[11] Northern Ireland Assembly Research and Information Service - correspondence with the Department of Health COR – 1495-2025

[12] Minister announces plans for Adult Safeguarding Bill for Northern Ireland | Department of Health

2.5 Beyond legislation: the need for systemic transformation

While the Adult Protection Bill responds to collective recommendations to place adult safeguarding on statutory footing, existing adult safeguarding literature emphasises that legislation alone is not a panacea. International research highlights that effective adult safeguarding depends on the interaction of multiple elements including clear legal frameworks, adequate resources, professional judgement and respect for individual rights and autonomy. Legal safeguards are widely regarded as central, but they form one part of a broader system of protection.

Importantly, there is a recognised gap in robust evaluation research. Much of the existing evidence of effective safeguarding practice is drawn from qualitative research, practitioner experience and policy analysis rather than from systematic or outcome based evaluations. Despite this, recurring themes emerge across jurisdictions, pointing to the importance of multi-agency collaboration, workforce capacity, data infrastructure and rights based practice. [13] [14] [15] [16] [17] These themes are evidenced in the experience of other countries that have introduced adult safeguarding legislation.

2.5.1 Wales

The Welsh Government commissioned a multi-year independent evaluation of the Social Services and Well-being (Wales) Act 2014, which concluded in late 2022. Findings from this evaluation indicate strong support for the Act's principles among professionals and stakeholders with nearly universal endorsement of concepts like person-centered care and early intervention. Importantly, practitioners have reported positive changes in

[13] Sinéad McGarry, Sarah Donnelly and Vivian Geiran, Position Paper on Adult Safeguarding, Legislation, Policy and Practice (Irish Association of Social Workers 2022)
[14] Adult Safeguarding Legislation and Policy Rapid Realist Literature Review - UCD School of Social Policy, Social Work and Social Justice
[15] Mental Capacity, Self-Neglect, and Adult Safeguarding Practices: Evidence Synthesis and Agenda for Change | PolicyBristol | University of Bristol
[16] Safeguarding adults: A concept analysis - Duffy - 2025 - Journal of Advanced Nursing - Wiley Online Library
[17] J Myhre and others, 'Elder abuse and neglect: An overlooked patient safety issue. A focus group study of nursing home leaders' perceptions of elder abuse and neglect' (2020) 20 BMC Health Services Research 1.

safeguarding practice: for example, the introduction of national safeguarding procedures and guidance has improved consistency and staff feel 'enabled to be less risk-averse', focusing on what matters to the person rather than defensive practice. Front-line workers appreciate that the law gives them clearer authority and duties, which can make it easier to advocate for necessary actions in complex cases.[18]

At the same time, the evaluation and other research highlight challenges in translating the principles of the Act into reality. There remains 'a divergence between the principles of the Act and the practice and experiences of people' in some areas, with factors like workforce shortages and budget pressures straining full implementation. For example, research has identified a 'postcode lottery' in the availability of preventive adult safeguarding services across different local authorities.[19] [20]

2.5.2 Scotland

There is continuing debate and practice locally and internationally about how to define 'adult at risk' and 'harm'. Jurisdictions vary from broad formulations to more narrowly defined categories. Research indicates that overly broad definitions can blur thresholds, leading to resource strain and inconsistent decision-making, whereas narrow definitions risk excluding people facing coercive or non-physical abuse.[21] [22]

Over time, the Scottish Government recognised challenges with how consistently the Adult Support and Protection (Scotland) Act 2007 was being applied across local authority areas and whether the definitions and processes still met contemporary practice needs. A review process began in the late

[18] From Act to Impact? Final Report of the Evaluation of the Social Services and Well-being (Wales) Act 2014
[19] Research Insights: Strengthening Safeguarding in Wales
[20] Microsoft Word - Clean Final Amended version 2 Thematic Review of Adult Practice Reviews August 2021.docx
[21] Jackson S. L., Hafemeister T. L. (2011). Risk factors associated with elder abuse: The importance of differentiating by type of elder maltreatment. Violence and Victims, 26(6), 738–757. 10.1891/0886-6708.26.6.738
[22] Jackson S. L., Hafemeister T. L. (2014). How case characteristics differ across four types of elder maltreatment: Implications for tailoring interventions to increase victim safety. Journal of Applied Gerontology, 33(8), 982–997

2010s, following joint inspections by the Care Inspectorate and Police Scotland which showed wide variation in performance.[23] Feedback from a public consultation undertaken as part of the review highlighted continued debate around definitions, particularly the threshold for when an individual is considered 'at risk' and how 'harm' should be framed. A revised code of practice was introduced in 2022 that set out updated definitions of harm. These updates attempted to provide clarity, though practice evidence indicates that complexity remains in applying these concepts consistently.[24]

The transformation programme underway in Northern Ireland reflects this broader understanding that Legislative reform needs to be accompanied by cultural, operational and structural change to ensure that safeguarding is proactive, consistent and responsive to the needs of adults at risk.

3 Scope, structure and implementation

This section outlines the main components of the Adult Protection Bill (Northern Ireland) 2025, grouped by its five Parts. It explains the purpose, core provisions and role of each part within the overall safeguarding framework, followed by notes on secondary legislation, statutory guidance and implementation.[25]

3.1 Part 1: Protection of adults at risk (Clauses 1–29)

Part one establishes the statutory foundation for adult safeguarding in Northern Ireland, defining who qualifies for protection and setting out the duties and powers of public authorities. It forms the operational core of the Bill, transitioning adult safeguarding from a policy based to a statutory system. Provisions include:

- Guiding principles (dignity, autonomy, prevention, proportionality, partnership and accountability) which are to be embedded in all safeguarding actions undertaken under the duties set out in part one.

[23] Joint inspections of adult support and protection
[24] Adult Support and Protection (Scotland) Act 2007: Code of Practice
[25] Adult Protection Bill - As Introduced

- Core definitions clarify who is considered an ‘adult at risk’ and what constitutes ‘harm’.
- Statutory duties that set out the Duty to Report, Duty to Inquire as well as the Duty to Cooperate and Share Information between agencies.
- Protective Powers that set out Production, Assessment, Removal and Banning Orders enabling timely and lawful intervention.

3.2 Part 2: The Adult Protection Board (Clauses 30–37)

Part two creates a single, statutory Adult Protection Board to provide independent leadership and oversight across Northern Ireland. Its purpose is to provide strategic and independent oversight to ensure consistent application of duties under Part one. Provisions under part two include:

- Formally establishing the Board as an independent statutory body promoting consistency and improvement.
- Publishing annual strategic plans and reports, commissioning Serious Case Reviews and monitoring safeguarding data.
- Empowering the Board to request information from public bodies and providers within data protection law.
- Regulations to define composition, governance and procedures.
- Providing for financial and administrative support.
- Publication of annual plans and reports.

3.3 Part 3: Offences of ill-treatment or wilful neglect (clauses 38–42)

Part three introduces new criminal offences to strengthen accountability for ill-treatment or willful neglect of adults receiving care or treatment. Part three adds an accountability and deterrence layer, reinforcing public confidence and promoting a culture of safe, respectful care. Provision include:

- A three-tier offence structure: individual (care worker), organisational (care provider) and corporate (body corporate or association); and
- Penalties of up to five years’ imprisonment and/or a fine.

3.4 Part 4: Regulation of CCTV in adult care settings (clauses 43–47)

Part four regulates the use of CCTV for safeguarding in care environments while protecting privacy rights under Article 8 European Convention of Human Rights. It sets out a legal framework that aims to ensure that surveillance supports safeguarding while maintaining dignity and data protection compliance. The provisions include:

- The scope of regulation which is set out as applying to residential and nursing homes, day care settings and HSC managed mental health units.
- Regulatory powers which empower the Department to make regulations on installation, consent, consultation, data handling and restrictions on where cameras can be placed.
- Designates RQIA as the enforcement authority with powers of entry, inspection and evidence seizure.
- Creates offences for non-compliance or obstruction and restricts disclosure except to prevent serious harm.

3.5 Part 5: General and final provisions (clauses 48–51)

Part five sets out the technical, regulatory and commencement provisions necessary to implement and maintain the Act. The provisions set out the regulatory and operational framework needed to implement the Bill effectively. These include:

- Regulations and orders that authorise the Department to make supplementary or transitional regulations;
- Confirmation that amendments to primary legislation will require affirmative resolution.
- Consequential and transitional provisions that ensure continuity of protection and alignment with existing laws.
- Staged implementation by commencement order to establish the Board, develop guidance and train staff.

- Title that specifies the Act's formal title as the Adult Protection Act (Northern Ireland) 2025.

3.6 Secondary legislation and statutory guidance

According to the Explanatory and Financial Memorandum (EFM), much of the operational detail of the new adult protection system will be set out in subordinate legislation and statutory guidance, allowing for flexibility and ongoing stakeholder consultation.[26]

3.6.1 Secondary legislation

Clause 48 (Regulations and Orders), provides the Department's overarching power to make regulations and orders:

> *'The Department may by regulations or order make such supplementary, incidental or consequential provision as appears to the Department to be necessary or expedient for the purposes of, in consequence of or for giving full effect to, any provision of this Act.'*
>
> Clause 48(1), Adult Protection Bill (as introduced)

It also defines the procedure for those regulations, regulations which amend or modify existing legislation require affirmative resolution, meaning they must be formally approved by the Northern Ireland Assembly prior to taking effect.

> '*Regulations or an order under this Act which amend or modify any provision of an Act shall not be made unless a draft has been laid before, and approved by resolution of, the Assembly'*
>
> Clause 48(3)

[26] Adult Protection Bill Explanatory and Financial Memorandum

All other regulations, those that do not amend existing legislation, are subject to negative resolution, meaning they can be annulled by the Assembly but do not require prior approval to come into force. Table one sets out the list of delegated powers within the bill and the procedure they are subject to.

Table 1: Summary of delegated powers in the Adult Protection Bill[27]

Clause	Purpose	Assembly Procedure
Clause 4	Adding to the list of organisations with a duty to report suspected abuse and cooperate with inquiries	Draft Affirmative
Clause 26	Arrangements for independent advocacy for adults at risk	Negative
Clause 27	Define who qualifies as a 'health professional'	Negative
Clause 30	Establishment and operational setup of the Adult Protection Board (APBNI) e.g. specifying which organisations are represented, how members are appointed and removed	Negative
Clause 31	Defining the core objective of the Board. Regulations will allow future amendments to the stated objective to reflect evolving safeguarding priorities or policy shifts.	Draft Affirmative
Clause 32	Setting criteria for when Serious Case Reviews must be carried out.	Negative
Clause 44	Regulate installation and use of CCTV in care settings.	Draft Affirmative

[27] Adult Protection Bill Delegated Powers Memorandum Prepared by the Department of Health

3.6.2 Statutory guidance

Clause 22 places a statutory duty on the Department to prepare and issue guidance to support the implementation of the Bill. This guidance is intended to promote consistent and lawful exercise of powers under the legislation. It forms part of the broader infrastructure required for the Act to become operational.

The Department informed the Committee that work on the guidance is progressing in parallel with the Bill's passage through the Northern Ireland Assembly, with development and implementation ongoing during this period. The Department is also expected to consult on the guidance and keep it under regular review to ensure it reflects evolving practice needs and stakeholder feedback.

3.7 Implementation details of the bill

The EFM and the Department's oral evidence to the Northern Ireland Assembly Committee for Health on 19 June 2025 set out the estimated costs and approach to implementing the Adult Protection Bill.

The EFM identifies an overall cost of approximately £12 million in the first year and £120.8 million over ten years. These figures have been confirmed by the Department in its evidence session. The Department advised that these figures represent new funding requirements, primarily for additional staffing to deliver the new statutory duties and powers created by the Bill. A detailed analysis of the funding requirements of the bill are provided in Northern Ireland Assembly Research Paper 210-2025 published alongside this paper.

The Department also indicated that trusts would need 'some time' to develop internal processes and that even with funding in place the legislation could not be brought into operation 'on day one after Royal Assent'.[28]

[28] Committee for Health Official Report (Hansard) Adult Protection Bill: Department of Health 19 June 2025

3.8 Operational Readiness and the Risks of Partial Rollout

The Western HSC Trust advised against a phased or incremental implementation of the Adult Protection Bill. Drawing on lessons from the roll out of the Mental Capacity Act (Northern Ireland) 2016, the Trust highlights that a staggered approach led to significant delays, operational confusion and practical challenges across services.

It highlighted that applying a similar model to adult protection would undermine patient and service-user safety, create uncertainty among staff and make it difficult for the public and elected representatives to understand which statutory duties are in effect at any given time.

The Trust further notes that such an approach could risk appearing 'delayed or ineffectual, potentially weakening public confidence in the new system and its ability to deliver meaningful protection for vulnerable adults.[29] This concern was also reflected by the Belfast HSC Trust.[30]

The Department indicated that the various powers under the Bill must be implemented together, rather than incrementally, to avoid incomplete investigations or potential legal challenges. For example, the statutory duty to report harm automatically triggers other responsibilities, such as the duty to investigate, which require trained staff and adequate resources. Implementing one part, like reporting, without the necessary support for the other, such as protection powers, could result in cases stalling due to a lack of legal authority or operational capacity.

However, the Department did acknowledge that there may be scope to establish the Adult Protection Board at an earlier stage, given its relatively low cost and that it is not linked in the same way as the duties in Part One of the Bill.

[29] Western Health & Social Care Trust response to call for evidence from the Northern Ireland Assembly Committee for Health – The Adult Protection Bill

[30] Belfast Health and Social Care Trust response to call for evidence from the Northern Ireland Assembly Committee for Health – The Adult Protection Bill

Evidence from England's implementation of the Care Act 2014[31] also supports the need for full operational readiness and the risks of partial rollout. Following the Act's introduction, safeguarding referrals increased sharply as awareness grew and statutory duties took effect, approximately doubling in the first six months, with sustained rises in subsequent years. [32] This surge reflected not only greater public and professional awareness but also the pressure that new statutory duties place on services.

The experience underlines that once adult protection moves onto a statutory footing, demand can rise sharply. Ensuring full operational readiness, with trained staff, clear guidance and aligned processes, appears to be central to managing that demand and avoid the risks of a partial rollout.[33]

3.9 Committee considerations: scope, structure and implementation

The Department has developed detailed cost estimates covering all aspects of the safeguarding framework including training, protective powers, advocacy and legal aid – detailed in the Northern Ireland Assembly Research Paper NIAR-210-2025. The Committee may wish to understand how work on the statutory guidance and related implementation planning is progressing alongside these costings, including the current stage of drafting, consultation and stakeholder engagement. Members may also wish to explore how inter-agency protocols and training plans are being developed, and whether the

[31] Care Act 2014
[32] Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 (executive summary) | Local Government Association
[33] Johnson, K., & Boland, B. (2019). Adult safeguarding under the Care Act 2014. BJPsych Bulletin, 43(1), 38–42

Department anticipates being fully system-ready once funding becomes available.

4 Core principles and definitions of the bill

Part 1 of the Adult Protection Bill sets out the overarching principles and definitions that underpin all functions carried out under this section. These provisions form the foundation of the Bill's approach to safeguarding adults who may be at risk of harm and provide the interpretive framework for the duties and powers established in the legislation.

4.1 Core principles

Clause 1 of the bill introduces seven principles. These principles apply specifically to the exercise of functions under Part 1 of the Bill. They are designed to guide professional judgement, encourage consistency across agencies and promote a balance between protection and respect for individual rights. The Department will be required to issue statutory guidance under Clause 22 to assist practitioners in applying these principles in practice.

The principles include:

1. **Prevention:** a commitment that harm to adults should, so far as possible, be prevented before it occurs and that safeguarding measures should be proactive.
2. **Autonomy:** a presumption that adults have the capacity to make their own decisions unless there is evidence to the contrary, including the right to make what others might consider unwise choices.
3. **Empowerment:** supporting and encouraging adults to make informed choices, participate in decisions about their lives and maintain independence wherever possible.

4. **Dignity:** promoting a rights based approach in which all actions under the Bill respect the dignity of the adult concerned.
5. **Proportionality:** ensuring that any intervention is the least restrictive option, in the best interests of the adult and does not cause further harm.
6. **Partnership:** recognising that effective protection depends on collaboration among adults at risk, their families and carers and the range of statutory and voluntary bodies involved.
7. **Accountability:** requiring openness and clarity about roles, responsibilities and lines of reporting.[34]

4.2 Stakeholder views on principles

During consultation, stakeholders broadly recognised the importance of setting out clear principles to guide adult protection practices. This section presents a selection of stakeholder responses to those principles, as submitted during the Department's consultation on the Bill and the Northern Ireland Assembly Committee for Health call for evidence.[35]

4.2.1 Autonomy and empowerment

Clause one's principles place strong emphasis on respecting the adult's autonomy and involving them in decisions about their care and protection. The Bill reflects what is often described in safeguarding practice as supported decision making - starting from the adult's right to make their own choices and seeking their consent wherever possible before any action is taken to protect them. [36]

While the Bill does not expressly state a presumption of capacity, it reflects the Mental Capacity Act (Northern Ireland) 2016, which provides that adults are assumed to have capacity unless proven otherwise.[37] The purpose of assumed capacity is to encourage a practice where adults are supported to make informed choices about their own safety and are involved as fully as possible in

[34] Health Minister introduces Adult Protection Bill to Assembly | The Northern Ireland Executive
[35] Northern Ireland Assembly Committee for Health - Call for Evidence: Adult Protection Bill
[36] The Institute for Research and Innovation in Social Services, 2023, Supported decision making.
[37] Mental Capacity Act | Department of Health

any safeguarding process. In the case of the Adult Protection Bill, this is reflected by requirements within the bill to consider the adult's wishes and feelings and to provide the support and information necessary for them to take part as fully as possible in decisions. The focus on empowerment under the principles of the bill has been welcomed by stakeholders as it aligns with modern adult safeguarding practice, which seeks to give adults at risk more control over their protection plans.

COPNI, for example, 'welcomes the proposal to include a clear set of principles' and agrees that principles like autonomy and empowerment have merit. They ensure the 'personal choice of an adult at risk' is central to interventions.[38]

The Northern Ireland Human Rights Commission (NIHRC) likewise noted that the principles echo the human rights concept of personal autonomy under Article 8 of the European Convention on Human Rights (right to private life). Protecting autonomy is recognised in both legal and policy literature as essential to rights-based safeguarding.[39]

The Royal College of Speech and Language Therapists (RCSLT) welcomed explicit recognition of the adults wishes and communication needs within the empowerment and autonomy principles, recommending that accessible communication and reasonable adjustments be considered part of good practice.[40]

However, stakeholders have also acknowledged the limits of autonomy, noting that the right to make independent choices must sometimes be balanced against the need to protect adults from harm. Hourglass NI cautioned that while autonomy is central, practitioners also need authority to act early when abuse is suspected, provided interventions remain proportionate. The need for staff to

[38] Legislative options to inform the development of an Adult Protection Bill for Northern Ireland Consultation Response from the Commissioner for Older People Northern Ireland
[39] Publication - NIHRC submission on legislative options to inform the development of an Adult Protection Bill in Northern Ireland | Northern Ireland Human Rights Commission
[40] Royal College of Speech and Language Therapists NI 2021 Response to the Department of Health Adult Protection Consultation

receive clear guidance on when intervention is justified and how to document best-interest decisions was noted as a priority.[41]

4.2.2 Dignity

The NIHRC and other consultees welcomed the inclusion of dignity, noting that it shifts the culture of adult protection away from paternalism towards one grounded in rights, participation and autonomy.

However, some stakeholders, particularly the NIHRC and COPNI, argued that the Bill's human rights foundation should be made explicit within the bill. While Clause one's language is consistent with human rights standards, it does not directly reference obligations under the Human Rights Act 1998. Both organisations recommended amending the clause to include an express duty to act compatibly with human rights law, reinforcing that adult protection practice must always respect dignity, autonomy and equality.

Stakeholders also stressed that embedding principles in legislation is insufficient without professional understanding. The NIHRC advised that resources must be allocated to train staff in applying rights based principles in daily safeguarding decisions. The Department has indicated its intention to roll out training alongside the new statutory duties.

4.2.3 Prevention

Stakeholders strongly supported the emphasis on prevention, viewing it as a necessary shift toward early, proactive safeguarding rather than reactive crisis management. Consultation responses emphasised that prevention extends beyond legal intervention to wider systemic measures - public awareness, workforce training and inter-agency coordination. Several organisations sought the development of statutory guidance to clarify how prevention should operate in practice, including through community engagement and early support

[41] Hourglass NI Response to the NI Department of Health Consultation on Legislative Options to Inform the Development of the Adult Protection Bill for Northern Ireland

services. The Department confirmed that broader prevention work will be supported by complementary policy initiatives rather than through the bill itself.[42] [43]

Professional and regulatory bodies noted that these principles align closely with existing ethical codes and safeguarding standards. The Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) observed that concepts such as autonomy, dignity and proportionality reflect duties already embedded in their professional regulations.[44] [45]

4.3 Definition of an 'adult at risk' and 'harm'

Clause 2 defines the key statutory terms that determine the Bill's scope: 'adult at risk' and 'harm'. It establishes the threshold for when HSC Trusts and other bodies must act and therefore underpins all subsequent duties and powers.

The definition is deliberately broad, recognising that vulnerability arises from the interaction of a range of different factors, mirroring comparable provisions in other UK jurisdictions.

Under Clause 2(1), an "adult at risk" is a person aged 18 or over who:

a) (a) is experiencing or at risk of harm;
b) (b) is unable to protect themselves and/or their property from that harm; and
c) (c) requires support or intervention from a public authority to do so.

Clause 2(2) defines "harm" to include physical, sexual, psychological, financial and neglectful abuse, as well as behaviour causing fear, distress, or loss of dignity. [46]

[42] Hourglass NI - Written Evidence Submission to the Northern Ireland Assembly Health Committee - Adult Protection Bill
[43] Agenda for Real Change - Written Evidence Submission to the Northern Ireland Assembly Health Committee - Adult Protection Bill
[44] Nursing and Midwifery Council (2025) Written Evidence Submission to the Northern Ireland Assembly Health Committee - Adult Protection Bill
[45] Legislative options to inform the development of an Adult Protection Bill 2021
[46] Adult Protection Bill Part 1—Protection of adults at risk of harm

4.4 UK and international definitions of 'adult at risk' and 'harm'

There is continuing debate and practice locally and internationally about how to define 'adult at risk' and 'harm'. Jurisdictions vary from broad formulations to more narrowly defined categories, shaping both eligibility for protection and the balance between autonomy and intervention.

In Canada for example, adult protection is governed by provincial legislation, leading to significant variation in scope and practice. Nova Scotia's Adult Protection Act (1989) adopts a relatively narrow approach, applying only to adults aged 16 or over who are 'incapable of protecting themselves from abuse or neglect' due to physical or mental disability. The Act places a universal legal duty to report suspected cases, with interventions focusing on adults lacking capacity or facing serious risk.[47] By contrast, British Columbia's Adult Guardianship Act (1996) takes a broader, rights based approach that applies to any adult 'who is abused, neglected, or self-neglecting and unable to seek support or assistance'.[48] It does not require incapacity as a threshold, nor does it impose universal mandatory reporting. Instead, it emphasises support, participation and the least restrictive form of intervention, recognising that adults are presumed capable of making their own decisions and that guardianship should be a last resort after less intrusive options are explored.

Across Canada, definitions of abuse commonly include physical, psychological, sexual, financial and systemic abuse, along with neglect and self-neglect, with some provinces explicitly recognising violations of rights, such as denial of privacy or communication, as abuse. [49]

Research suggests that, while mandatory reporting regimes like Nova Scotia's can improve detection, they also risk overreach and potential paternalism, whereas autonomy-centred models like British Columbia's may face limitations when adults decline assistance in situations of coercion or isolation.[50]

[47] Practical Guide to Elder Abuse and Neglect Law in Canada - Canada Centre for Elder Law
[48] BC's Adult Guardianship Laws: Supporting Self Determination for Adults in British Columbia.
[49] Strengthening the Right to Personal Autonomy and Protection of Vulnerable Adults: from Human Rights to Domestic and European legislation on Voluntary Measures | SpringerLink
[50] Conflicting purposes: Guardianship law, mental health law and involuntary detentions

4.5 Adult at risk

In the UK, definitions of 'adults at risk' also vary between nations but are broadly aligned in terms of having a broader definition of adult at risk. The Adult Support and Protection (Scotland) Act 2007[51] defines an adult at risk as someone who is unable to safeguard their own wellbeing, property, rights or interests and is at risk of harm; similar concepts underpin England's Care Act 2014[52] and the Social Services and Well-being (Wales) Act 2014.[53]

The definition of an "adult at risk" generally centres on:

- Situational vulnerability: The adult is experiencing or at risk of harm, abuse, or neglect.
- Inability to protect oneself: The adult cannot safeguard their own well-being, property, or rights.
- Need for support or intervention: The adult requires help from public authorities to prevent or respond to harm.

These definitions reflect a circumstance-based approach, where the emphasis is on the adult's current situation rather than inherent traits like age or disability.

While Scotland's definition of an 'adult at risk' includes reference to personal characteristics such as disability or illness, all four UK jurisdictions broadly align with British Columbia's rights-based approach, which emphasises situational vulnerability and support, rather than Nova Scotia's narrower model that requires incapacity as a threshold for protection

4.6 Definition of harm

Across the United Kingdom, legislation and statutory guidance adopt similar but not identical definitions of 'harm' in the adult-safeguarding context. The Care Act 2014 (England) defines safeguarding duties around adults who have needs for care and support and are experiencing, or at risk of, abuse or neglect; the term 'harm' itself is not defined in statute but is interpreted broadly through

[51] Adult Support and Protection (Scotland) Act 2007
[52] Care Act 2014
[53] Overview of the Social services and well-being… | Social Care Wales

guidance to include physical, emotional, sexual and financial abuse, neglect and acts of omission. The Social Services and Well-being (Wales) Act 2014 uses a similar approach, referring to adults 'at risk of abuse or neglect,' again without a closed statutory definition of harm.[54] The Adult Support and Protection (Scotland) Act 2007 defines 'harm' to include all conduct that causes physical or psychological harm, unlawful conduct such as theft or fraud and conduct causing self-harm.[55]

The Northern Ireland Bill aligns most closely with the Scottish model by embedding 'harm through abuse, neglect or exploitation' within the definition of an adult at risk, but, unlike Scotland, expressly excludes self-harm.[56]

4.7 Interpreting risk and harm in practice

Research and reviews of practice in all three jurisdictions have highlighted that variation in interpretation of 'risk' and thresholds of 'harm' continue to create inconsistencies. For example, in Scotland, the Code of Practice accompanying the Adult Support and Protection (Scotland) Act 2007 was revised and re-issued in 2022 to clarify definitions of harm and streamline decision making processes. However, evidence indicates that challenges remain in achieving consistent application of these concepts across local authorities.[57]

Social workers report that the challenge with applying the adult at risk definition lies less in establishing risk of harm or that the adult was affected by disability and more in determining if an adult was unable to safeguard their wellbeing. Domestic abuse, abusive relationships more widely and where the adult may have some degree of cognitive impairment, are cited as particularly difficult situations to assess.[58]

[54] Social Services and Well-being (Wales) Act 2014
[55] Adult Support and Protection (Scotland) Act 2007

[57] Adult safeguarding legislation: Navigating the borderlands between mental capacity, mental health and social care law and practice - ScienceDirect
[58] What difference does the Adult Support and Protection (Scotland) 2007 make to social work service practitioners' safeguarding practice? | The Journal of Adult Protection | Emerald Publishing

Overall, comparative evidence from the UK and Canada demonstrates that definitions of 'adult at risk' and 'harm', whether broad or narrow, profoundly influence practice. Broader definitions can enhance inclusivity, but may lead to ambiguity in thresholds and increased demand on resources. Conversely, narrower definitions risk excluding individuals experiencing coercive or non-physical forms of abuse. The ongoing challenge for all jurisdictions lies in maintaining a balance between protection and autonomy, ensuring that interventions remain proportionate, rights-based and responsive to individual circumstances.

4.8 Stakeholder views on definitions

Stakeholder feedback during consultation indicated general support for an inclusive definition, though some respondents sought greater clarity on how key terms would be interpreted in practice. Concerns were raised about the potential ambiguity of phrases such as 'unable to protect oneself' and 'harm' and the need for statutory guidance to provide illustrative examples to support consistent decision making across agencies.

The Southern HSC Trust expressed concerns about the term 'adult at risk,' noting that it may lead to confusion in practice. Under the current 2015 framework, there is a clear distinction between 'adults at risk' and 'adults at risk who are also in need of protection.' However, the Bill merges these definitions, meaning all adults at risk are considered in need of protection. The Trust noted that this change will require a significant shift in culture and practice, along with comprehensive training and education for those responsible for making referrals.[59]

Furthermore, the British Association of Social Workers NI (BASW NI) highlights that without clear statutory guidance on the threshold for intervention, different

[59] Southern Health and Social Care Trust - Written Evidence Submission to the Northern Ireland Assembly Health Committee - Adult Protection Bill 2025

HSC Trusts and social work teams may interpret the definition inconsistently.[60] This could lead to a 'postcode lottery' for protection, where an individual's access to safeguarding is determined by their geographical location. This is supported by research from Queens University Belfast which demonstrated variability in the way safeguarding reports were managed across trusts, suggesting that local practice and resource factors may influence how concerns are escalated.[61] The research also identified a clear social gradient in adult safeguarding referrals with higher rates of screening and protection plans in areas of greater deprivation.

ARC NI suggested that over-reporting could lead to 'noise' that distracts from serious cases.[62] The NIHRC stressed proportionality, noting that indiscriminate reporting could also undermine Article 8 ECHR rights to privacy. Effective implementation in NI will therefore depend on thresholds, training and clear guidance on when a concern reaches the threshold for reporting.

4.8.1 Interaction with the Mental Capacity Act (NI)

Stakeholders have consistently highlighted the need for greater clarity on how the Adult Protection Bill will operate alongside the Mental Capacity Act (NI) 2016, particularly in relation to consent and capacity

The Mental Capacity Act (NI) 2016 sets out the legal test for deciding whether someone has the mental capacity to make a specific decision and establishes safeguards for acting in a person's best interests if they cannot do so themselves. It allows for interventions like restraint or deprivation of liberty only when proportionate, necessary and in line with human rights protections, with oversight through independent advocates and tribunals.[63] [64]

[60] BASW NI - Written Evidence Submission to the Northern Ireland Assembly Health Committee - Adult Protection Bill 2025
[61] Lorna Montgomery and others, 'Adult Safeguarding Inequalities in Northern Ireland: An Exploratory Study' (2024) British Journal of Social Work
[62] Agenda for Real Change: Written Evidence Submission to the Northern Ireland Assembly Health Committee - Adult Protection Bill 2025
[63] BMA Ethics Toolkit Mental Capacity in Northern Ireland
[64] Mental Capacity Act | Department of Health

Organisations such as BASW NI, COPNI and BMA NI expressed concern that the Bill may overlap with, or duplicate, aspects of the Mental Capacity Act, as it adopts certain definitions but does not clearly set out how these should be applied in practice.

The Bill allows for intervention where an adult 'lacks capacity', but it does not explicitly require a formal capacity assessment before consent can be overridden. Stakeholders have warned that this could lead to inconsistent or unlawful decision-making. COPNI has recommended that any decision to override consent on the basis of capacity should be formally assessed and recorded to ensure transparency and compliance with statutory safeguards.

Advocacy groups have also cautioned that the Bill could unintentionally encourage paternalistic practice, particularly in respect of people with learning disabilities who retain capacity and wish to make their own decisions about risk and support. Across all submissions, there was broad agreement that clear statutory guidance, supporting regulations and professional training will be required to clarify how both frameworks operate together and to promote lawful, proportionate interventions.[65] [66]

4.8.2 Self-neglect

In other UK jurisdictions, cases of self-neglect have highlighted challenges for practitioners in applying the criteria for identifying an adult at risk. The LGA's Second National Analysis of Safeguarding Adult Reviews(reviews carried out after the death or serious harm of an adult at risk) found that self-neglect and neglect or omission accounted for the majority of cases reviewed in England, demonstrating the difficulties professionals face in identifying, assessing and responding to these forms of harm.[67] In Wales, national reviews demonstrate a lack of understanding of neglect and self-neglect. Locally, some adult protection committees have begun to address this but it has been recognised

[65] General Medical Council (GMC), Response to DoH (NI) Consultation: Legislative Options to Inform the Development of an Adult Protection Bill (2021)
[66] Nursing and Midwifery Council (NMC), Response to Legislative Options Consultation (2021)
[67] Local Government Association (2024). Second National Analysis of Safeguarding Adult Reviews: April 2019 – March 2023. London: LGA/ADASS.

that a national response is required to coordinate resources, capability and experience [68]

In Scotland the revised Code of Practice. published in 2022, now provides guidance to distinguish between being ‘unable’ and ‘unwilling’ to safeguard oneself, aiming to reduce ambiguity and promote consistency in practice.

According to the code, capacity alone does not exclude someone from being considered at risk. However, it does make a key distinction between:

- Being unable to safeguard oneself (e.g. due to coercion, cognitive impairment, or mental illness); and
- Being unwilling to accept help, which may reflect a competent decision.

In cases where a person is self-harming but has capacity and refuses support, the Code advises that:

- Practitioners must assess whether the refusal is due to undue pressure or impaired decision-making.
- If the person is capable and freely refusing help, intervention under the Act may not be justified.

Other frameworks (e.g. mental health legislation or suicide prevention strategies) may be more appropriate.[69]

The Northern Ireland Bill explicitly excludes cases of self-harm and self-neglect where no third party is involved. This exclusion has prompted debate, as some stakeholders argue that individuals who place themselves at risk may still require protective intervention. The Department has indicated that such cases may be addressed through other frameworks, such as mental health or capacity legislation.

[68] Triennial review of initial and significant case reviews for adults 2019-2022

[69] Supporting documents - Adult Support and Protection (Scotland) Act 2007: Code of Practice - gov.scot

4.8.3 Restrictive practices

Stakeholders have raised concerns that restrictive practices, including seclusion, physical, psychological and chemical restraint, are not explicitly referenced in the Draft Adult Protection Bill, despite their potential to cause significant harm. Families argue that such practices, particularly when used inappropriately or excessively, should be recognised as potential abuse or neglect within the Bill's definition of 'harm' and 'adult at risk.'[70]

The Department published a Regional Policy on the Use of Restrictive Practices in 2023, promoting a rights-based, least-restrictive approach across health and social care.[71] While the Mental Capacity Act (NI) 2016 references restraint, there is currently no dedicated legislation regulating restrictive practices.

4.8.4 Domestic abuse and coercive control

Stakeholders have raised concerns about how the definition of an 'adult at risk' would apply in complex situations such as domestic abuse involving coercive control. They argue that adult-protection law should explicitly recognise that coercive or controlling behaviour can leave an adult unable to protect themselves, even where they retain decision-making capacity. While the Bill's inclusion of psychological harm and its broad interpretation of personal circumstances suggest that such cases could fall within scope, effective implementation will rely heavily on professional judgment.

The Department's Domestic and Sexual Abuse Strategy (2024–31) already provides a framework for identifying and supporting adults affected by coercive control or abuse within intimate, family or caring relationships. Under current arrangements, HSC staff receive specialist training to recognise indicators of abuse, understand patterns of coercion and dependency and respond appropriately. When concerns arise, professionals complete a Domestic Abuse, Stalking and Harassment (DASH) risk assessment and make a safeguarding referral. In high-risk cases, referrals are escalated to the Multi-

[70] Families Involved NI Written submission to Northern Ireland Assembly Committee for Health Call for Evidence Adult Protection Bill 2025

[71] Regional policy on the use of Restrictive Practices in Health and Social Care Settings – Public consultation – Consultation Analysis Report and individual responses | Department of Health

Agency Risk Assessment Conference (MARAC), where the PSNI, HSC Trusts, housing and voluntary sector partners coordinate safety planning and protection measures. The Strategy also acknowledges that older adults and people reliant on carers may face additional barriers, such as loyalty, shame, fear of losing care or financial dependence and that these can obscure signs of harm.[72]

Within the Adult Protection Bill, the inclusion of psychological harm and coercive or controlling behaviour aligns with the Strategy's emphasis on intersectional vulnerability. However, effective protection will depend on joined up implementation. Clear statutory guidance and consistent cross sector training are noted as key to ensuring that practitioners can distinguish when an adult's apparent consent is undermined by coercion and when to use criminal justice powers alongside adult safeguarding interventions to provide proportionate and protective support.[73]

4.9 Committee considerations: core principles and definitions

The Bill establishes a set of overarching principles, namely, prevention, autonomy, empowerment, dignity, proportionality, partnership and accountability, which are intended to guide all actions taken under the part one of the legislation. While there is broad support for these principles and for the core definitions of 'adult at risk' and 'harm,' evidence from stakeholders and policy bodies indicates that their practical application will depend heavily on how they are interpreted and implemented through statutory guidance. Members may also wish to consider:

[72] Assembly Questions Written 20791/22-27

[73] Belfast Health and Social Care Trust – Written Submission to the Committee for Health Call for Evidence on the Adult Protection Bill 2025

Principles in practice

Members may wish to ask how the Department will ensure the consistent application of the Bill's principles across all functions under part 1. They may also wish to consider whether multi-agency protocols will be updated to reflect these statutory principles and whether a process will be established to collect and monitor data on how consistently they are being applied in practice.

In addition, Members may wish to explore whether referencing the Human Rights Act 1998 or equality duties within the Bill would strengthen its legal foundation, and whether the absence of a statutory duty to act compatibly with human rights could undermine the strength of the principles underpinning the legislation.

Defining capacity

Stakeholders have highlighted the need for greater clarity on how the Adult Protection Bill will operate alongside the Mental Capacity Act (NI) 2016, particularly around the assessment and recording of capacity and consent. The Committee may wish to ask how the Department intends to ensure consistency between the two frameworks and whether formal capacity assessments will be required before consent is overridden in adult protection cases.

Restrictive practices

Whether restrictive practices like seclusion or chemical restraint should be explicitly recognised as potential harm.

Domestic abuse and coercive contol

Members may wish to consider how the definition of an adult at risk will capture cases involving coercive control, and how

statutory guidance and training will support practitioners to recognise when apparent consent is compromised. They may also wish to explore how adult protection processes will align with the Domestic and Sexual Abuse Strategy and the criminal justice response to coercive behaviour.

5 Duties created by the bill

Part 1 of the Bill establishes three key statutory duties designed to create clearer accountability within the adult protection system. In doing so, it transforms what had previously been a policy led safeguarding framework into a statutory model, ensuring that responsibilities previously described in guidance now carry the force of law. Together, these duties, to report, to make enquiries and to cooperate, are intended to strengthen multi agency coordination and provide consistent expectations for professionals and organisations across Northern Ireland. Statutory guidance under Clause 22 will set out the operational arrangements for these duties once enacted.

The duties in Part one represent the core procedural elements of the new adult protection system. They define how concerns about adults at risk must be raised, how those concerns must be followed up and how agencies must collaborate to ensure effective safeguarding. These provisions are complemented by later powers of investigation and intervention, which enable action once a duty has been triggered. The following subsections describe each of the three duties in turn.

5.1 Duty to make enquiries

Clause 3 places a duty on each HSC Trust to investigate where a concern about an adult at risk has been reported or otherwise comes to its attention and where the trust has ‘reasonable cause to suspect’ that an adult may be at risk. The purpose of the enquiry is to determine whether the adult is at risk and, if so, what action should be taken to protect them.

Clause three also notes that the trust must have regard to the importance of the provision of an independent advocate to the adult concerned. The Bill a makes provision for an independent advocate in clause 26, stating that HSC Trusts must make arrangements to ensure that an independent advocate is available to support and assist the adult who is being assessed. The advocate's role is to help the adult be involved in and influence decisions taken about their care and protection, which is in keeping with the principles of autonomy and empowerment.

5.2 Duty to report

Clause 4 introduces a statutory duty to report. It requires certain bodies and individuals to notify the relevant HSC Trust where they have 'reasonable cause to suspect' that an adult is at risk and in need of protection. This duty applies to:

- HSC trusts,
- members of the police force and of any Harbour or Airport Police,
- the Regional Agency for Public Health and Social Well-being,
- RQIA,
- the Probation Board for Northern Ireland,
- the Northern Ireland Housing Executive; and
- persons providing primary medical services under Part 6 of the Health and Personal Social Services (Northern Ireland) Order 1972 or in accordance with arrangements made under Article 15B of that Order, independent providers commissioned or contracted to provide health care or social care.[74]

The list of bodies may be amended by regulation, allowing flexibility to include additional agencies in future.

The Department noted at a Northern Ireland Assembly Committee for Health Meeting on the 19 June 2025 that, at present, the Northern Ireland Prison

[74] Bill - As Introduced

Service is not listed as a body subject to the statutory duty to report under Clause 4 of the Adult Protection Bill.

The Department expressed its view that the Prison Service should be included within the scope of this duty and is actively engaging with Prison Service colleagues to reach agreement. While there is no formal resistance, discussions are ongoing to clarify how the proposed powers would apply within the prison estate. The Department indicated that an amendment to include the Prison Service may be brought forward during the Bill's passage, contingent on securing agreement. Justice Minister Naomi Long, MLA, has expressed support for the Bill overall, while noting the need for further engagement on the issue.[75]

5.3 Duty to cooperate

Clause 4 introduces a statutory duty to report and cooperate in adult protection inquiries, replacing the previous discretionary arrangements under the Adult Safeguarding: Prevention and Protection in Partnership policy (2015).[76] This measure addresses long standing barriers to information sharing and inconsistent responses to safeguarding concerns. It places legal duties on key bodies, including HSC Trusts, the PSNI, RQIA, the Public Health Agency and the Probation Board, to report suspected harm and to cooperate fully in inquiries.[77]

Policy and research evidence from other jurisdictions supports this emphasis on clear statutory cooperation. In Scotland, the establishment of statutory Adult Protection Committees under the Adult Support and Protection (Scotland) Act 2007 has been credited with improving consistency, transparency and multi-agency oversight.[78] In England, national analyses by the LGA (2019–2023) found that effective joint working was a key factor in successful safeguarding

[75] Northern Ireland Assembly, Committee for Health. (2025). Oral Evidence: Adult Protection Bill – Department of Health. Meeting held on 19 June 2025.
[76] Adult Safeguarding: Prevention and Protection in Partnership key documents
[77] EFM - As Introduced
[78] Iriss (2023) ASP: Everyone's Business. Glasgow: Institute for Research and Innovation in Social Services.

outcomes, while many serious case reviews highlighted weak information-sharing as a recurring failure.[79] Internationally, the United States has developed multidisciplinary elder-abuse forensic centres that coordinate input from police, health and social-care professionals,[80] while South Australia and the Australian Capital Territory have established Adult Safeguarding Units to act as lead agencies, promoting cooperation across agencies.[81]

5.4 UK experience of enquiries, reporting and cooperation

Across the United Kingdom, approaches to mandatory or statutory reporting of adult-protection concerns vary in scope and legal force. England and Wales, place a duty on local authorities to make enquiries when they have reasonable cause to suspect abuse or neglect, but they stop short of imposing a universal statutory duty on individual practitioners or agencies to report concerns.[82] [83] Reporting remains an expectation through guidance rather than a legal obligation.

Scotland, by contrast, under the Adult Support and Protection (Scotland) Act 2007, imposes a clear statutory duty on specified public bodies, including health boards, local authorities and the police to report adults believed to be at risk of harm to the local authority. The proposed Northern Ireland duty aligns most closely with the Scottish model by creating an explicit legal obligation to report but it also reflects learning from the English and Welsh systems by emphasising proportionality and professional judgement rather than automatic referral in every instance.

Reviews of safeguarding incidents in other UK jurisdictions consistently highlight that signs of abuse and neglect are frequently overlooked or inadequately escalated. The LGA's national analysis of Adult Safeguarding Reviews (2019–2023) found that over half of cases examined involved failures

[79] Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 | Local Government Association
[80] Evaluating The Los Angeles County Elder Abuse Forensic Center
[81] South Australian Law Reform Institute 'Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995 (SA)
[82] Social Services and Well-being (Wales) Act 2014
[83] Care Act 2014

to recognise abuse or neglect, while 44 per cent identified a lack of 'professional curiosity', where professionals noticed but didn't question concerning circumstances.[84]

Similarly, the All-Wales Thematic Review of Adult Practice Reviews (2025) reported that staff frequently hesitated to report because of uncertainty about thresholds, unclear definitions, or a belief that someone else would take responsibility.[85]

Experience from England and Wales demonstrates that legislation can improve vigilance only when accompanied by a positive reporting culture. Safeguarding Adults Reviews (SARs) in England and Adult Practice Reviews (APRs) in Wales, consistently show that organisations with a 'learning, not blame' culture respond more quickly and effectively to emerging risks.[86]

5.5 Stakeholder views of duties created by the bill

During consultation, stakeholders broadly supported the principle of a mandatory duty to investigate and report, for example, Hourglass NI welcomed the introduction of the statutory duties, describing them as a means to increase awareness, encourage early reporting and reduce tolerance of abuse or neglect. However there was also universal acknowledgement of the importance of clear definitions and proportionate application.

5.5.1 Training and guidance to ensure proportionality

Training and guidance were identified by the majority of stakeholders as essential to ensure that staff understand what constitutes 'reasonable cause to suspect' and how to balance reporting obligations with respect for the individual's rights. Stakeholders suggested there could be a risk of a 'postcode lottery,' in which thresholds for reporting or intervention could vary geographically if guidance is not sufficiently prescriptive.

[84] Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 | Local Government Association
[85] Thematic Review of Adult Practice Reviews (APRS) Wales 2025 - Safeguarding Board Wales
[86] London SARs Report Final Version

Professional and regulatory bodies, including the NMC, the GMC and the BMA NI, also sought assurance that the statutory duty to enquire and report would align with their existing professional obligations and preserve respect for patient confidentiality and autonomy.

The Southern HSC Trust highlighted the need for further clarity within the statutory guidance regarding what constitutes 'reasonable cause to suspect.' This concept is central to both the duty to report and the decision to initiate inquiries and clearer guidance would help ensure consistency across sectors. For example, 'reasonable cause to suspect' is referenced in Clause 3 (duty to inquire) and Clause 4 (duty to report). While the Trust is responsible for determining whether this threshold is met for initiating inquiries, Clause 4 places a duty on listed organisations to report concerns based on the same threshold.

The Trust expressed concern that this could lead to uncertainty across sectors, particularly regarding the level of evidence required to assess the conduct of another person, as referenced in Clause 2(b). They emphasised that organisations should not be expected to investigate or evaluate the behaviour of staff or volunteers before deciding to report. Instead, the focus should remain on identifying whether an adult may be at risk and whether protective action is needed, rather than making determinations about others' conduct.

5.5.2 Practical implications of the role of advocates

Concerns were also raised about the need for greater detail in how the provision of an independent advocate to support an adult would function in practice. The Southern HSC trust noted that it is unclear whether an advocate should be appointed in every case or only when professional judgement deems it to be in the adult's best interests. The Trust requested clarification on the timing of such appointments, specifically, whether they should occur prior to the initial assessment of a referral or at the commencement of an investigation.[87]

[87] Southern Health and Social Care Trust. Adult Protection Bill Consultation Response Northern Ireland Assembly Committee for Health September 2025

5.5.3 Responsibility for making enquiries

Staff within the Southern HSC Trust sought clarity on which professional groups are responsible for making inquiries under Clause 3(1). While Clause 5(1) specifies that a social worker must be present during visits to determine risk and the need for intervention, similar clarity is lacking in relation to the duty to inquire which states that 'an HSC trust must make inquiries'. The Trust recommended that the Bill explicitly state which professionals are expected to carry out inquiries, noting that under current policy, this responsibility lies with social workers, particularly Designated Adult Protection Officers.

5.5.4 Statutory cooperation

COPNI and other cautioned that the Bill does not specify consequences for non-compliance, which could weaken its impact in practice.

Several organisations, including the BMA NI and BASW NI, also sought clarity on how multi-agency enquiries will be coordinated, how timescales will be set and who will assume lead responsibility in complex cases. The NMC and BASW NI further stressed that the new duty should be embedded within a culture of psychological safety, ensuring staff can raise concerns without fear of reprisal or blame.

5.5.5 Statutory duty of candour

During the Second Stage debate, several Members raised the possibility of introducing a statutory duty of candour alongside the Adult Protection Bill. While there was broad cross-party support for the principle, it was acknowledged that the detail is complex and may be better developed in parallel rather than within this Bill. Contributors argued that, if introduced, the duty should apply to individuals (e.g. practitioners) rather than solely to organisations. Linked to this, Members asked what deterrents or consequences would apply if a person failed to participate fully and transparently in an inquiry. [88] COPNI and other

[88] Official Report: Monday 30 June 2025 Adult Protection Bill 2nd Stage

stakeholders suggested that the absence of an explicit reference to candour in the Bill could represent a gap. [89]

5.5.6 Psychological safety and whistleblowing protections

The debate around candour also connected to the broader theme of psychological safety within adult safeguarding. Members and stakeholders emphasised that transparency and openness must be supported by a culture where staff feel safe to speak up without fear of reprisal. The effectiveness of any duty of candour depends not only on legal obligations but also on the presence of robust whistleblowing protections and governance structures that promote trust. It was stressed that any new reporting obligations should be matched by safe, confidential routes for staff to raise concerns and by oversight arrangements that are independent of HR functions to protect whistleblowers. The Minister acknowledged significant cultural issues around whistleblowing and referred to ongoing work to develop recommendations.[90]

5.5.7 Inclusion of Individual Practitioners in Clause 4

Tied to this point, the GMC, in its submission to the Northern Ireland Committee for Health's call for evidence on the Adult Protection Bill, stated that it now understands individual practitioners—such as Medical Practitioners—could be named in the legislation. This has raised concerns, as the current draft of Clause 4 was initially understood to apply to organisations holding general medical services contracts, rather than individual professionals. The GMC have expressed that imposing a legal duty on individuals would be inconsistent with adult safeguarding legislation in other UK nations, where such responsibilities are typically placed at the organisational level. There is also concern that, even with provisions to protect professional discretion, the existence of such a duty could discourage professionals from exercising their judgement for fear of legal

[89] Commissioner for Older People for Northern Ireland (2021) Response to DoH Consultation on Adult Protection Bill.

[90] Official Report: Monday 30 June 2025 Adult Protection Bill 2nd Stage

consequences. It is therefore suggested that learning from the implementation of safeguarding legislation in Scotland, Wales, and England should be considered before proceeding.[91]

5.5.8 Data protection and information sharing

The Information Commissioner's Office (ICO) emphasised that any reporting and information-sharing obligations under the Bill must remain compliant with data protection legislation. To support this, the ICO recommended the use of formal data-sharing agreements and protocols to manage confidentiality and ensure lawful processing of personal information.[92]

5.5.9 Inclusion of professional and regulatory bodies

Professional and regulatory bodies suggested that health and social care regulators, such as the NMC, GMC and the Social Care Council, should be explicitly included among the cooperating bodies under the Bill. These organisations play a key role in overseeing professional conduct and fitness to practise and their involvement would strengthen the safeguarding framework. The Department has indicated that operational details at this level will be addressed through statutory guidance and updated inter agency protocols once the Bill is enacted.[93]

5.5.10 Resources and workload

The introduction of mandatory reporting and statutory enquiry processes is expected to increase workloads for Trusts and partner organisations. The Department has acknowledged the need for additional training and resources to support consistent implementation across HSC Trusts which is discussed across this paper.

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[91] General Medical Council (GMC), Response the Northern Ireland Assembly Committee for Health Call for Evidence on the Adult Protection Bill 2025

[92] Information Commissioner's Office (ICO), Response to DoH (NI) Consultation on the Proposed Adult Protection Bill (2021)

[93] Northern Ireland Assembly, Committee for Health. (2025). Oral Evidence: Adult Protection Bill – Department of Health. Meeting held on 19 June 2025.

5.5.11 Public awareness

Some consultees also highlighted the need for public awareness initiatives and cross-sector communication to ensure that service providers, voluntary organisations and the public understand their responsibilities under the new law.

5.6 Committee considerations: duties created by the bill

The Bill transforms Northern Ireland's adult-safeguarding framework by placing reporting, enquiry and cooperation duties on a statutory footing. Evidence from the UK and internationally suggests that these duties can improve accountability and coordination, but their success depends on the clarity of definitions, the strength of statutory guidance and the adequacy of implementation resources. In scrutinising these provisions, Members may wish to consider the following points:

Clarity and thresholds for reporting - Members may wish to ask whether statutory guidance under Clause 22 will clearly define 'reasonable cause to suspect' and provide practical examples to support consistent reporting thresholds and avoid regional variation ('postcode lottery') in safeguarding responses.

Consequences for non-compliance - Members may wish to consider COPNI's observation that the Bill does not specify consequences for failure to report or cooperate. The Committee may wish to explore whether enforcement mechanisms will be clarified through secondary legislation or guidance.

Coordination and leadership in multi-agency enquiries Members may wish to seek clarity on how leadership, timescales and coordination will be managed when multiple agencies are involved and how disputes or overlaps in responsibility will be resolved.

Creating a learning culture - Members may wish to consider how the Department and HSC Trusts will promote a learning culture that supports professional curiosity and safe reporting, rather than blame, as emphasised by the NMC and BASW.

Public awareness and accessibility - Members may wish to ask whether a public-awareness campaign will accompany implementation to ensure providers, voluntary organisations and the public understand the new reporting obligations and how to raise concerns.

6 Protective powers

The duties described in section one establish the procedural foundations of adult protection under the Bill. They define how concerns must be raised, examined and coordinated among agencies. This section of this paper will examine the protective powers that complement these duties which enable authorities to act where enquiries confirm that an adult is at risk of harm.

Clauses 8-16 outline a structured sequence of powers of intervention, beginning with the power of entry and interview, which enables a qualified social worker to access premises and speak privately with an adult to assess whether they are making decisions freely. This initial step is investigative in nature and designed to establish whether further protective action is required.

Following this, the Bill introduces a series of court-authorised orders, including production, assessment, removal and banning orders which serve both to confirm that an adult is at risk and to implement protective measures.

Because these powers authorise entry to private property and potential interference with liberty, they engage rights under the European Convention on Human Rights, notably Article 8 (right to respect for private and family life) and, in certain circumstances, Article 5 (right to liberty and security). The Bill seeks

to ensure compliance by embedding procedural safeguards, which are covered in more detail in section 6. Some of those safeguards require that:

- Every use of power requires magistrate approval (the court must be satisfied that there is reasonable cause to suspect harm);
- Under normal circumstances the orders will only be granted where the court is satisfied that the adult at risk has consented, however, the bill makes provision that court may proceed without consent if it is satisfied that the adult:
  - Lacks capacity, or
  - Is under undue pressure or coercion (Clause 17);
- Adults have the right to have an advocate appointed to support them (clause 26) and access to legal aid (Clause 21);
- There are penalties for obstruction (Clause 23) but also avenues for appeal in certain circumstances e.g. banning orders (Clause 25).

The overall aim is to balance the duty to protect with respect for autonomy and due process. As mentioned previously, the Department has indicated that detailed guidance and training materials will further support practitioners in applying the orders in a proportionate, rights compliant manner. The Department has also committed to a public consultation on the guidance to ensure stakeholder input into its design and content.[94]

6.1 Power of entry, interview and medical examination

Under Clauses 5 and 6 of the proposed Adult Protection Bill, a suitably experienced, trained and qualified social worker is authorised to enter premises to interview an adult in private and determine whether the individual qualifies as an adult at risk. This power is investigative in nature, enabling the social worker to assess the level of risk and decide whether further protective action is necessary.

[94] Northern Ireland Assembly, Committee for Health. (2025). Oral Evidence: Adult Protection Bill – Department of Health. Meeting held on 19 June 2025.

Clause 6 further clarifies the interview process. It states that a social worker and any person accompanying them may conduct a private interview with any adult found on the premises during a visit under Clause 5. The adult must be informed that they are not required to answer any questions, ensuring the interview respects the individual's autonomy and legal rights. This power applies regardless of whether a court has granted an assessment order (clause 10) authorising the interview to take place elsewhere.

These provisions should be read in conjunction with Clause 18, which outlines the conduct and limitations of such visits. During any visit, the social worker must:

- State the purpose of the visit; and
- Provide evidence of authorisation to enter the premises.

They may also:

- Examine the premises;
- Bring in other persons or equipment reasonably required to fulfil the visit's purpose; and
- Take any other reasonable actions necessary to achieve the objectives of the visit.

However, Clause 18 explicitly prohibits the use of force during or to facilitate entry, reinforcing the principle that interventions must be least restrictive and respectful of the adult's rights and dignity.

Clause 7 introduces the power to conduct medical examinations during such visits. If the social worker reasonably believes the person is an adult at risk and either they or someone accompanying them is a health professional, that professional may carry out a private medical examination. This power also applies regardless of whether a court has granted an assessment order. The adult must also be informed of their right to refuse the examination.

6.2 Access to records and legal safeguards

In addition to powers of entry, interview and medical examination, the Bill provides for the examination of health, financial, or other personal records where a social worker has reasonable cause to suspect an individual is an adult at risk (Clause 8). Access to records held by third parties requires the adult's consent, unless they lack capacity or refuse, in which case the HSC trust may seek a production order from a magistrates' court. Clause 9 outlines the procedural safeguards for such applications, including the adult's right to be notified, heard and supported by an advocate or representative. These provisions are designed to ensure that access to sensitive information is proportionate, legally justified and respectful of the adult's rights, reinforcing the Bill's overarching principles of transparency, accountability and least restrictive intervention.

6.3 Assessment orders

Clause 10 provides a mechanism for Health and Social Care (HSC) Trusts to apply to a magistrates' court for an assessment order. This order authorises a trained social worker to remove an adult from their current premises to a more suitable location for the purpose of conducting a private interview and/or medical examination. The primary aim is to enable the Trust to determine whether the individual meets the definition of an adult at risk and whether protective intervention is necessary.

To grant the order, the court must be satisfied that:

- There is reasonable cause to suspect the adult is being, or is likely to be, seriously harmed;
- Relocation is necessary to carry out the assessment; and
- The proposed premises are appropriate for the interview or examination.

The assessment order may authorise:

- A private interview by a social worker (as provided for under Clause 6),

- a private medical examination by a health professional nominated by the Trust (as outlined in Clause 7),
- or both, depending on the circumstances.

The adult may only be removed from their current location if it is not practicable to carry out the assessment during a standard visit under Clause 5, typically due to lack of privacy or the presence of others who may exert influence or control.

Under normal circumstances, the adult's consent is required before the order can be executed. However, the court may proceed without consent if it believes the adult lacks capacity or is subject to undue pressure or coercion, as further supported by Clause 17, which addresses consent and capacity.

The order is valid for seven working days and is subject to safeguards designed to protect the adult's rights, dignity and privacy. Execution of the order may involve entry to premises, which is governed by Clause 18, requiring the social worker to state the purpose of the visit, show authorisation and not use force.

If entry is refused or urgent access is needed, the Trust may apply for a warrant under Clause 19, which authorises entry using reasonable force if necessary.

This power is intended to support fact finding in situations where assessment cannot safely or effectively take place in the adult's current environment. Statutory guidance is expected to clarify how these orders should be applied in practice, including evidentiary thresholds, procedural safeguards and the role of advocacy and representation.

6.4 Removal orders

Clause 11 provides a mechanism for an HSC Trust to apply to a magistrates court for a removal order where there is clear evidence of imminent serious harm to an adult at risk. This emergency measure authorises a trained social worker to remove the adult from their current premises to a place of safety within 72 hours of the order being made. The order is valid for up to seven working days and cannot be renewed.

The court may grant the order only if satisfied that:

- The adult is likely to be seriously harmed if not moved.
- The proposed premises are both available and suitable for the adult's protection.

The order may also include provisions allowing specified individuals to have contact with the adult during the order's duration, subject to conditions. Before making such provisions, the court must consider:

- Representations from the HSC Trust.
- The views of the adult, those seeking contact and others with an interest in the adult's wellbeing or property.

To execute the order, a social worker is authorised under Clause 11(5) to enter premises to carry out the removal. This power is subject to the conditions set out in Clause 18, which governs the conduct of visits, requiring the social worker to state the purpose, show authorisation and not use force.

If entry is refused or urgent access is needed, the Trust may apply for a warrant under Clause 19, which authorises entry using reasonable force if necessary.

While the EFM notes that removal would normally require the adult's consent, the Bill allows the court to proceed without consent if the adult is at risk and the legal criteria are met. This aligns with Clause 17, which addresses consent and permits the court to disregard refusal where the adult lacks capacity or is under undue pressure.

This power is intended to stabilise high-risk situations, providing short term protection while further assessment or intervention is considered. It operates alongside other protective provisions in the Bill, including assessment orders (Clause 10) and banning orders (Clause 12), forming part of a tiered response to safeguarding adults at risk.

6.5 Banning and temporary banning orders

Clauses 12 to 16 establish a court-authorised power enabling a HSC Trust to protect an adult at risk by excluding a person who is causing, or is likely to cause, serious harm.

Clause 12 introduces the banning order, allowing a magistrates' court to prohibit a named individual from:

- Entering or remaining in specified premises,
- approaching the adult in a defined area,
- removing specified items from the premises

and may include conditions such as supervised access or preservation of property.

The order may last for up to six months and is designed to allow the adult to remain safely at home, rather than being displaced. The court must consider representations from the Trust, the adult at risk, the subject of the order and others with a relevant interest.

Clause 13 permits a temporary banning order while the court considers a full application. It may include any provision that could be included in a full banning order. The court must determine the full application within six months.

Clause 14 sets out the conditions for applying for a banning order, including that the adult is being or likely to be seriously harmed and that banning the individual is a less disruptive alternative to removing the adult.

Clause 15 allows the court to vary or revoke a banning or temporary banning order if justified. This links with Clause 18, which provides flexibility for early discharge if the risk reduces.

Clause 16 makes it an offence to breach a banning or temporary banning order without reasonable excuse. The offence is punishable by a fine up to level 3 on the standard scale (maximum fine of £1,000).

The adult at risk may also request the order and there is a statutory right of appeal for the individual who is banned (Clause 25). The adult may be supported by an independent advocate during proceedings (Clause 26) and the court must consider issues of consent and capacity as outlined in Clause 17.

6.6 Comparative insights on protective powers and practice

Research from Scotland, where equivalent powers exist under the Adult Support and Protection (Scotland) Act 2007, shows that assessment and removal orders are rarely used and are regarded as a last resort. Their mere existence often promotes voluntary cooperation, reducing the need for formal intervention. Practitioners emphasise relationship-based negotiation prior to legal enforcement.[95] [96]

Evaluations from Scotland indicate that protection orders are most effective when embedded in coordinated safeguarding plans, with multi-agency follow up, victim support and clear enforcement mechanisms. Orders issued in isolation have limited long-term impact and work best as a 'pause point' to assess risk and stabilise circumstances rather than as a final solution.[97]

In Wales, the Social Services and Well-being (Wales) Act 2014 does not include a statutory power to remove an adult from harm. In fact, Section 129 of the Act explicitly abolishes the previous power under the National Assistance Act 1948 that allowed local authorities to apply for a court order to remove people in need of care and attention from their homes.[98] Instead, Adult Protection and Support Orders (APSOs) provide access for assessment, not removal. Any protective action following assessment must be taken under other legal frameworks, such as the Mental Capacity Act 2005 or the inherent jurisdiction of the High Court.[99]

Evidence from Wales suggests that APSOs are also used sparingly, with single digit applications per year but have proven valuable when voluntary access is refused. Both jurisdictions highlight that early, voluntary engagement usually

[95] Stewart, A. (2016) Implementing the Adult Support and Protection (Scotland) Act 2007: A Critical Analysis. PhD thesis, University of Glasgow.
[96] Chapter 13: Removal orders - Adult Support and Protection (Scotland) Act 2007: code of practice - gov.scot
[97] Quality framework for ASP September 2024.pdf
[98] Social Services and Well-being (Wales) Act 2014; Section 129 - Abolition of local authority's power to remove persons in need of care and attention - Adults
[99] working-together-to-safeguard-people-volume-4-adult-protection-and-support-orders.pdf

prevents escalation but that statutory powers provide legal certainty where resistance or coercion prevents access.[100]

Research indicates that protection orders of this kind can reduce risk when embedded in coordinated safeguarding plans, orders are most effective when coupled with multi-agency follow-up, victim support and clear enforcement. Orders issued in isolation have limited long-term impact. Scottish evaluations echo this, noting that orders work best as a 'pause point' to assess risk and stabilise circumstances rather than as a final solution. These findings suggest that any use of Clauses 12 - 16 should be accompanied by structured review, advocacy and case coordination.

Interviews with adults subject to protective orders in Scotland and England report mixed experiences: some initially felt disempowered but later recognised the necessity of intervention. The decisive factor was the quality of communication and whether advocacy or trusted supporters were involved. This underscores the importance of clear explanation, empathy and independent representation throughout the process to promote understanding and trust.[101]

Finally, the LGA National Analysis of Safeguarding Adult Reviews (2019–2023) and the All-Wales Adult Practice Review Thematic Report (2025) both found that delays in gaining access or information were recurring causes of failure in safeguarding cases. These findings highlight the need for timely cooperation between social work, health, police and legal services to ensure that any orders are carried out effectively and without delay.[102]

[100] Stewart, A. (2016) Implementing the Adult Support and Protection (Scotland) Act 2007: A Critical Analysis. PhD thesis, University of Glasgow.

[101] Joint inspection of adult support and protection overview report August 2023

[102] Research Insights: Strengthening Safeguarding in Wales; Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 (executive summary) | Local Government Association; From Act to Impact? Final Report of the Evaluation of the Social Services and Well-being (Wales) Act 2014

6.7 Stakeholder views protective powers

A selection of stakeholder views on the Bill's protective powers is presented below. At a strategic level, both the NIHRC and the Health and Care Professionals Council (HCPC) emphasised that any use of protective powers must be underpinned by robust capacity assessment, supported decision-making and compliance with the European Convention on Human Rights (ECHR). They stressed that consistent application of these principles will require clear statutory guidance, alongside comprehensive training and supervision.[103]

6.7.1 Power of entry

Consultation views on power of entry were mixed but generally supportive. Organisations such as Hourglass NI argued that the power closes a long-recognised gap in the law, citing cases where professionals were unable to see an adult privately because access was blocked by family or carers.

Professional bodies, including the NMC and BMA NI, accepted the need for the power but sought assurances on the personal safety of staff and on potential legal liability if an order were later challenged. The bodies also emphasised that training and clear operational guidance will be essential to ensure proportionate and lawful use.

Feedback from practice leads within HSC Trusts suggests the power of entry should be extended to appropriately trained adult protection officers or other qualified practitioners accompanying the social worker, reflecting the multidisciplinary nature of adult protection.

Defined multi agency protocols for joint visiting arrangements, particularly in higher-risk situations are deemed essential. Practitioners also highlighted safety considerations for staff conducting visits, joint attendance with PSNI and appropriate managerial oversight are recommended.

[103] Health and Care Professionals Council Submission to the Northern Ireland Assembly Committee for Health – Adult Protection Bill

6.7.2 Assessment, removal and banning orders

Stakeholder responses recognised the value of the graded orders but urged caution. Professional associations supported the availability of court authorised interventions while noting that criteria should be tightly defined to prevent overuse. BASW and COPNI stressed the importance of ensuring that removal or banning orders are accompanied by suitable aftercare and review mechanisms. BMA NI recommended guidance on medical assessment and consent where physical or psychological examinations are undertaken under an Assessment Order.

In line with the UN Convention on the Rights of Persons with Disabilities (2006), the Bill emphasises supported rather than substituted decision-making. The RCSLT NI noted that adults with communication needs may require tailored support to understand or give consent. Providing accessible communication, advocacy and trauma-informed practice will be essential to ensure that orders are applied fairly and respect autonomy.

The GMC and NMC both advised that guidance and training will be vital to help professionals navigate complex consent and entry situations. Research carried out with social workers in Scotland found that clear warrant procedures increased practitioner confidence in using legal powers appropriately.[104]

Trust representatives have also highlighted the need for clarity around when a formal assessment of capacity is required, particularly in the context of assessment orders and any emergency interventions. The reliance on Consultant Psychiatrists to complete an assessment presents practical challenges due to limited availability, associated costs and potential delays – particularly in urgent situations. There is also uncertainty about the tools or frameworks to be used in assessing whether someone is being 'unduly

[104] Mackay, K. and Notman, M. (2017) 'What difference does the Adult Support and Protection (Scotland) Act 2007 make to social work practitioners' safeguarding practice?' *Journal of Adult Protection,* 19(2), pp. 67–79.

pressurised' and whether adequate training and guidance will be provided to support consistent and lawful decision-making.[105]

6.8 Key committee considerations: protective powers

Legal safeguards and thresholds

Members may wish to consider whether the Bill should define key thresholds such as 'serious harm' and 'undue pressure' to support consistent decisions across HSC Trusts.

Members may wish to ask whether guidance will clarify how capacity and coercion are assessed in urgent cases and who is qualified to carry out formal psychiatric assessments.

Members may also wish to explore whether Clauses 8–16 provide sufficient procedural safeguards to protect rights under Article 8 (private life) and Article 5 (liberty) of the European Convention on Human Rights. These clauses authorise interventions that may involve entry to private property, access to records, or temporary restrictions on a person's liberty. Such actions engage fundamental rights and must therefore be lawful, necessary and proportionate. The Committee may wish to consider whether safeguards such as judicial authorisation, time limits, advocacy, consent provisions and rights of appeal are sufficiently robust to ensure compliance with human-rights standards.

[105] Belfast Health and Social Care Trust (BHSCT) feedback in relation to the Northern Ireland Adult Safeguarding Bill

Operational implementation

Members may wish to consider whether powers of entry should extend to other trained adult protection officers, not just social workers.

Out of hours applications

Members may wish to seek clarity on how urgent or out-of-hours applications, such as removal or banning orders, will be handled, including access to courts and legal support.

Public and professional confidence

Members may wish to ask how the Department will communicate the scope and safeguards of protective powers to service users, families and providers.

Members may wish to consider whether adults subject to intervention orders will have guaranteed access to independent advocacy and legal representation.

7 Supporting provisions for part 1 of the bill

This section summarises the remaining provisions of Part 1 of the Adult Protection Bill relating to implementation, enforcement and rights-based safeguards. It outlines measures to support access to justice and statutory guidance, establishes accountability mechanisms and describes provisions on advocacy, workforce competence and family engagement, all aimed at ensuring lawful, consistent practice across HSC Trusts.

7.1 Safeguards and procedures governing protection orders (Clause 17-20)

Clauses 17 to 20 set out the supplementary rules that govern the operation of protection orders. These provisions define how consent, duration, review, entry and visits will work in practice. Together, they ensure that the use of protective powers introduced under Clauses 10 - 16 remain lawful, proportionate and compatible with human rights.

Clause 17 affirms the principle of consent, stating that a protection order (assessment, removal, or banning) cannot be granted or executed if the adult at risk has refused consent - unless the court believes the refusal results from coercion or lack of capacity. Clause 18 regulates the duration, variation and recall of protection orders, providing that they should last only as long as necessary as well as providing flexibility for early discharge if risk reduces. Clause 19 allows the court to issue a warrant for entry, authorising entry to premises and where necessary, the use of reasonable force, supported by the PSNI. The PSNI indicated in their response to the Northern Ireland Committee for Health's call for evidence that police should not be the default accompaniment on social work visits. Rather, it should be the exception, guided by a clear risk assessment/escalation route (who decides, when and how disagreements are resolved) that aligns with 'Right Care, Right Person' principles.[106]

Clause 20 regulates the process for visits and interviews. Officers must identify themselves, explain the purpose of their visit and respect the adult's right to privacy. The RCSLT NI highlighted that adults with communication difficulties may require reasonable adjustments or advocacy to participate effectively. This reflects findings from England's Making Safeguarding Personal evaluations (LGA 2020), which show that person-centred communication enhances cooperation and reduces distress.[107]

[106] Adult Protection Bill PSNI Views September 2025
[107] Making Safeguarding Personal | Local Government Association

7.2 Implementation, enforcement and rights based practice

This section summarises provisions relating to access to legal aid and statutory guidance, offences and appeal rights and the duties on HSC Trusts concerning independent advocacy, workforce competence and family engagement.

7.2.1 Legal access and guidance (Clauses 21–22)

This clause ensures that individuals subject to protection orders under the Bill, such as assessment, removal, or banning orders, are eligible for legal aid. It reinforces the right to access legal representation, enabling affected adults to challenge or respond to court applications. This safeguard supports compliance with human rights obligations, particularly the right to a fair hearing under Article 6 of the ECHR.

Clause 22 requires the Department to issue, consult on and keep under review statutory guidance for all public authorities exercising functions under Part 1. This guidance will set thresholds, define evidential standards and clarify roles across agencies.

7.2.2 Enforcement and accountability (Clauses 23–25)

Clause 23 creates an offence of obstruction, making it unlawful, without reasonable excuse for any person to prevent or obstruct an authorised person from exercising powers under the Bill.

The PSNI welcomed the inclusion of an obstruction offence but sought clarification on how it will operate in practice. They queried whether HSC Trusts or social workers would be able to refer obstruction offences directly to the Public Prosecution Service (PPS), or whether all such cases must be referred via the PSNI for investigation.

The PSNI cautioned that the latter approach could increase operational demand and recommended early agreement between the Department, PPS and HSC on clear referral and evidential pathways. They also asked that statutory guidance

distinguish the new obstruction offence from existing police obstruction provisions to prevent duplication or uncertainty.[108]

Clause 24: organisational and corporate liability

Clause 24 establishes a legal mechanism for prosecuting both organisations and responsible individuals when offences under the Bill—such as ill-treatment or wilful neglect (Clauses 38–42)—are committed. It applies to corporate bodies and unincorporated associations, assigning liability where harm results from systemic or managerial failings rather than isolated individual misconduct.

The clause introduces two key forms of responsibility:

- Corporate liability: Organisations such as care providers, partnerships, or charities can be prosecuted where offences arise from how their activities were managed or organised.
- Personal liability: Senior officers, including directors, managers or trustees, may be held personally accountable if the offence occurred with their consent, connivance or neglect.

This structure ensures joint accountability, recognising that serious harm often stems from organisational culture, poor oversight, or unsafe systems, not just frontline actions. It reflects modern principles of corporate responsibility, extending criminal liability to those who design and oversee care environments.

Evidence from England in cases such as Winterbourne View and Mid Staffordshire NHS Trust has shown that leadership failures can contribute significantly to abuse and neglect.[109] In Northern Ireland, inquiries into Muckamore Abbey Hospital and Dunmurry Manor similarly exposed gaps in governance and accountability. Clause 24 addresses this by:

- Enabling prosecutions where harm results from structural or managerial failings;

[108] Adult Protection Bill PSNI Views September 2025

[109] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - GOV.UK; Winterbourne View: Abuse footage shocked nation - BBC News

- Preventing organisations from shielding themselves behind complex corporate arrangements; and
- Holding senior leaders accountable when their actions, or inaction, enable abuse to occur.

Stakeholders widely supported stronger organisational accountability, noting that leadership and governance failures have repeatedly contributed to harm in care settings.[110] [111]

Clause 25: appeals

Clause 25 sets out the appeal rights for protection orders. Only banning and temporary banning orders, including their variation or revocation, are appealable. These orders can last up to six months and may significantly restrict an individual's liberty or access to premises, so a specific right of appeal provides an important safeguard and ensures proportionality through independent judicial review.

By contrast, assessment, removal and warrant orders are short term and cannot be appealed. These measures are subject to judicial oversight at the point of issue, which ensures proportionality without delaying urgent protection.

7.3 Advocacy, workforce and engagement (Clauses 26–29)

7.3.1 Independent advocacy (Clause 26)

Clause 26 places a statutory duty on each HSC Trust to make arrangements to ensure that an independent advocate is available. The advocate's role is to support and assist adults at risk and help them be involved in and influence decisions taken about their care.

[110] Submission from Care Campaign for the Vulnerable (CCFTV) the Northern Ireland Assembly Committee for Health Call to Evidence on the Adult Protection Bill

[111] Hourglass NI Response to the NI Department of Health Consultation on Legislative Options to Inform the Development of the Adult Protection Bill for Northern Ireland

The Equality Commission noted in its submission to the Northern Ireland Committee for Health that the Department should consider learning arising from the Care Act 2014's implementation, where advocacy gaps led to low prosecution rates.[112] Early post-implementation evaluations of the Care Act revealed widespread deficiencies. By February 2015, only 20% of councils had decided on advocacy providers for Care Act duties and just one in ten advocacy services had clarity on funding levels, risking breaches of statutory obligations and leaving vulnerable adults without support to report abuse or neglect. These gaps persisted, with a 2022 National and Care Excellence Institute for Health (NICE) guideline noting that despite the Act's requirements, advocacy uptake remains inconsistent, often due to inadequate commissioning, awareness and resource allocation.[113] [114]

Scotland's experience of delivering independent advocacy within a statutory adult safeguarding framework may provide insight for Northern Ireland.

Evaluations of adult safeguarding practice in Scotland report that adults at risk of harm benefit from having an independent advocate. Independent advocates were reported to give invaluable support to adults at risk of harm and help them to understand and navigate the adult support and protection process.[115]

However, evidence indicates that access to advocacy under Scotland's 2007 Adult Support and Protection Act remains inconsistent. In some areas, adults are not routinely offered advocacy, or it is introduced too late, sometimes immediately before or after key meetings, limiting its effectiveness. Availability varies across settings such as hospitals, care homes and community teams, reflecting uneven staff awareness about when and how to make referrals. Findings note that adults perceived to have impaired capacity were sometimes

[112] ECNI Consultation response - Adult Protection Bill
[113] Why councils risk breaching the Care Act and failing people entitled to independent advocacy - Community Care
[114] Rationale and impact | Advocacy services for adults with health and social care needs | Guidance | NICE
[115] ASP The joint inspection of adult support and protection overview report June 2023

excluded from advocacy altogether, despite the Act's emphasis on participation and supported decision making.[116]

Advocacy workers also described tensions with professionals, particularly when challenging whether proposed interventions were genuinely least restrictive or aligned with the adult's wishes. These tensions often stemmed from role confusion and inconsistent communication between agencies.

Overall, the findings highlight that the effectiveness of advocacy depends less on statutory design and more on consistent practice, clear professional understanding and early, proactive engagement with adults at risk.[117] [118]

7.3.2 Workforce capacity and family considerations (Clause 27- 28)

Clause 27 places a statutory duty on HSC Trusts to appoint a sufficient number of adult protection social workers with appropriate competence to carry out functions under the Bill. It also defines who qualifies as a health professional, including registered doctors, nurses and midwives, with scope to include others by regulation. The clause clarifies that certain functions, such as applying for protection orders are exercisable only by designated adult protection social workers, while other tasks like visits or interviews may be carried out by any social worker. These duties apply only to adults ordinarily resident in the Trust's operational area. Clause 27 also updates existing legislation to formally integrate adult protection responsibilities into the broader framework of social care functions.

Research and practice evaluations underline that a well-trained and confident workforce is fundamental to effective safeguarding. Evidence from Scotland's experience of implementing a statutory adult protection framework show that multi agency training increased practitioner confidence in recognising harm and

[116] National Adult Support And Protection Resource - Best Practice For Effective Access And Involvement Of Independent Advocacy For An Adult In Adult Support And Protection Processes

[117] Adult safeguarding legislation: Navigating the borderlands between mental capacity, mental health and social care law and practice - ScienceDirect

[118] national Adult Support And Protection Resource (2024) Best Practice for Effective Access and Involvement of Independent Advocacy for an Adult in Adult support and Protection Processes

applying statutory powers appropriately.[119] Reviews of adult safeguarding in England similarly identify gaps in professional development, particularly around capacity assessment and risk analysis.[120]

The BMA NI, GMC and NMC all raised workforce capacity and training as crucial to effective implementation, emphasising that adult protection demands 'a significant programme of training' and alignment with professional standards. ARC NI highlighted workforce shortages as a major barrier citing that without a recruitment and training strategy, appointing specialist social workers risks diluting already stretched staff.

7.3.3 Family engagement

Clause 28 requires trusts, where practicable, to ascertain and consider the views of relatives, carers and other relevant persons and to keep them informed of safeguarding actions. Hourglass NI and Care Campaign for the Vulnerable submissions to the Northern Ireland Assembly Committee for Health supported structured family engagement, emphasising that relatives can contribute valuable insight and reassurance when consulted transparently and safely.

In Wales, the Care Inspectorate's review of adult case reviews between 2019-22 identified that too often, reviews did not include or reflect the views of the adult or their family. This meant reviews lacked insight from people with lived experience.

Reviews in Wales have also highlighted that limited involvement of families and adults with lived experience can reduce the depth and effectiveness of case reviews, underscoring the importance of their inclusion in post-incident learning processes too.[121]

[119] ASP The joint inspection of adult support and protection overview report June 2023

[120] Implementation of the Making Safeguarding Personal Approach to Strengths-based Adult Social Care: Systematic Review of Qualitative Research Evidence | The British Journal of Social Work | Oxford Academic

[121] Triennial review adult initial case reviews and significant case reviews 2019-22

7.3.4 Interpretation and clarity (Clause 29)

Clause 29 provides definitions for key terms used throughout Part 1 of the Bill, such as 'harm', 'adult at risk', 'assessment order' and 'banning order'. Stakeholders have highlighted that the definitions are essential for ensuring clarity and consistency in the application of the Bill's powers and have emphasised the need for this guidance to include clear explanations, illustrative examples and practical case scenarios to help professionals apply the definitions appropriately in diverse settings. The clause also sets out that whenever the Bill refers to a social worker visiting premises, it should be understood as the social worker exercising a legal right of entry under specific provisions.

7.4 Committee Considerations: Supporting Provisions for Part 1 of the Bill

Supplementary safeguards and procedure

Members may wish to consider whether the safeguards governing consent, review and entry under Clauses 17- 20 in the text of the Bill and forthcoming statutory guidance provide sufficient detail to ensure that protective orders are applied consistently and in a manner compatible with human-rights standards. These clauses determine when consent can be overridden, how long orders remain in force and the conditions for entry to private premises. Ensuring that both the legislation and accompanying guidance set out clear and comprehensive safeguards and that these are applied consistently across all HSC Trusts will be central to maintaining lawful, proportionate and transparent intervention.

Members may also wish to explore how the Department intends to align the operational use of police support with Right Care, Right Person principles. Under this model, police involvement

should only occur where there is a clear, assessed risk that requires their presence, rather than as standard practice. This approach promotes proportionate intervention, preserves the lead role of health and social-care professionals, and avoids unnecessary use of police resources. The Committee may therefore wish to ask whether joint-working protocols, risk-assessment procedures and escalation processes will be formalised to clarify when and how police assistance should be sought.

Implementation, enforcement and accountability

Members may wish to consider whether the Bill and subsequent statutory guidance will provide clear direction on enforcement and referral pathways, particularly in relation to the new offence of obstruction under Clause 23. Clarity on whether such cases will be referred directly to the Public Prosecution Service or via the PSNI are cited as central to ensuring consistent application and avoiding duplication. The Committee may wish to ask whether these operational arrangements will be formalised through guidance and whether they will include agreed procedures between the Department, PPS and HSC Trusts.

Members may also wish to explore how corporate and personal liability provisions under Clause 24 will be implemented in practice and how the Department will ensure that both care providers and regulators understand and meet their new responsibilities. Guidance will play a key role in explaining how liability will be established and how the RQIA's existing regulatory powers will align with the new offences.

Finally, Members may wish to consider whether the appeals framework under Clause 25 provides sufficient balance between the need for responsive protection and access to justice. While short term orders are subject to judicial oversight

at the point of issue, longer term banning orders are appealable. The Committee may wish to consider whether these arrangements are fair, practical and allow people to challenge decisions quickly without causing unnecessary delays

Advocacy and workforce

Members may wish to consider whether the Bill and accompanying guidance will ensure that independent advocacy is consistently available, adequately funded and introduced early enough to influence decision-making. Evidence from other jurisdictions indicates that delays or gaps in advocacy provision reduce participation and confidence in safeguarding processes. The Committee may wish to ask how the Department will set out clear criteria for referral, minimum standards for advocacy commissioning and the advocate's role where there are disagreements about intervention or risk.

Members may also wish to seek assurance that there will be a sufficiently trained and supported workforce to meet the new statutory duties under Clause 27. The guidance will be important in clarifying role boundaries between designated adult protection social workers and other practitioners and in establishing expectations for multi-agency training. The Committee may wish to explore whether workforce planning and training commitments have been fully costed and how implementation will align with professional standards.

Family engagement and lived experience

Members may wish to consider how the Bill and accompanying guidance will promote safe, transparent engagement with families and carers while respecting the adult's wishes and confidentiality. Structured consultation and information sharing

processes can strengthen trust and improve outcomes. The Committee may wish to ask how guidance will define when and how family views should be sought, and how adults and relatives will be involved in post-incident learning and review processes.

8 The Adult Protection Board for Northern Ireland

Clauses 30 to 36 establish the APB for Northern Ireland. The Board is intended to provide independent leadership, coordination and oversight of adult protection arrangements across health, social care, justice and regulatory sectors. These clauses define the Board's legal status, outline its membership and core functions and set out its reporting duties and powers to request information from relevant bodies. Together, they form the governance and accountability framework for the new adult protection system. A summary of the relevant clauses is provided in Table 2.

Table 2: An overview of clauses relating to the proposed Independent Adult Protection Board

Clause	Description
30	**Establishment of the Adult Protection Board** Formally establishes the APB as a statutory body, independent of the Department, with a duty to promote consistency and improvement in adult protection practice.
31	**Functions of the board** • publishing an annual strategic plan and report; • commissioning and overseeing Serious Case Reviews (SCRs); • monitoring patterns and trends in safeguarding data; • promoting inter-agency cooperation and public awareness.

32 Power to require information

Gives the Board power to request information from any public body or independent provider where this is relevant to its functions.

33 Regulations on membership and procedures

Allows the Department to make regulations on membership and procedures.

34 Funding and support

Provides for funding and support to enable the Board to perform its functions.

35 Publication and reporting duties

Sets out requirements for the publication of annual plans and reports.

36 Interpretation

Defines key terms relating to the Board's operation.

8.1 UK experience of adult safeguarding boards

Creating a statutory Adult Protection Board reflects similar approaches across the UK, though with notable structural differences. In England, the Care Act 2014 established Safeguarding Adults Boards (SABs), which are independently chaired but operate as statutory multi-agency partnerships hosted by local authorities rather than as independent bodies. Evaluations show that SABs have improved strategic oversight, accountability and transparency, although

challenges remain around data quality, consistency of follow-up and inter-agency engagement.[122] [123]

In Wales, Part 7 of the Social Services and Well-being (Wales) Act 2014 created Regional Safeguarding Boards for adults and children. These, too, are statutory partnerships with independent chairs, designed to promote joint accountability and learning across local authorities, health boards and police. Evaluations by Care Inspectorate Wales and the Welsh Government found that the regional model improved collaboration and consistency but remains constrained by dependence on host authorities for administrative and financial support, with the extent of their effectiveness shaped by local leadership and resourcing.[124]

In Scotland, the Adult Support and Protection (Scotland) Act 2007 requires every local authority to establish an Adult Protection Committee (APC). While not independent statutory bodies, these committees are independently convened and bring together partners from health, social care and justice. Reviews by the Scottish Government and the Care Inspectorate found that independent conveners play a key role in promoting objectivity, constructive challenge and partnership improvement, though outcomes vary depending on local engagement and support.[125] [126]

For Northern Ireland, the proposed single, statutory Adult Protection Board represents a distinctive approach - establishing a region wide, independent body with formal powers to coordinate, monitor and promote improvement across all HSC Trusts. This structure addresses concerns about fragmented oversight under the current policy framework (Adult Safeguarding: Prevention and Protection in Partnership, 2015) and offers greater structural independence than the partnership based models elsewhere in the UK.

[122] Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 (executive summary) | Local Government Association
[123] Annual Report 2022-23 - Safeguarding Board Wales
[124] From Act to Impact? Final Report of the Evaluation of the Social Services and Well-being (Wales) Act 2014
[125] Scottish Government & Care Inspectorate (2018), Joint Inspection of Adult Support and Protection Measures: Overview Report, Scottish Government, Edinburgh;
[126] Care Inspectorate (2023), Triennial Review of Adult Support and Protection Arrangements.

Stakeholders broadly welcomed the creation of an independent statutory body but emphasised that its success will depend on a clear remit, well-defined powers and adequate resourcing. The BMA NI supported the need for 'a single, clear accountability structure' across agencies. The GMC and NMC noted the importance of the Board promoting consistent professional standards and clear expectations for inter-agency cooperation. Experience from England, Scotland and Wales indicates that resourcing and clarity of role are central to the success. Under-resourced boards and committees have tended to become reactive and process driven, while those with clear statutory duties and analytical capacity are better able to identify systemic risks and drive continuous improvement.[127]

8.1.1 Serious case reviews and learning culture

Under Clause 31, the Adult Protection Board will be responsible for Serious Case Reviews (SCRs) where an adult at risk has died or suffered serious harm and there is potential learning for agencies.

A national review of over 650 Safeguarding Adults Reviews (SARs) in England, conducted between 2019 and 2023, identified recurring issues in risk assessment, communication, role clarity and professional accountability. While learning was frequently captured, it was not consistently embedded in practice, with similar failings appearing across multiple reviews. The analysis recommended stronger independent oversight, systematic tracking of implementation and improved mechanisms for sharing learning across regions.[128]

The national analysis found that while learning was frequently identified, it was not always embedded in practice and similar issues reappeared across multiple reviews. It recommended stronger independent governance of review

[127] Local Government Association & ADASS (2024), Second National Analysis of Safeguarding Adults Reviews: April 2019 – March 2023, LGA Publications.
[128] Local Government Association & ADASS (2024), Second National Analysis of Safeguarding Adults Reviews: April 2019 – March 2023, LGA Publications.

processes, systematic tracking of implementation and mechanisms for sharing learning across regions.

In Wales, findings from a review of Adult Practice Reviews (APRS) highlighted inconsistency in the quality and follow-through of case reviews.[129] In Scotland, Serious Case Reviews are overseen by Adult Protection Committees, with findings showing variation in review quality and how learning is shared across agencies.[130]

For Northern Ireland, these experiences underline the importance of a clear, centralised and well resourced review process. Stakeholders, including Hourglass NI and the Care Campaign for the Vulnerable, stressed that lessons from serious incidents must lead to tangible policy, workforce and practice improvements, not remain confined to reports or recommendations.[131] A single statutory Board could ensure consistent standards and visible accountability for implementing review findings across all Trusts.

8.1.2 Information sharing and data quality

Clause 32 gives the Adult Protection Board statutory powers to request relevant information from public bodies and care providers. The ICO welcomed this as a lawful and proportionate basis for data sharing, provided it complies with data protection requirements. Across the UK, inconsistent data has been a major barrier to effective oversight. Reports from Safeguarding Adults Boards in England show that fragmented recording systems make it difficult to monitor outcomes or identify trends. [132]

The Board's powers in Northern Ireland represent a significant step forward, enabling regional data standardisation, greater transparency and improved

[129] Research Insights: Strengthening Safeguarding in Wales

[130] Scottish Government, Edinburgh and Care Inspectorate (2023), Triennial Review of Adult Support and Protection Arrangements.

[131] Submission from Care Campaign for the Vulnerable (CCFTV) To: Northern Ireland Assembly Adult Protection Committee

[132] Local Government Association & ADASS (2024), Second National Analysis of Safeguarding Adults Reviews: April 2019 – March 2023, LGA Publications;

comparability of adult protection performance. The Bill allows the Board to collect and analyse information to monitor trends and support system learning. However, it does not specify how data will be collected, standardised or reported across HSC Trusts. Stakeholders including the ICO have emphasised that any data sharing or analysis must comply with UK GDPR and be supported by clear protocols and formal data sharing agreements.

Scotland has established a national minimum dataset for adult protection under the Adult Support and Protection (Scotland) Act 2007. It aims to standardise data collection across local authorities and support cross-area analysis of protection activity. In its 2024–25 publication the Scottish Government reported 63,144 referrals and 47,314 enquiries under the dataset.[133] The report emphasises that this dataset functions not only as a statistical release, but also as a tool for learning and improvement by providing a glossary of terms, background methodology and indicators on data quality.

Despite these developments, the Scottish data release notes that inconsistencies across local authorities in how client categories are defined have a direct impact on the consistency of data received nationally.[134] This suggests that while Scotland's dataset represents a significant step towards systematic oversight of adult protection, it also highlights the challenges of achieving comparable data across jurisdictions and underscores the importance of clear definitions, data governance and methodological alignment.

8.1.3 Inter-agency collaboration and workforce learning

Evidence from across the UK and submissions to the Department's consultation on the Adult Protection Bill, as well as to the Northern Ireland Assembly Health Committee's call for evidence, highlight that sustained improvement in adult protection relies on collaborative leadership and shared learning. In Scotland, multi-agency Adult Protection Committees have supported joint training and coordinated decision making, leading to earlier intervention and fewer repeat

[133] Scottish Government (2023) Adult Support and Protection: May 2023 Statistical Release. Edinburgh: Scottish Government.
[134] Scottish Government (2023) Adult Support and Protection: May 2023 Statistical Release. Edinburgh: Scottish Government.

concerns.[135] Similarly, evaluations in Wales found that regional joint training frameworks strengthened professional relationships and improved understanding of safeguarding thresholds.[136]

The NMC and GMC noted that Northern Ireland's Board should perform a comparable function, promoting shared professional learning and consistent safeguarding standards across health, social care and justice sectors. The Board's independence and region wide remit provide an opportunity to establish common training frameworks and shared professional standards at scale.

8.1.4 Public confidence and transparency

Research indicates that the visibility and openness of safeguarding boards and committees directly influence public trust. In England, Safeguarding Adults Boards and in Wales, Regional Safeguarding Boards, are required by law to publish annual reports and summaries of learning from reviews. These statutory duties support transparency and help build community confidence in adult protection systems.[137] In Scotland, the Care Inspectorate noted that effective Adult Protection Committees routinely publish accessible reports, improving public understanding and accountability.[138]

Experience from Manitoba, Canada, illustrates the risks of weak or dependent oversight. Under the Protection for Persons in Care Act 2000, the Protection for Persons in Care Office (PPCO) was tasked with investigating abuse in health-care settings but was criticised by the Manitoba Ombudsman (2023) for lengthy delays, lack of transparency and for dismissing credible abuse allegations. Plans to replace it with an independent review body have stalled, leaving victims without timely redress and significantly eroding public confidence. The

[135] Scottish Government, Edinburgh and Care Inspectorate (2023), Triennial Review of Adult Support and Protection Arrangements.
[136] From Act to Impact? Final Report of the Evaluation of the Social Services and Well-being (Wales) Act 2014
[137] Safeguarding Adults Boards – Annual reports - SCIE
[138] Scottish Government, Edinburgh and Care Inspectorate (2023), Triennial Review of Adult Support and Protection Arrangements.

Manitoba case demonstrates that adult protection systems without independent scrutiny can become defensive and opaque.[139]

The Adult Protection Bill mirrors this approach: Clause 35 will require the Board to report annually on its activities, findings and outcomes. The Care Campaign for the Vulnerable and Hourglass NI both welcomed this commitment, emphasising that proactive communication and visible accountability are essential to restoring confidence following high profile institutional failures such as Muckamore Abbey.[140]

8.1.5 Board membership

Health Minister Mike Nesbitt MLA clarified that the membership and structure of the Adult Protection Board mirrors those of the existing Safeguarding Board for Northern Ireland (SBNI). Under Clause 30 of the Adult Protection Bill the Board will comprise both statutory and appointed members. Statutory members will be representatives of key public bodies such as HSC Trusts the PSNI and the RQIA who will remain employed by their respective organisations. In addition the Department of Health will appoint other members through the established public appointments process which is designed to ensure transparency fairness and independence.

The Minister emphasised that this mixed composition is consistent with the model used for other arms length bodies and that while statutory members are drawn from within the health and social care system the inclusion of publicly appointed members and the Board's arms length status are intended to provide an appropriate level of independence and safeguard against potential conflicts of interest.[141]

[139] Investigation of the Protection for Persons in Care Office (PPCO) 2023 - Office of the Auditor General Manitoba; Overhaul of seniors' protection office on hold as $1M report sits on health minister's desk | CBC News

[140] Submission from Care Campaign for the Vulnerable (CCFTV) to the: Northern Ireland Assembly Adult Protection Bill

[141] Assembly Questions Written 29508/22-27

8.2 Committee considerations – The Adult Protection Board for Northern Ireland

Governance and independence

Members may wish to consider whether the Board's statutory independence and powers are sufficiently defined in the Bill and forthcoming regulations to ensure genuine autonomy from the Department. While statutory members will represent key public bodies, the Committee may wish to explore how independence will be maintained and whether publicly appointed members will have a meaningful role in providing oversight and setting priorities.

Functions, remit and resourcing

Members may wish to examine whether the Board's remit under Clause 31 is clearly defined and achievable within the resources available. Experience across the UK suggests that safeguarding boards need analytical capacity and clear statutory duties to drive improvement. The Committee may wish to seek assurances on how the Board's work will align with existing bodies such as the SBNI, RQIA and HSC Trusts to avoid duplication or blurred accountability.

Serious case reviews and learning

Members may wish to explore how the Board will ensure consistent, high-quality Serious Case Reviews and effective follow-through on recommendations. Clear procedures and adequate resourcing will be needed to ensure that lessons lead to measurable changes in practice rather than repeated failings.

Information sharing and data quality

Members may wish to ask how the Board's new information request powers will operate in practice and how data will be

standardised and shared lawfully under UK GDPR. Establishing a regional dataset for adult protection could improve consistency and oversight but would require clear protocols, definitions and data governance arrangements.

Collaboration, learning and transparency

Members may wish to consider how the Board will promote joint learning and professional standards across health, social care and justice, including through shared training frameworks and leadership engagement. They may also wish to ask how the Board's reporting duties will support public transparency, including how learning from reviews and performance data will be published in accessible formats.

Membership and Representation

Members may wish to consider whether the Board's composition achieves the right balance between representation and independence. The Committee may wish to ask how independent and statutory members will be appointed, how potential conflicts of interest will be managed and whether lived-experience or voluntary-sector voices will be represented.

9 Offences of ill-treatment or willful neglect

The introduction of offences covering ill-treatment and willful neglect follows recognition that existing legal remedies did not adequately address institutional patterns of neglect or abuse. Investigations such as Muckamore Abbey Hospital in Northern Ireland and Winterbourne View in England exposed

weaknesses in organisational accountability and the limits of professional disciplinary action.[142]

Clauses 38 to 42 of the Adult Protection Bill introduce new criminal offences of the ill-treatment or willful neglect of adults receiving care. Together with Clause 24, which extends liability to senior officers and corporate bodies, these provisions establish a connected framework of individual, organisational and corporate accountability. The offences aim to strengthen protections for adults at risk while ensuring that staff acting in good faith and within professional standards are not unfairly penalised.

The care provider offence sets a high threshold for liability, requiring a gross breach of duty. Providers that have implemented effective policies, supervision and staff training would not be guilty due to a single incident by an individual worker. The offences are intended to capture systemic disregard rather than isolated human error.

This mirrors the approach taken in England's Criminal Justice and Courts Act 2015,[143] which criminalises organisational ill-treatment and neglect and Scotland's Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016,[144] which introduced equivalent offences for healthcare and social care settings.

9.1 Ill-treatment or wilful neglect by a care worker

Clause 38 creates a new criminal offence for individual care workers who ill-treat or wilfully neglect an adult under their care. This applies to anyone providing care, whether as an employee, volunteer, or contractor and covers both acts and omissions that cause harm.

The offence is designed to address serious misconduct that may not meet the threshold for existing offences like assault but still results in significant harm, breaches of dignity or failures to meet basic needs. It targets deliberate

[142] Winterbourne View: Abuse footage shocked nation - BBC News; Muckamore Abbey Hospital Inquiry

[143] Criminal Justice and Courts Act 2015, ss. 20–25 (England and Wales).
[144] Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016, ss. 1–2.

mistreatment or reckless neglect, reinforcing accountability at the individual level.

Penalties include:

- On indictment: up to 5 years' imprisonment, a fine, or both.
- On summary conviction: up to 6 months' imprisonment, a fine up to the statutory maximum, or both.

9.2 Offence by a care provider

Clause 39 establishes a parallel offence to Clause 38, applying to care providers such as residential homes, nursing homes, domiciliary care agencies and other regulated bodies. A provider is guilty of the offence if an adult is ill-treated or neglected by someone acting on its behalf and the behaviour arose from the way the provider's activities were managed or organised.

This clause recognises that neglect often stems from systemic failings, such as inadequate staffing, poor training, lack of supervision, or unsafe policies, rather than solely from individual misconduct. It introduces corporate accountability, ensuring that organisations can be held criminally responsible where their operational decisions or culture contribute to harm.

The offence reflects modern principles of safeguarding and corporate responsibility, acknowledging that organisational structures and leadership decisions can create environments where abuse or neglect occurs. It complements Clause 24, which sets out how both organisations and senior officers may be prosecuted when harm results from consent, connivance or neglect at a managerial level.

9.3 Penalties

Clause 40 provides for a range of sanctions following conviction under Clause 39, which addresses organisational ill-treatment or wilful neglect of adults receiving care. These include:

- Fines: up to the statutory maximum on summary conviction or an unlimited fine on indictment.

- Remedial orders: requiring the provider to address identified systemic failings.
- Publicity orders: obliging the provider to disclose the conviction and the remedial steps taken.

This structure mirrors the approach taken in England and Wales under Sections 21–22 of the Criminal Justice and Courts Act 2015, which also allows for unlimited fines, remedial orders and publicity orders for care provider offences.[145]

However the PSNI and some professional bodies, have questioned whether the maximum financial penalties proposed under Clause 40 will act as an effective deterrent. While the Bill allows for unlimited fines on indictment, concerns were raised that in practice, fines imposed may not reflect the scale of harm or the size of the provider.

Stakeholders have suggested that:

- Tiered penalties based on provider size or turnover could enhance deterrence;
- Clear sentencing guidelines should accompany the legislation to ensure consistency and proportionality; and
- Publicity orders should be used strategically to reinforce accountability and public trust.[146]

9.4 Application to corporate bodies

Clause 41 clarifies how criminal liability applies to unincorporated associations, such as partnerships, charities or informal care organisations. It ensures that offences under Clause 39 (care provider offence of ill-treatment or wilful neglect) can be prosecuted even when care is delivered through complex

[145] Criminal Justice and Courts Act 2015 - Explanatory Notes

[146] Department of Health 2021 Adult Protection Bill Consultation Analysis Report

governance or contractual arrangements and not just through formal corporate entities.

The clause enables an organisation to be held criminally liable as a single legal entity, meaning that prosecution does not require identifying one individual as solely responsible. It also defines who qualifies as a 'senior officer', such as a director, manager or partner

This clause complements Clause 24, which sets out how both organisations and senior officers may be held liable when offences result from consent, connivance or neglect.

9.5 Stakeholder feedback on offences

Consultation responses showed broad support for the introduction of criminal offences, particularly from Hourglass, COPNI and BMA NI, who viewed them as essential to closing accountability gaps and reinforcing deterrence. However, several stakeholders - the NMC, GMC and the NIHRC - emphasised the need for clarity on thresholds and safeguards to avoid discouraging professional judgment or compassionate risk taking.[147]

The NIHRC stressed that any new offences must comply with the European Convention on Human Rights, in particular, Article 6 (right to a fair trial) and Article 8 (right to private/family life).[148]

The PSNI advised that repeated references to the word 'charge' within clauses 40 - 42 could create unintended operational constraints. Under current criminal procedure, a 'charge' typically requires arrest and custody before referral to the PPS, potentially excluding proportionate alternatives such as adult cautions or report by summons. The PSNI recommended replacing 'charge' with 'prosecute' or clarifying that non court disposals remain permissible, to allow for

[147] Adult Protection Bill PSNI Views September 2025 Northern Ireland Assembly Committee for Health Call for Evidence, NIHRC (2021) Submission to DoH Consultation on Adult Protection Bill, COPNI (2021) Response to DoH Consultation on Adult Protection Bill

[148] European Convention on Human Rights

flexibility while still retaining the possibility of formal prosecution in the most serious cases.[149]

9.6 Prosecutions and Article 6 considerations

Article 6 of the ECHR requires that individuals and organisations facing prosecution have access to a fair and public hearing within a reasonable time, by an independent and impartial tribunal. [150] In the context of the Bill, this means that providers accused of a 'gross breach' must be able to challenge the evidence against them effectively and understand the legal standards being applied. Without clear prosecutorial guidance, there is a risk that terms such as 'gross breach' or 'wilful neglect' could be applied inconsistently, undermining legal certainty and fairness. During the Department's consultation, there was significant agreement that the offences be tightly defined, with clear thresholds, to avoid inconsistency.

9.7 Publicity Orders and Article 8 considerations

Article 8 of the ECHR protects the right to private life, which includes an individual's or organisation's reputation. This is particularly relevant in the context of criminal proceedings, where prosecution, or even public allegation, can have significant reputational consequences.

The Bill's provision for publicity orders, which require convicted care providers to publicly disclose details of their offence and any remedial actions, highlights this issue. On one hand, there is a legitimate public interest in knowing when a care provider has been found guilty of abuse or neglect. On the other, compelled disclosure represents an intrusion into the affairs of the organisation and may have long-term reputational impacts.

The NIHRC has emphasised the need for prosecutorial safeguards to ensure that such measures are used proportionately with publicity orders reserved for

[149] Adult Protection Bill PSNI Views September 2025 Northern Ireland Assembly Committee for Health Call for Evidence

[150] Department of Health 2022 Adult Protection Bill Consultation Analysis 2022

cases where public disclosure is clearly necessary to support accountability. Furthermore, any information released should be limited to what is essential for that purpose.

To support fair and consistent application, the development of clear guidance from the Public Prosecution Service (PPS) is recommended. Such guidance would help ensure that Publicity Orders are used appropriately, protecting adults at risk while also upholding the due process rights of those accused.

9.8 Experience in England, Wales and Scotland

The experience of England, Wales and Scotland offers useful insight into how offences of ill-treatment and wilful neglect have operated in practice and how they might inform implementation in Northern Ireland.

In England and Wales, the Criminal Justice and Courts Act 2015 introduced offences broadly comparable to those proposed in the Adult Protection Bill. While prosecutions under the Act have been relatively rare, this is largely expected, as the offences were designed to act as a backstop for serious or gross breaches, rather than for routine enforcement.[151]

Despite the low number of prosecutions, commentators and legal analysts have noted that the offences carry significant symbolic value. Their introduction was closely linked to public concern following high profile failures in care, such as those at Mid Staffordshire NHS Foundation Trust, where widespread neglect and systemic failings prompted national outrage and reform.[152]

Scotland introduced willful neglect offences for health and care settings in 2016. As with England, conviction rates for these offences also remain low. Commentators suggest this is partly a consequence of the inherent difficulties in proving these types of offences. Various analyses noted that Scottish prosecutors have struggled to meet the burdens of proof associated with the offences. Furthermore, commentators highlight that the operational definitions

[151] Criminal prosecution for ill-treatment or wilful neglect | Hodge Jones & Allen
[152] Care Provider Offences | Insights | Corker Binning; https://academic.oup.com/slr/article-abstract/37/1/1/2362896

of ill-treatment and neglect were not fleshed-out in guidance, which made the offences difficult to identify and apply, even though they were legally available. These evidential challenges, combined with prosecutors' relative lack of experience in handling such cases, limited the number of successful prosecutions. This highlights the importance of equipping investigators and prosecutors with specialist training and guidance.[153] [154]

9.9 Committee Consideration: offences of ill-treatment or wilful neglect

Purpose and scope of the offences

Members may wish to consider whether the Bill and forthcoming prosecutorial guidance clearly define the scope and thresholds of the new offences so that serious, systemic failings can be prosecuted without discouraging good faith professional judgment. The offences are intended to capture deliberate or reckless mistreatment, not isolated human error, but the Committee may wish to seek clarity on how 'wilful neglect' and 'gross breach' will be interpreted in practice and communicated to staff and providers.

In particular, Members may wish to ask how the Department and the PPS will ensure that staff understand where the line lies between a mistake, poor practice and criminal conduct. Clear definitions and practical examples in statutory or prosecutorial guidance will be essential to give professionals confidence that they can exercise judgment and take proportionate risks in care without fear of unfair prosecution, while still holding individuals and organisations fully accountable for deliberate or reckless harm

[153] Neglecting justice? Exploring Scottish convictions for ill-treatment and wilful neglect | The Journal of Adult Protection | Emerald Publishing
[154] Mackay K, Notman M (2017), "Adult Support and Protection (Scotland) Act 2007: reflections on developing practice and present day challenges". The Journal of Adult Protection, Vol. 19 No. 4 pp. 187–19

Proportionality and safeguards

Members may wish to explore whether the offences and associated penalties are proportionate and legally robust under Articles 6 and 8 of the ECHR. They may wish to ask how prosecutors will ensure fair process and protect reputational rights, particularly where publicity orders are used. Guidance from the PPS will be important to ensure that decisions to prosecute or publish are consistent, necessary and proportionate.

Organisational and corporate accountability

Members may wish to examine whether Clauses 39 - 41 provide sufficient clarity on corporate and managerial liability, including how responsibility will be determined where harm arises from systemic or governance failures. The Committee may wish to ask how these provisions will interact with Clause 24 and whether regulators such as RQIA will play a formal role in identifying organisational offences or referring cases for investigation.

Penalties and Enforcement

Members may wish to consider whether the financial and ancillary penalties available under Clause 40 such as fines, remedial and publicity orders are strong enough to act as an effective deterrent, particularly for large providers.

Operational and Procedural Clarity

Members may wish to seek clarification on how investigations and prosecutions will be handled in practice. The PSNI has raised concerns that repeated references to ‘charge’ in the Bill could restrict operational flexibility and exclude alternatives such as cautions or report-by-summons. The Committee may

wish to ask whether the Department will amend the wording to 'prosecute' or provide guidance confirming that proportionate non-court disposals remain available.

10 The use of CCTV in care settings

This set of clauses establish a regulatory framework for the use of closed-circuit television (CCTV) systems in certain adult care establishments, namely, day-care settings, nursing homes, residential care homes and HSC managed mental health units. These provisions respond to public and stakeholder concern about abuse and neglect in care settings and the potential role of surveillance in safeguarding adults at risk. The framework introduces regulation, enforcement and safeguards to balance the aims of protection against privacy and dignity.

10.1 Legislative provisions

The specific legal provisions in the bill relating to CCTV are set out in table three.

Table 3: Provisions relating to CCTV cameras in the Adult Protection Bill

Clause 43: settings covered

Defines the establishments to which these provisions apply, namely: day-care settings, nursing homes, residential care homes and HSC managed mental-health units (excluding private mental-health facilities).

Clause 44: regulations

Empowers the Department to make regulations governing installation and use of CCTV for safeguarding purposes. Regulations may cover assessment prior to installation, consultation and consent procedures, prohibitions on cameras in private areas, publication of information and the processing and disclosure of recordings

Clause 45: offences

Makes infringement of these regulations an offence, punishable by a fine up to level 3 on the standard scale. Prosecutions may only be brought by the RQIA or with the consent of the Director of Public Prosecutions.

Clause 46: role of RQIA

Assigns RQIA the function of monitoring and enforcing compliance. It grants powers of entry and inspection, examination of CCTV systems, seizure of records and private interviews with staff, managers or consenting residents. Obstruction of these powers constitutes an offence, liable to a fine up to level 4.

Clause 47: data protection

Restricts disclosure of confidential or identifying information obtained under these powers, allowing it only with consent, anonymisation or where the RQIA considers there is a serious and urgent risk to safety.

10.2 Evidence Base for the use of CCTV

Evidence on the use of CCTV in adult care settings remains limited and inconclusive. A review commissioned by RQIA found insufficient evidence to demonstrate that surveillance consistently improves safety or care outcomes in residential environments. The review noted that most available studies are

small-scale, observational or descriptive rather than robust trials capable of establishing clear causal links between CCTV and improved safeguarding outcomes.[155]

Where benefits have been identified, CCTV has been shown to deter incidents of abuse or aggression, assist in investigating allegations and provide reassurance to families concerned about the quality of care. However, these benefits must be weighed against significant ethical and practical risks. Surveillance during personal or intimate care raises questions about privacy, dignity and respect for autonomy. The issue of consent is particularly challenging since many residents in care settings may lack capacity, meaning that decisions about surveillance are often taken by families or advocates on their behalf.

Evidence also suggests that continuous monitoring may negatively affect staff morale and workplace culture. Some studies indicate that being constantly observed can erode trust, increase stress and foster defensive rather than reflective practice. Nonetheless, a number of staff report that CCTV in communal areas can protect them from false allegations or provide objective evidence in the event of disputes. More broadly, overreliance on surveillance can shift attention away from human vigilance and the importance of relationship-based care, potentially undermining the quality of interpersonal support that is central to good safeguarding practice.[156] [157] [158] [159] [160]

The Care Quality Commission in England advises that CCTV should not be routine or a default approach, but rather a last resort to be implemented only when other, less intrusive safeguards have been exhausted. Proportionality and transparency are cited as key: clear consultation with residents, relatives

[156] CCTV for communal areas of care homes - House of Commons Library
[157] The Use of Surveillance Technology in Residential Facilities for People with Dementia or Intellectual Disabilities
[158] Experiences of using surveillance cameras as a monitoring solution at nursing homes: The eldercare personnel's perspectives
[159] The Ethics of Using Cameras in Care Homes
[160] Human rights and the use of cameras and other recording equipment in health & social care: A short guide

and staff, visible signage and detailed policies on data handling, access and retention are considered essential prerequisites for ethical use.[161]

10.3 Stakeholder perspectives on the use of CCTV

The NIHRC emphasised that intrusive surveillance may breach Article 8 of the ECHR, which protects privacy and dignity, particularly in contexts involving personal or intimate care. In some situations, continuous monitoring may amount to a deprivation of liberty under Article 5 ECHR, particularly where it results in constant supervision and control in private areas such as bedrooms. The Bill's framework therefore needs to provide clear guidance to providers on how to determine when surveillance crosses the threshold into deprivation of liberty and what authorisation processes should follow.[162]

Staff perspectives highlight similar tensions. Trade unions such as UNISON have expressed concern that surveillance may erode morale and trust, arguing that cameras should not substitute for adequate staffing levels or quality care. Workers should be fully consulted before CCTV is introduced and have clear information about how recordings may be used, including for disciplinary or investigative purposes. [163]

Families are more likely to view CCTV as an essential safeguard in a care environment, which faces staffing shortages, rising dementia complexity, financial pressures and growing public scrutiny. For families, CCTV provides reassurance and reflects openness, honesty and accountability. With CCTV already accepted in hospitals, schools and nurseries, families increasingly see its use in care homes as both appropriate and necessary, given the vulnerability of residents.[164]

The ICO stresses that CCTV footage constitutes personal and often special category, data under the UK General Data Protection Regulation (UK GDPR).

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[161] Using surveillance in your care service - Care Quality Commission

[162] NIHRC_Submission_on_legislative_options_to_inform_an_Adult_Protection_Bill_in NI.pdf

[163] Use of surveillance in health and care settings

[164] Submission from Care Campaign for the Vulnerable (CCFTV) To: Northern Ireland Assembly Committee For Health Call for Evidence on the Adult Protection Bill

Providers must therefore establish a lawful basis for processing such data, apply strict data minimisation principles and conduct Data Protection Impact Assessments (DPIAs) prior to installation. Best practice includes restricting CCTV to communal areas, avoiding audio recording unless absolutely necessary, consulting residents and families before implementation and setting clear policies on access, retention periods and data security.[165]

Taken together, stakeholder feedback suggests that CCTV should not be regarded as a primary safeguarding measure but as a supplementary tool, appropriate only when used proportionately, transparently and with clear regulation and oversight.

10.4 The Commissioner for Older People's position

COPNI has welcomed the inclusion of powers in the Bill that enable the use of CCTV in care settings where justified but not as a blanket requirement across all facilities. This proportionate approach, in COPNI's view, allows CCTV to be deployed as a targeted safeguarding measure in higher-risk environments while avoiding unnecessary intrusion into private life.

COPNI nonetheless identifies several areas that require stronger safeguards. Consent, they argue, can be problematic in institutional settings where residents may feel pressured to agree to surveillance or fear disadvantage if they refuse. Regulations should make explicit that refusal to consent must not result in denial of care or disadvantage, except where the Department authorises an exception in the public interest.

In communal areas, the complexity of balancing conflicting consent, where some residents agree to CCTV and others do not, poses additional ethical and legal challenges. COPNI urges that regulations set out clear procedures for managing these situations in a way that protects both privacy and safety.

Regarding enforcement, COPNI supports the role of the RQIA but expresses concern that Clause 46(2) effectively limits RQIA's usual powers under existing

[165] ICO Response to DOH proposed Adult Protection Bill

care standards legislation, creating a separate enforcement regime for CCTV. COPNI recommends integrating CCTV compliance within the broader care standards framework to ensure consistency and effectiveness.

COPNI further advises that the RQIA should be legally required to publish regular data on CCTV inspections, breaches and enforcement actions to promote transparency and public confidence. Providers should also be mandated to complete and submit CCTV impact assessments to RQIA prior to installation and to review them periodically, ensuring continued necessity and proportionality.

For residents who lack capacity or who may feel coerced, COPNI recommends that the Bill explicitly require the appointment of an independent advocate under Clause 26 to support them in decisions about surveillance. Finally, COPNI questions whether the proposed financial penalties for breaching CCTV regulations, currently set at Levels 3 and 4, are sufficient to deter non-compliance by large providers, suggesting that higher fines and clearer escalation to existing enforcement powers under care standards law may be needed.

10.5 Committee Considerations: The use of CCTV in care settings

Regulatory oversight and enforcement

Members may wish to consider whether the RQIA will have the necessary resources and expertise to inspect and enforce compliance with the new CCTV regime. The Bill assigns RQIA responsibility for oversight but it is unclear whether these functions will operate under existing care standards legislation or through a separate enforcement framework. The Committee may wish to clarify whether aligning the two systems could reduce duplication and strengthen accountability.

Consent, capacity and coercion

The issue of consent will be central to lawful CCTV use. Members may wish to seek assurances that the forthcoming regulations will set out clear procedures for obtaining informed, voluntary consent, particularly where residents lack capacity or may feel pressured to agree. The Committee may also wish to ask how conflicting consents will be managed in shared or communal spaces. Clear guidance on these points has been cited as essential to ensure compliance with human rights and data protection standards.

Shared spaces and privacy

Members may wish to explore how regulations will manage situations where some residents consent to CCTV while others do not, especially in communal areas. This will require a careful balance between safeguarding and privacy. The Committee may also seek clarity on whether cameras will be prohibited in bedrooms or bathrooms and what safeguards will be in place to prevent inadvertent recording of personal or intimate care.

Data protection and compliance

Members may wish to examine how the Department intends to ensure compliance with UK GDPR, including whether DPIAs will be mandatory before installation, as recommended by the ICO. Questions may also include how data minimisation, storage, access and retention will be regulated and whether providers will be required to publish CCTV policies or share them with residents and families.

Advocacy and support

Members may wish to consider whether independent advocacy under Clause 26 will be available to residents who lack capacity or may feel unable to express a view about surveillance. This

would help ensure that decisions about CCTV are made transparently, with the individual's rights fully represented.

Penalties and enforcement mechanisms

Members may wish to assess whether the proposed penalties (Levels 3 and 4 fines) are proportionate and sufficient to deter non-compliance, particularly for large care providers. The Committee could ask whether stronger or tiered sanctions are being considered and whether enforcement can escalate through existing care standards legislation.

Transparency and public reporting

Members may wish to explore how the Department and RQIA will ensure transparency and public confidence in the new system. This could include a statutory requirement for RQIA to publish annual data on CCTV inspections, breaches and enforcement actions. Public reporting would promote openness and reassure families that surveillance is being used responsibly and effectively.

Evaluation and learning

Members may wish to ask how the Department will evaluate the impact of CCTV on safety, dignity, staff morale and care culture. The evidence base remains inconclusive and ongoing monitoring will be essential to ensure that CCTV enhances, rather than undermines, trust and quality of care.

11 Rural considerations for adult safeguarding

While the Department has screened the Adult Protection Bill as having no distinct rural impact, evidence from across the UK indicates that adult safeguarding and social care can present particular challenges in rural areas. Research by the IMPACT Network notes that rural communities in all parts of the UK tend to have older populations, greater social isolation and more limited service infrastructure, which can delay identification of harm and make coordinated intervention more difficult.[166]

Evidence from Northern Ireland indicates that delivering social care in rural areas presents distinct operational challenges that could affect adult-protection practice. A 2024 Carers UK report found that rural residents face longer waiting times, fewer care options and unreliable service availability, particularly for care packages requiring multiple staff.[167] The Rural Health and Care Toolkit for Northern Ireland similarly highlights geographical isolation, poor transport links and low population density as key barriers to equitable access and continuity of care.[168] The Northern HSCT, whose population is over 40 % rural, has acknowledged these pressures and reports annually on its compliance with the Rural Needs Act (NI) 2016, confirming that service design must take rural accessibility into account.[169] These challenges are compounded by wider workforce shortages and the additional costs of providing care across dispersed populations.

Collectively, the evidence suggests that while the Adult Protection Bill is designed to apply uniformly, implementation in rural areas will require targeted planning for workforce, transport and service access to ensure consistent protection outcomes across all communities.

[166] IMPACT-Network-Rural-Areas-Discussion-material-FINAL-revised.pdf
[167] Carers UK (2024) Social Care in Rural Areas: A Carer's Perspective (Northern Ireland).
[168] Rural Community Network (2022) Northern Ireland Rural Health and Care Toolkit, in partnership with the Department of Agriculture, Environment and Rural Affairs.
[169] NORTHERNTRUST HSCNI RURAL NEEDS

12 Equality and human rights considerations

The Department of Health's Equality Screening and Human Rights Assessment (March 2024) concluded that the Adult Protection Bill would apply equally across all sections of the community and therefore did not require a full Equality Impact Assessment under Section 75 of the Northern Ireland Act 1998.[170] The screening did acknowledge, however, that the Bill's provisions would be most strongly felt by those falling under the definition of an adult at risk - a group proportionally more likely to include adults with disabilities and older people.

However, the Department did not identify any adverse or differential impacts for disability or age categories, nor did it outline specific mitigation measures. The assessment noted a potential risk of indirect discrimination under Article 14 of the European Convention on Human Rights (ECHR), given the likelihood that disabled and older adults may be disproportionately affected by the legislation's operation. Monitoring of equality impacts is to be undertaken by the future Adult Protection Board, although the screening did not specify what equality-disaggregated data will be collected. The section on Disability Duties was recorded as 'not applicable'.

Stakeholder feedback, including from ARC NI, emphasised the importance of supported decision making, accessible communication and safeguards against overprotective or discriminatory practices, particularly for individuals with learning disabilities, autism, or other support needs. Submissions highlighted the need for statutory guidance and training to ensure participation, respect for autonomy and non-discriminatory thresholds for intervention.

The Department's screening also included a brief analysis of the Bill's other interaction with Convention rights, identifying potential impacts on Articles 2 (right to life), 3 (freedom from torture or degrading treatment), 5 (liberty and security), 8 (private and family life) and Protocol 1, Article 1 (peaceful enjoyment of possessions). However, the assessment did not address all concerns raised by stakeholders, including the NIHRC. For example, while Article 8 was considered,

[170] Department of Health (2025) Equality Screening, Disability Duties and Human Rights Assessment.

the assessment did not reference the Bill's provisions on CCTV use in care settings.

It is not clear whether a further human rights assessment has been undertaken since March 2024, or whether a more detailed Human Rights Impact Assessment has been published.

In light of these considerations, Members may wish to explore:

Whether the Department has undertaken any further human rights assessment since March 2024.

Whether concerns raised by NIHRC and other stakeholders have been addressed.

Whether the eligibility and other provisions within the Bill are fully compliant with the ECHR.

1 Data protection implications for the bill

The Department's screening confirms that a full Data Protection Impact Assessment (DPIA) was required and completed.

The DPIA outlines the anticipated data protection implications arising from the legislation. While the Department will not directly process personal data under the Bill, the legislation introduces new statutory powers for a range of organisations including HSC Trusts, the PSNI and RQIA which will act as data controllers for the personal data they process in relation to adult safeguarding.

The DPIA acknowledges that although some data processing practices may remain unchanged, the introduction of new powers, such as the ability to apply for Protection Orders and share data with magistrates, may result in expanded or altered processing activities. These changes require careful consideration of privacy impacts, particularly in relation to the necessity and proportionality of data collection and sharing.

Concerns were raised regarding the use of consent as a lawful basis for processing, with the DPIA noting that the Bill's language may not meet the threshold for explicit consent under UK GDPR. Instead, the DPIA identifies legal obligation and public interest under Article 6 and substantial public interest and health/social care under Article 9, as the more appropriate lawful bases for processing.

The DPIA also highlights the importance of ensuring that privacy notices are accessible and understandable, especially for vulnerable adults and that organisations follow ICO guidance on matters such as data sharing and CCTV use. Statutory Guidance is to be developed to support consistent implementation of data protection responsibilities across organisations, including training provisions and mechanisms for ongoing review of DPIAs.

Finally, the DPIA recommends further consultation with affected organisations to fully assess and mitigate risks, including those related to inconsistent data protection standards, potential misuse of powers and individuals' understanding of how their data is used.[171]

[171] Department of Health (2025) DATA PROTECTION IMPACT ASSESSMENT (DPIA) Adult Protection Legislation.