



Comisiynydd Pobl Hŷn Cymru
Older People's Commissioner for Wales

Protection of Older People in Wales

A guide to the law

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The Older People's Commissioner for Wales

The Older People's Commissioner for Wales protects and promotes the rights of older people throughout Wales, scrutinising and influencing a wide range of policy and practice to improve their lives. She provides help and support directly to older people through her casework team and works to empower older people and ensure that their voices are heard and acted upon. The Commissioner's role is underpinned by a set of unique legal powers to support her in reviewing the work of public bodies and holding them to account when necessary.

The Commissioner is taking action to end ageism and age discrimination, stop the abuse of older people and enable everyone to age well.

The Commissioner wants Wales to be the best place in the world to grow older.

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Foreword

A wide range of legislation underpins our health, social care and adult protection systems, designed to safeguard and protect older people and to place duties on organisations and individuals delivering services.

This guide aims to help practitioners be more aware of the law available to support them in their day-to-day work and whilst it is not a substitute for obtaining legal advice, nor a definitive statement of the law, it offers a detailed overview, providing context and helpful examples of the ways in which they can use the law.

This is the third edition of the guide, which has been updated to reflect recent Welsh legislation, such as the Social Services and Well-being (Wales) Act 2014 and the Regulation and Inspection of Social Care (Wales) Act 2016, and ensures that practitioners have the most up-to-date information at their fingertips.

I would like to thank John Williams, Emeritus Professor of Law at Aberystwyth University, for all of his hard work in drafting this updated version. John's commitment to championing human rights and safeguarding older people is inspiring, and his ability to communicate complex concepts in a straightforward way makes this a valuable resource for practitioners.

Legislation provides an important foundation on which many of our public services are built, but the way that the law is interpreted, applied and utilised is equally as important. Through this guide, I want to ensure that the law is understood as widely as possible and used effectively, crucial to help to ensure that older people can access the services and support they may need, that their rights are upheld and respected, and that they are safeguarded and protected.



Heléna Herklots CBE
Older People's Commissioner for Wales

Chapter 1: Human Rights and Adult Safeguarding

Introduction

Human rights belong to everybody; older age is not a ground for denying or restricting a person's human rights and many international agreements guarantee human rights to **all** people, without discrimination. The Universal Declaration on Human Rights, approved by the United Nations General Assembly, is one of the best-known agreements. The United Kingdom voted for the United Nations Resolution approving the Declaration. As a General Assembly Resolution, the Declaration does not have direct legal effect in the United Kingdom. However, it is recognised that the Declaration is now part of customary international law and is a benchmark for human rights compliance.

The United Nations Principles for Older Persons (see Appendix 2) identify Independence, Participation, Care, Self-fulfilment and Dignity as key principles. Whilst the Principles are not directly enforceable, they can be used to underpin and guide work with older people. The Older People's Commissioner for Wales must have regard to the Principles in performing her role and the Social Services and Well-being (Wales) Act 2014 (SSW(W)A 2014) also requires local authorities and others working under the Act to have 'due regard' to the Principles. Under the Regulation and Inspection of Social Care (Wales) Act 2016, the Government must include details in its annual report of how the due regard duty affected the exercise of the regulatory process.

In 2006, the United Nations adopted the Convention on the Rights of Persons with Disabilities, which aims to make sure that people with disabilities are not objects of charity, medical treatment, and social protection, but are treated as subjects having rights. Although it does not define 'disability', the Preamble emphasises that it

"...results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders full and effective participation in society on an equal basis with others."

Among the general principles in the Disabilities Convention are non-discrimination, respect for dignity, and respect for difference. Being an older person is not a disability and many older people live free of disability. However, some older people have disabilities and fall within the Convention. The United Kingdom has signed and ratified the Convention, but it has not been made part of our law so cannot be directly enforced in the courts. However, this has not prevented the courts from referring to it as an aide to interpreting legislation such as the Mental Capacity Act 2005 (MCA 2005) and the Mental Health Act 1983 (MHA 1983). The European Court of Human Rights often refers to the Disabilities Convention when interpreting the European Convention on Human Rights (ECHR).

Within Europe, the key human rights treaty is the ECHR. The United Kingdom is a party to the ECHR and played a significant part in its drafting. The Human Rights Act 1998 (HRA 1998) belatedly made it part of United Kingdom law and enforceable in national courts and tribunals. Public authorities (for example local authorities, Health Boards, the Crown Prosecution Service, the police, the Welsh Government and National Assembly for Wales) must comply with the ECHR. As seen below, changes in the law have also clarified the status of the many private

providers of adult social care in Wales.

Human rights impose duties on the state to ensure that it treats us appropriately, openly, and fairly. They also require the state to make sure people are protected from others unjustly interfering with their rights. It is important not to over-simplify how human rights work in practice: a careful balancing act is required as rights often appear to conflict with each other. For example, in the abuse of older people, it is often necessary to balance the duty to protect the older person with the duty to respect their right to decide for themselves. It is therefore important to consider whether intervention is necessary and, if so, how it should be done.

In some circumstances, the state has a genuine interest in ‘interfering’ with a person’s human rights. For example, if they have committed a criminal offence, imprisonment after a trial is a fair response, even though it takes away the person’s freedom. There may also be occasions when it is necessary to interfere with a person’s right to decide for themselves in order to protect the rights of others - if an abuser is a professional carer working with other older people, for example.

Human rights apply to adult safeguarding and protection in two ways:

- Violating a person’s human rights is abusive – for example, unlawful deprivation of liberty, unnecessary sedation, or ageist ‘do not resuscitate’ policies violate a person’s human rights and are abuse.
- Human rights require the state to act to prevent abuse, wherever it happens, and to respond to it. Article 13 ECHR requires that there should be an effective remedy where human rights are violated. Failure by the state to do so will be abusive.

Human Rights:

- Belong to everybody – whatever their age.
- Are based on fairness, equality, dignity and respect.
- Mean that the state must not unlawfully interfere or allow interference with rights, for example by treating people in an inhuman or degrading way.
- Require the state to act to protect rights, for example, to protect life.

What does the law say?

It is necessary to understand and use the range of human rights instruments signed up to by the United Kingdom. This is the case with the United Nations Principles given the ‘due regard’ duty in the SSW(W)A 2014, although the term ‘due regard’ is unclear. In a case involving the public-sector equality duty under the Equality Act 2010 where there is a similar ‘due regard’ duty, the court said:

“(T) he duty must be exercised in substance, with rigour and with an open mind. The duty has to be integrated within the discharge of the public functions of the authority. It is not a question of ‘ticking boxes’.”

Directly enforceable duties are found in the HRA 1998, through its incorporation of the ECHR rights into United Kingdom law. Following the HRA 1998, ECHR rights can be argued in any

court or tribunal in the United Kingdom and the Act requires that ‘a public authority’ must not act incompatibly with ECHR rights.

As noted above, government, police, local authorities and Health Boards are public authorities. There are, however, questions around whether private providers of home-based and residential care services are public authorities. The independent sector is the main provider of domiciliary and residential care for older people in Wales, there is little direct provision by local authorities or Health Boards. The Care Act 2014 (the English equivalent to the SSW(W)A 2014) provides that where a local authority funds the care or has made arrangements under the SSW(W)A 2014 for care, then the private provider of the service will be a public authority and bound by the HRA 1998 and the ECHR. This does not apply when the person receiving the service pays for it and has not involved the local authority in arranging the care.

The courts stress that the ECHR imposes a positive duty on public authorities to prevent rights being violated, rather than responding after a violation. In **A v UK**, the European Court of Human Rights said vulnerable individuals are entitled to state protection in the form of effective deterrence against breaches of their personal integrity. There is a positive duty to protect and the European Court has said the state must protect rights even though the abuse happens in a private space, such as the person’s home or a privately run care home.

The European Convention on Human Rights includes rights relevant to the abuse of older people:

Article 2: Everyone’s right to life shall be protected by law. This is sometimes mistakenly called the right to life; it is a right to have life protected. When an older person’s life is threatened by abuse or neglect, the state has a duty to protect them. This may include using the criminal law and/or intervention under safeguarding laws and procedures. The assumption is that such laws and procedures exist. This article may include ageist based ‘do not resuscitate’ notices, failing to intervene in cases of abuse and neglect, moving an older person to another setting without a proper assessment, and misuse of medication.

Article 3: No one shall be subjected to torture or to inhuman or degrading treatment or degrading punishment. The important words here are ‘inhuman or degrading treatment’. Treatment is inhuman or degrading if it is assessed as being of a minimum level of severity after considering all the circumstances, including the length of the treatment; its physical and mental effects; the sex, age and state of health of the person ; and the purpose of the treatment, including the reason behind it and the context. It includes suffering flowing from illness (physical or mental) where it is, or risks being, worsened by poor treatment for which a public authority is responsible (for example, poor care in a care home of a person living with dementia).

Article 5: Everyone has the right to liberty and security of person. We cannot lock up older people in their bedroom, a hospital ward, or a care home. This would be abuse and unlawful, even when the person doing it thinks it is in the older person’s ‘best interests’. The Article recognises that there may be circumstances where it is necessary to take away or restrict somebody’s liberty - where they are at risk of harm, for example. However, there must be a law that permits this and sets out criteria for the use of the power. The law must also provide safeguards against abuse or misuse. The Deprivation of Liberty Safeguards under the MCA 2005 is an example of such a law.

Article 6: Everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. This right extends not only to criminal proceedings (for both defendants and witnesses) but also to any hearing where the outcome will significantly affect a person’s life, such as a Mental Health Review Tribunal.

Article 8: Everyone has the right to respect for private and family life, home and correspondence. This is a wide-ranging right. Private life includes the right to decide, being treated with dignity and respect, the right to make what others may think are ‘unwise or eccentric decisions’, and the right to refuse medical treatment. Family life includes being able to maintain contact with family without too many obstacles placed in the way. A person’s home is also important and must be respected. Home is not restricted to a house or flat that an older person may own or rent - it also includes a care home. Correspondence, which includes phone calls, emails and letters, must be respected.

Article 9: Everyone has the right to freedom of thought, conscience and religion. This includes the ability to worship in accordance with the person’s chosen religion and meeting any dietary needs.

Article 10: Everyone has the right to freedom of expression. Everybody has the right to an opinion and belief. There are restrictions on expressing opinions, such as making defamatory comments or hate speech.

Article 11: Everyone has the right to freedom of peaceful assembly and to freedom of association with others, including the right to form and to join trade unions for the protection of their interests. This includes the right to belong to support or action groups without fear of reprisal.

Article 12: Men and women of marriageable age have the right to marry and found a family

Article 14: The enjoyment of the rights and freedoms [in the European Convention on Human Rights] shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status. Although age is not mentioned, it does fall within ‘or other status’.

The above rights fall into one of three categories—absolute, limited and qualified:

Absolute rights:	The state cannot restrict the exercise of these rights in any circumstances.	Article 2 - protection of life. Article 3 - prohibition of inhuman and degrading treatment.
Limited rights:	These rights include circumstances in which they may be lawfully interfered with.	Article 5 - the right to liberty and security.

Qualified rights:	These rights are subject to qualification.	<p>Article 8 - family life, private life, home and correspondence.</p> <p>Article 9 - freedom of thought, conscience and religion.</p> <p>Article 10 - freedom of expression.</p> <p>Article 11 - freedom of assembly and association.</p>
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It is important to understand these different types and how they work in practice. As the name suggests, absolute rights cannot be qualified; inhuman or degrading treatment can never be justified.

A limited right can only be interfered with if the action falls within one of the categories listed in the article. For example, the Article 5 right to liberty may only be interfered with if the following two conditions are satisfied:

1. If it is under a procedure prescribed by law. For example, the Deprivation of Liberty Safeguards in the MCA 2005 (or from Spring 2020, the Mental Capacity (Amendment Act) 2019), or the powers to detain in the MHA 1983. People cannot be deprived of their liberty simply because it is thought to be the best thing for them.
2. The reason for the interference is for one of the reasons listed in the Article. These include people of, in the words of the Article, 'unsound mind'. The wording reflects the time when the ECHR was drafted. However, its contemporary meaning includes mental disorder and impaired mental capacity.

Qualified rights involve assessing whether any interference with the right is allowed under the ECHR. As noted above, Article 8 gives a right to respect for private and family life, home and correspondence. However, under Article 8(2) the state can interfere with this right if it satisfies the following:

- It is 'necessary in a democratic society': this requires the public authority to balance the individual's rights with the broader interests of society. In cases of the abuse of older people, for example, the person may refuse any involvement by social services or the police. That is their right to a private life, namely their right to autonomy. However, the broader public interest may require intervention, particularly if others are at risk of abuse. Practitioners need to show that they have undertaken this balancing act. A balance sheet approach may help.
- There must be a law that permits the restriction: If there is not, it will be a breach of the right.
- The aim of the interference must be legitimate: The Article lists the categories of legitimate aims and these include public safety of the country, preventing disorder or crime, protecting health or morals, or protecting the rights and freedoms of others.

- The interference must go no further than is necessary in the individual circumstances—it must be proportionate: Proportionality requires the decision-maker to achieve a fair balance between the demands of the general interests of the community and protecting the individual’s human rights. What is proposed (for example, the use of the Deprivation of Liberty Safeguards) must be suitable to achieve the aim and must be the least restrictive course of action possible.

Dignity is not referred to in the ECHR, but the European Court recognises that protecting dignity and human freedom is “the very essence” of the ECHR (See McDonald V UK 2014 and SW v UK 1995); Articles 2, 3 and 8 are embedded in dignity.

An important feature of human rights is that people must be able to present their own views and opinions. Not listening to an older person violates their human rights. Independent advocacy is therefore important as the voice of the older person must be heard whether they are in their own home, care homes, hospital or elsewhere. This helps to ensure they are central to any investigation and in deciding how best to respond to allegations of abuse or neglect. The older person’s voice must be heard throughout any investigation and not only at particular stages.

The social care practitioner’s ability to advocate for an older person is limited as there may be conflicts with their agency’s approach. The advocate’s independence is important. An advocate is not a threat to practitioners, but rather provides an opportunity to learn more about the older person, and what it is they want. Advocacy is discussed in Chapter 2.

When should it be used?

Human rights underpin decisions taken by public authorities. Decisions by practitioners in responding to the abuse of older people and neglect must be human rights compliant and they must be able to show that this is the case. Embedding human rights into policy, procedures and practice is essential. The Care Inspectorate Wales guidance [Human Rights: CIW’s commitment to promoting and upholding the rights of people who use care and support services](#) is a good example of how human rights can be mapped onto the inspection theme and potential lines of enquiry template, by focusing attention on the human rights engaged in the inspection process.

How should it be used?

When using human rights law, remember that there will be competing rights and interests. The balancing act requires the following to be addressed:

- What right(s) is/are engaged? There may be more than one right engaged in cases of the abuse of older people and neglect - the Article 3 right and the Article 8 right, for example.
- If more than one right is engaged and there is a conflict between them, which one prevails? For example, the Article 3 right to be protected from inhuman or degrading treatment may conflict with a decision by the person to refuse intervention (the Article 8 right). Practitioners must weigh the competing evidence and make a professional judgement as to which one is to prevail. Each case is different and decided on its own facts.
- Are the human rights of another person affected? If so, what weight should be given to them? For example, the rights of another resident in a care home.

- Is the right engaged an absolute, limited or conditional right? If it is limited, does it fall within one of the listed reasons for intervention and is there a law that permits what is proposed? If it is qualified, does it meet the conditions justifying interference?
- Is the proposed intervention proportionate?

What are its limitations?

One of the most frustrating aspects of human rights law is that it is often reactive– the right has already been violated and the practitioner is seeking to make amends. Human rights awareness must be present at all stages (including policy development) of health and social care practice, and in investigating cases of abuse and neglect.

Points to remember

- Human rights belong to everyone.
- Older age is not a reason for denying somebody respect for human rights.
- Human rights do not require the avoidance of all risks.

Chapter 2: Advocacy

Introduction

The word advocacy has many meanings. In a very formal sense, a lawyer acting for a client will advocate by presenting the client's case to a court, tribunal or an opposing party. In a less formal sense, an advocate is somebody who speaks up for another or for a cause. Types of advocacy include self-advocacy, peer advocacy, citizen advocacy, professional advocacy and advocacy resulting from provisions in legislation such as the Mental Health Act 1983 (MHA 1983), which is known as statutory advocacy.

Within adult safeguarding, advocacy ensures the voice of the older person is heard within social care, health and criminal justice settings. As seen in the chapter on Human Rights, the right to private life embraces the right to decide; the right to decide presupposes that the person has contributed to the decision making. Some people may advocate for themselves and not feel the need for an advocate. The only issue is that they have enough information to make an informed decision and practitioners must ensure this is the case. Carers and family members may also make effective advocates, although it is necessary to be aware of any conflict of interests.

Others are less able to advocate on their own behalf and have nobody to advocate for them. They may have a disability that makes it difficult to present their own wishes and feelings, or they may be intimidated by the process, particularly if it involves the criminal justice system. The risk is that they will be disadvantaged and there is the risk that things are done to them rather than with them. It is in these circumstances that the support of an advocate is essential if the human rights of the person are to be protected.

What does the law say?

Independent Professional Advocacy (IPA) - Social Services and Well-being (Wales) Act 2014 (SSW(W)A 2014)

The SSW(W)A 2014 seeks to place the person and their well-being outcomes at the centre of the legal framework. Essential to achieving this is giving people a voice and ensuring it is listened to. In some cases, the person may need assistance to ensure their voice is heard. This assistance may vary in intensity depending upon the person's ability to advocate for themselves.

The SSW(W)A 2014 defines 'advocacy services' as 'services which provide assistance (by way of representation or otherwise) to persons for purposes relating to their care and support' (s.181(2)). This does not just apply to safeguarding but applies to care and support planning, assessment, review and other local authority functions under the SSW(W)A 2015.

Section 181 SSW(W)A 2014 enables the Welsh Government to make regulations requiring local authorities to arrange for advocacy services to be available to people with needs for care and support, although no such regulations have been made. Instead, the Welsh Government opted to include arrangements for advocacy in the **Social Services and Well-being (Wales) Act: Part 10 Code of Practice (Advocacy)**. The Government's justification for this is that advocacy is pervasive throughout the Act – it is the 'golden thread'. Opinions differ on this approach.

The Code identifies two main themes for advocacy. The first is to speak up for individuals who are not being heard and help them express their views and make informed decisions and contributions. The second theme is to safeguard individuals at risk.

Safeguarding is one of the functions under the SSW(W)A 2014 where local authorities 'must consider individuals needs for advocacy and support.' The Code says that the need for advocacy may be heightened when there is an adult at risk and there is a s.126 enquiry, action under s.127 (Adult Protection and Support Orders), or s.128 (the duty to report adults at risk). The safeguarding duties are discussed in Chapter 6.

The Code says that:

“Local authorities must arrange for an independent professional advocate, ... when a person can only overcome the barrier(s) to participate fully in the assessment, care and support planning, review and safeguarding processes with assistance from an appropriate individual, but there is no appropriate individual available.” (para 47)

An appropriate individual may be a family member, friend, or somebody from a wider social network. Under the Code, if appropriate individuals can ensure the person's involvement, then they can advocate. However, such a person cannot act if:

1. The adult at risk does not want that person to support them.
2. The person may be unlikely to be able or available to support the person.
3. That person is implicated in the safeguarding process (a suspected perpetrator, for example). (Code para 61).

In most cases it will be difficult for practitioners such as social workers to advocate on behalf of their clients given the actual or perceived conflict of interests. Other advocates may be involved, such as an Independent Mental Capacity Advocate. Paragraph 86 of the Code notes the importance of continuity and the need to avoid duplication. Where possible, a single advocate should be agreed.

Independent Mental Health Advocate (IMHA)

Under s.130E MHA 1983, the Welsh Government must make arrangements to enable IMHAs to be available to help patients when required by the Act. This was implemented by the Mental Health (Wales) Measure 2010. The right to an IMHA applies to 'qualifying patients', who fall into two categories:

1. Qualifying compulsory patients: This covers people detained or liable to be detained (including those on leave of absence), conditionally discharged, subject to guardianship, or subject to a community treatment order. In all of these, the hospital or registered establishment must be located within Wales.
2. Qualifying informal patients: This covers inpatients in a hospital or registered establishment where they are receiving treatment or being assessed in relation to a mental disorder. They must not be subject to any powers under the Act making them liable to be detained.

For the sake of clarity, qualifying compulsory patients include patients detained under the s.4 emergency provisions or the holding powers in s.5. It also includes anybody being considered for treatment to which s.57 applies (treatment requiring consent and a second opinion) whether they are detained or not. It excludes people detained in a place of safety under s.135 or s.136 of the MHA 1983.

The Mental Health Act 1983: Code of Practice for Wales (2016) outlines the role of the IMHA, which includes supporting the patient in getting information and understanding their rights under the MHA 1983. The IMHA must also ensure that the patient’s voice is heard by supporting them at multi-disciplinary team meetings. Included in the role is supporting patients in counteracting any actual or potential discrimination. The IMHA must also signpost other services to the patient and the patient to other services, which may include safeguarding teams.

Although not directly involved with safeguarding, the IMHA has a role to play in ensuring they report any concerns if the patient is potentially an adult at risk.

Independent Mental Capacity Advocates (IMCA)

Section 35 of the Mental Capacity Act 2005 (MCA 2005) introduced the IMCA service, allowing for the appointment of an IMCA in some decisions involving people lacking capacity. An IMCA must be appointed where a decision is needed about a long-term change in accommodation, such as entering a care home, where serious medical treatment is proposed, or where a deprivation of liberty authorisation is sought. In these cases, there must be nobody else who is appropriate who can or should advocate on the person’s behalf (the person is said to be ‘unfriended’).

There is a power (not a duty) to appoint an IMCA in adult protection cases; the unfriended requirement does not apply. However, if a deprivation of liberty is contemplated as part of the adult safeguarding process, an IMCA must be appointed only if the person is unfriended. The use of IMCAs may be summarised as follows:

A long-term care move	An IMCA must be appointed if there is nobody able to support the person.
Serious medical treatment	An IMCA must be appointed if there is nobody able to support the person.
A care review	The appointment of an IMCA is discretionary where there are no family and friends who are appropriate to support them and the person has been staying, or is likely to stay, in the accommodation for a continuous period of more than 12 weeks.
Adult safeguarding procedures	The appointment of an IMCA in safeguarding is discretionary. An IMCA may support the person who is being abused or neglected, or the person suspected of abuse. In both cases, the person being supported must lack capacity. The requirement that there is nobody else to support the person does not normally apply. However, if a DoLS is being considered as part of the safeguarding intervention, it is necessary to show that there is nobody else to support the person.

(Note the revised procedure for deprivations of liberty under the Liberty Protection Safeguards which are due to be implemented in Spring 2020 – see Chapter 4).

The IMCA's role in adult protection is critical and an important safeguard. The IMCA does not decide, but instead ensures that decision-makers give appropriate consideration to the person's wishes, feelings and beliefs.

The Mental Capacity Act 2005: Code of Practice states that:

'Any information or reports provided by an IMCA must be taken into account as part of the process of working out whether a proposed decision is in the person's best interests.'(p.179)

An IMCA has access to all relevant healthcare and social care records. Under the Code, their role is to:

- be independent of the person making the decision;
- provide support for the person who lacks capacity;
- represent the person without capacity in discussions to work out whether the proposed decision is in the person's best interests;
- provide information to help identify what is in the person's best interests; and
- raise questions or challenge decisions that appear not to be in the best interests of the person. (para 10.4)

The IMCA's independence ensures that the person contributes, as far as they can, to the decision-making process. The involvement of IMCAs in safeguarding as in other areas of decision-making is essential to ensure that processes and procedures do not override people's rights.

Independent Domestic Violence Advisor (IDVA)

Although not strictly an advocate – the role is one of an advisor – IDVAs contribute to supporting high risk older victims of domestic abuse and this can involve advocacy. The IDVA role is to support victims of domestic abuse and to help them to become safe. This includes working with statutory services victims will meet such as safeguarding, health, criminal justice, and housing. IDVAs also ensure that the voice of the victim is at the centre of multi-disciplinary proceedings.

Other advocacy services

In addition to the above, there are other advocacy services provided by third sector organisations. These may be linked to specific groups of service users, or they may provide a generic service.

How should it be used?

The need for an advocate in safeguarding should always be considered. It may be necessary to revisit an earlier decision not to appoint an advocate as circumstances may have changed. Caution needs to be exercised in allowing family members and others to advocate. Whilst they may be effective, and the person may feel comfortable having them as an advocate, there may be cases where family members and others have conflicts of interest.

What are its limitations?

The biggest limitation is the ability to access an advocacy service. Age Cymru report that there has been a 32% drop in the number of advocacy services specifically for older people in Wales between 2016 and 2018. Furthermore, the fact that the advocacy provisions under the SSW(W) A 2014 are found in the Code rather than in regulations is disappointing. Local authorities must follow the provisions of the Code and they are unable to use the s.147 procedure for departing from its requirements. However, it is regrettable that, unlike England, where regulations have been made, independent advocacy is not on a full statutory basis.

Points to remember:

- Advocates ensure that the voice of the older person is heard and that their wishes and feelings are made known to decision- makers.
- Advocates should inform people of their rights.
- Advocates should be challenging when appropriate.
- Advocates must be independent.

Chapter 3: Consent, Refusal and Mental Capacity

Introduction

Capacity is something we take for granted. When we go shopping, make a will, enter into a mortgage agreement or lease, or refuse medical treatment, we take it for granted that our capacity to do so will not be challenged. Deciding for ourselves is part of our human right to a private life and that includes making decisions others may regard as misguided, wrong, or perverse. It consists of the right to say 'yes' and, importantly, the right to say 'no'.

For some people, however, capacity to decide is less clear. A person's capacity to choose may be impaired because of a stroke or brain injury, a mental health problem, dementia, a learning disability, confusion, drowsiness, unconsciousness because of an illness or treatment, or substance or alcohol misuse.

Capacity may be lost temporarily, when somebody is unconscious or suffering the side effects of medication. A urinary tract infection or delirium may also lead to temporary loss of capacity. Alternatively, it may be a long-term or permanent impairment. Another variable factor is that a person may have the capacity for some decisions (to consent to or refuse a dental examination, for example) but lack capacity to make other decisions (such as consenting to or refusing to undergo major surgery).

To assess somebody as lacking or having impaired capacity has far-reaching implications. It would be absurd to deny the person medical treatment because doctors do not have the necessary consent. For this reason, the courts devised what was referred to as the 'doctrine of necessity', under which decisions affecting an adult lacking capacity are lawful if made in his or her 'best interests.' However, best interests risk heavy paternalism and people may feel that doing what they consider appropriate is always going to be in the person's best interests. This may ignore any previously expressed wishes or go against their religious or personal beliefs.

Assessments of capacity and deciding what is in the best interests of somebody lacking capacity have significant human rights implications and raise a number of questions. How confident are we that the person lacks capacity? What can we do to maximise their ability to decide for themselves? What factors should be considered when deciding what is in their best interests? What safeguards are there against abuse or misuse of the responsibility to make these decisions?

What does the law say?

General rules on consent and refusal

Before considering capacity, it is worth noting the legal requirements for lawful consent or refusal. This is relevant in deciding whether abuse has taken place (for example, was the person coerced into signing the property transfer?) and in obtaining their consent to participate in the safeguarding process. The law requires the following:

- Information
- Capacity
- Decision made of the person’s own free will

Information

Sometimes it is difficult to decide how much information to provide to help people make what can be complex decisions. It is impossible to give a person all of the information, but they are entitled to be made aware of the more important matters affecting the decision. For example, as part of a safeguarding investigation, moving an older person to a care home may be considered as an option. He or she must have information on the potential financial and other implications before deciding whether to agree to the move.

In financial abuse cases, it is important to consider whether the older person was given the necessary information to make a decision on, for example, transferring their home to a family member. There is an obligation on practitioners to ensure that people have information and to honestly and fully answer any questions they may ask, even if knowing the answer is not what is thought to be best for them.

The United Kingdom’s Supreme Court reviewed the law on consenting or refusing medical treatment in 2015 in a case known as *Montgomery v NHS Lanarkshire*. It decided that doctors must take reasonable care to ensure that a patient is aware of any material risk and any alternative treatments. A material risk is one to which:

“(A)reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.”

This moves away from the previous law under which doctors decided what information to give based on what a responsible body of their medical peers would have done – the so-called Bolam test. In describing risk, the Court said doctors should not rely on the percentage chance of something happening or not happening. Instead, risk assessments should address the nature of the risk and the effect on the patient, the importance to the patient of any benefit of the treatment, and the alternatives available. The Court emphasised that:

“... the doctor’s duty is not... fulfilled by bombarding the patient with technical information, which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form.”

Although a medical negligence case, *Montgomery* identifies the essential components of consent or refusal in cases of the abuse of older people and neglect, and social care more generally. The goal is not to get a signature on a form, but rather to be sure that the person has made an informed decision. The signature is not necessarily conclusive unless it is underpinned by appropriate information.

Capacity

The person must have capacity (see below).

Free will

The person must make the decision freely and without coercion. Although a signature is usually conclusive evidence of consent, one obtained because of threats of violence or psychological pressure is not valid. The law recognises that what is now known as controlling or coercive behaviour nullifies consent or refusal. Previously this was referred to as undue influence.

The cross-Government definition of domestic violence and abuse defines controlling or coercive behaviour as:

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

In safeguarding cases, coercive or controlling behaviour is a consideration as it is highly likely that the harmer exercises control and authority. This behaviour often takes place in a closed environment, such as the person's home where it is hidden. Coercive or controlling behaviour is discussed in greater detail in Chapter 7. For present purposes, consider the following points when deciding whether consent or refusal is the will of the person:

- Is the person suspected of behaving in a coercive or controlling manner in a position of trust (for example, care home staff, carer, or relative)?
- In cases of financial abuse, or the transfer of property such as a home, has the older person been offered independent legal or financial advice?
- Has the practitioner been able to talk to the older person without the alleged harmer being present?
- Is the act untypical and out of character based on what you know or have been told about the older person by somebody close to them?

None of these on its own is conclusive but merely indicative and suggests that further investigation is necessary.

The Mental Capacity Act 2005

The Principles

The Mental Capacity Act 2005 (MCA 2005) codifies the law and replaces the earlier judge-made law. The MCA 2005 applies to most of the decisions people make, although there are exceptions. These include:

- Relationship type decisions, such as consent to marriage or a civil partnership, sexual relations, and divorce or dissolution based on two years' separation
- Treatment under Part IV of the Mental Health Act 1983
- Voting

The MCA 2005 contains legal principles that must be followed. The principles are:

1. A presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have the capacity to do so unless proved otherwise.
2. The right for individuals to be supported to make their own decisions - people must be given all practicable help before concluding they cannot decide.
3. The individual has the right to make what might be seen by others as eccentric or unwise decisions.
4. 'Best interests' – anything done for or on behalf of people without capacity must be in their best interests.
5. Least restrictive intervention – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedom.

Decision-makers must ensure that these principles are followed and be able to demonstrate, through record keeping, that this is the case. Whilst the Principles are self-explanatory, it is important to note the following:

Principle 1 – the presumption of capacity: this is the starting point for capacity assessments. The assessed person need not prove they have capacity; the decision-maker must prove, on a balance of probabilities, they do not. The question is whether, based on the relevant evidence, it is more likely than not that the person lacks capacity. Different people assess capacity - it may be an unpaid carer or social care worker, or a clinician or senior social care practitioner. The type of decision varies from daily living matters to moving to residential care, a legal transaction, or medical intervention. Although the complexity of decisions vary, the criteria in the MCA 2005 apply in all cases. In complicated cases, the decision-maker may seek expert advice. However, the courts emphasise that the decision is that of the decision-maker and not the expert who may have advised.

Principle 2 – supporting people to make their own decisions: this principle imposes an extensive duty on the decision-maker, who must demonstrate (to a court if necessary) that all practicable steps have been taken to support the person. Chapter 3 of the Mental Capacity Act **Code of Practice** provides guidance on supporting people to decide for themselves. Many techniques can be used, including alternative forms of communication such as the use of pictures and other more accessible methods to help the person develop their communication skills. The duty to provide information applies and the decision-maker must present information in an appropriate form. Consideration must also be given to the timing and location of any assessments: a person may respond better in their own homes in the afternoon rather than early morning in a doctor's surgery.

Principle 3 – unwise or eccentric decisions: the fact that a person makes an 'irrational decision' does not of itself mean they lack capacity. This has long been the position of the courts which adopted a functional approach to capacity before the MCA 2005. Everyone has

the right to make what others think of as a foolish decision; one judge summed this up by saying that the right to choose exists ‘... notwithstanding that the reasons for making a choice are rational, irrational, unknown or even non-existent.’ The Code recognises that whilst an unwise or eccentric decision may prompt the decision-maker to consider further investigations, making such a choice is not in itself sufficient grounds for concluding that the person lacks capacity.

Principle 4 – ‘best interests’: more on this below.

Principle 5 – least restrictive intervention: this principle applies the doctrine of proportionality outlined in the Chapter 1. When a person is assessed as lacking capacity, it does not follow that decision-makers have a free hand to decide what is ‘best for them’. It may be that there is no need to do anything. If action is required, there may be different options, some of which are not so intrusive and interfere less with the person’s human rights. In deciding what to do (for example, whether to apply for a Deprivation of Liberty authorisation or undertake a forensic examination), the proposed action must be restricted to what is necessary to achieve the intended result. Therefore, whilst it may, for example, be agreed that a Deprivation of Liberty authorisation is in the best interests of the person, the duration of that deprivation should not be disproportionate to the risk.

Practitioners must remember that the principles are legal principles. In the rare cases that go to court, they may be asked to show how they applied the principles. Good record keeping is therefore essential. Even if the case does not go to court, the individual and his or her family or representatives are entitled to know that any decisions were taken within the framework of the MCA 2005.

Treating people equally and avoiding stereotyping is also essential. The MCA 2005 makes clear that a lack of capacity cannot be established merely by reference to a person’s age or appearance, or a condition or behaviour that might lead people to make unjustified assumptions about capacity. Paragraph 4.8 of the Code gives guidance on the use of the word ‘appearance’:

“The Act deliberately uses the word ‘appearance’, because it covers all aspects of the way people look. So, for example, it includes the physical characteristics of certain conditions (for example, scars, features linked to Down’s syndrome or muscle spasms caused by cerebral palsy) as well as aspects of appearance like skin colour, tattoos and body piercings, or the way people dress (including religious dress).” (Mental Capacity Act Code, para 4.8)

Similarly, the use of the word ‘condition’ is meant to be inclusive and non-discriminatory:

“The word ‘condition’ is also wide-ranging. It includes physical disabilities, learning difficulties and disabilities, illness related to age, and temporary conditions (for example, drunkenness or unconsciousness). Aspects of behaviour might include extrovert (for example, shouting or gesticulating) and withdrawn behaviour (for example, talking to yourself or avoiding eye contact). (Mental Capacity Act Code of Practice, para 4.9).”

Assessing capacity – the functional approach

The MCA 2005 follows the functional approach adopted by the courts before it came into being. Section 2 states that a person lacks capacity:

“... in relation to a matter if at the material time he/she is unable to make a decision for him/herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.”

Three points should be noted:

- 1. The test is subject sensitive** – it refers to the assessment being ‘in relation to a matter’. A person may have the capacity to do some things at the same time as lacking capacity for others. Avoid blanket labels of ‘incapacity’; rarely will a person completely lack capacity.
- 2. The test is time sensitive** – it refers to the ‘material time’, which is the time of the decision. An assessment that a person lacks capacity at a particular time does not mean they lack capacity forevermore. The assessment must be reviewed to ensure that if the person later regains capacity, they can decide. The MCA 2005 says that the ‘impairment or disturbance’ may be permanent or temporary. If it is likely that the person may regain capacity in the future, and the decision can wait until then, it should be deferred.
- 3. The test refers to being ‘unable to decide’ because of ‘impairment of or disturbance in the functioning of the mind or brain’. There is a causal link between the two** – the fact that somebody cannot decide does not mean they lack capacity. It must be because of the impairment or disturbance. Similarly, the fact that the person has an impairment does not mean that they lack capacity if they can decide for themselves.

The MCA 2005 refers to being ‘unable to decide’ and it is important to consider what this means. Section 3 MCA 2005 provides the definition; a person is unable to decide if they are unable:

- 1. to understand the information relevant to the decision:** A vital part of this is the right of the person to have information to enable them to decide. As noted above, Principle 2 requires supporting the person by presenting the information in a way that they can understand, in an accessible format, familiar setting, and at an appropriate time.
- 2. to retain that information:** For how long is it necessary to retain the information? The simple answer is ‘as long as is necessary’ to use or weigh the information as part of the decision-making process. For those with fluctuating or rapidly declining capacity, there may only be a relatively short period in which to decide. Somebody in this situation may not have the luxury of spending a longer time deciding. However, they must be provided with every opportunity to make the decision even though the time available may not be ideal. Section 3(3) MCA 2005 states that the fact that a person may only be able to retain relevant information for a short period does not prevent him or her from being able to decide.
- 3. to use or weigh that information as part of the process of making the decision:** This is about the person’s ability to comprehend the information and use it to make the

decision. The courts have also emphasised the importance of the person believing the information provided.

4. **to communicate the decision whether by talking, sign language or any other means:** This is a residual category and is not intended to relieve practitioners of the obligation to use all possible ways of communication (for example, signing). The category is designed to cover people who probably have capacity under the conditions referred to above, but are incapable of communicating their wishes even with assistance. The example often given is somebody with locked-in syndrome.

Temporary incapacity

The MCA 2005 recognises that loss of capacity may be temporary. Temporary incapacity may result from physical or medical conditions that cause confusion, drowsiness or loss of consciousness, delirium, concussion following a head injury, or through alcohol or drug use. Section 2(2) MCA 2005 makes it clear that it does not matter whether the loss of capacity is permanent or temporary. A decision by a person during a period of temporary lack of capacity is not legally binding. However, once the person regains capacity, he or she can make a binding decision. A legally binding decision made during a period of capacity (for example the refusal of medical treatment) does not cease to be effective during a period of temporary (or indeed permanent) incapacity.

If the loss of capacity is temporary, decision-makers must consider whether it is likely that the person will regain capacity. If it is likely, can the decision be delayed? This will enable the person to decide. Where urgent action is required, delay may not be possible.

The best interests test

If a person lacks capacity in relation to a particular matter at a particular time, decisions must be made based on what is in their 'best interests'. It is difficult to identify what is in somebody else's best interest and to be able to make this judgement it is necessary to know as much about the person as possible and to discover what might have influenced their decision if they had the capacity. There is a risk of decision-makers imposing their value judgements on the person – they may use the argument that 'if this were me, I would want ...'. This is not the correct approach. To assist the decision-maker the MCA 2005 introduces a checklist of factors that should be considered.

As with capacity assessments, the MCA 2005 warns against making best interest decisions based merely on a person's age or appearance, or on a condition or aspect of his or her behaviour, which might lead others to make unjustified assumptions about what might be in his or her best interests.

As noted above, practitioners must consider whether the person may regain capacity at some time in the future and, if so, when that is likely to be. It is also incumbent upon the decision-maker to permit and encourage the person to participate in the process as thoroughly as possible; this may include enhancing their ability to participate.

The MCA 2005 also requires the decision-maker to take into consideration (as far as is 'reasonably ascertainable'):

- the person’s past and present wishes and feelings (in particular, any written statement made during capacity);
- the beliefs and values that would be likely to influence their decision if he or she had capacity; and
- the other factors that they would be likely to consider if he or she were able to do so.

Written statements are considered below. Past wishes may be gleaned from personal knowledge, talking to friends and carers, what other professional say, and earlier courses of conduct. Regard must be had to the present wishes and feelings of the person. The loss of capacity does not mean the person’s view should not be sought and considered when it is reasonably ascertainable. The fact that a person lacks capacity does not mean that they cannot be involved in decision-making.

Under the MCA 2005, when deciding a person’s best interests, account must be taken of the views of:

- anyone named by the person as someone to be consulted on the matter in question or on matters of that kind;
- anyone engaged in caring for the person or interested in their welfare;
- any donee of a lasting power of attorney granted by the person; and
- any deputy appointed for the person by the Court of Protection.

This only applies where it is practicable and appropriate to consult them. If it is an emergency, for example, it may not be practicable to consult. Similarly, it may not be appropriate to consult somebody suspected of abusing the person who lacks capacity, or where there is an estranged relationship. The consultation is undertaken to elicit what is in the best interests of the person lacking capacity and not what the consultee wants to happen.

The courts emphasise there is no hierarchy between the different factors discussed above and that the weight given to each depends upon individual circumstances and the assessment of the best interests’ assessor. The wishes of the person will always be significant, but there is no overriding importance given to them. The MCA 2005 directs the decision-maker to the best interests checklist. The decision-maker then has to form a judgment giving effect to the paramount statutory instruction that any decision is in the person’s best interests.

Planning for incapacity

Under common law, there is no general power to give proxy consent on behalf of an adult lacking capacity. Getting the ‘consent’ of a spouse or partner, or of a son or daughter or parent of an adult child, does not normally have legal effect. However, under the MCA 2005 there are ways in which such proxy decision-making is allowed:

Lasting Power of Attorney (LPA): this is a legal document whereby a person with capacity (the donor) appoints others (the donees) to look after their affairs if they lose capacity. It is essential that the donor has capacity when making the LPA. If they do not, making one ‘on their behalf’ is abuse. Unless it says otherwise, the LPA power is only exercisable when the donor

loses capacity. The LPA must be registered with the Office of the Public Guardian. A decision lawfully taken by a donee under an LPA is legally valid, but only if it falls within the terms of the LPA. An LPA may cover:

- the person's personal welfare in general, or a specific aspect of it (for example, where the donor wishes to live), and/or
- the person's property and affairs in general, or a specific aspect of them (for example, the sale of the donor's home).

Special provisions apply to the giving or refusing of consent to the carrying out or continuation of life-sustaining treatment. The LPA must include an express provision allowing the donee to make such decisions.

Where an LPA exists, practitioners must check that the person claiming to be the donee has the authority claimed and whether they have the authority under the terms of the LPA. The claim 'I am a donee under an LPA therefore I can decide' needs confirming. Of course that may not be practical in an emergency where immediate action is required, but this should still be checked afterwards if possible.

Unfortunately, procedures introduced to protect people from abuse are sometimes misused and abused. This may happen with an LPA where the donee has extensive or complete control over the finances of an older person who lacks capacity. They may abuse this power and use it for their own benefit. For example, they may withdraw money from the account for their use and not that of the donor. If you suspect that this is happening, your concerns should be reported to the appropriate person in your organisation. Concerns should be reported to the Office of the Public Guardian for them to investigate.

There is a power in the MCA 2005 to remove a donee who is abusing their power. Whilst the procedure for setting up an LPA makes abuse less likely than under the previous system of Enduring Powers of Attorney, there is always the risk.

Practitioners may still encounter an Enduring Power of Attorney (EPA) made under the previous law. If made before the LPA provisions came into effect, EPAs are still valid, although a significant difference is that they only apply to property and financial affairs and not to welfare.

Advance Decisions (AD): These are sometimes known as 'living wills' or 'advance directives'. An AD allows a person to specify during capacity that, in the event of them losing capacity, they do not wish a treatment to be initiated or continued. Again, the AD does not come into operation unless the person loses capacity and an AD may be withdrawn or altered at any time during capacity. If the AD includes life-sustaining treatment special provisions apply, including the need for the person to state unequivocally in writing that such treatment is covered. The document must be signed and witnessed in such cases.

Doctors can override an AD if there are reasonable grounds for believing that circumstances exist which the person did not anticipate at the time of making it, and which would have affected the decision had they anticipated them.

The Court of Protection: The Court supervises the working of the MCA 2005. As part of its role, the Court may appoint a deputy to make decisions for a person who lacks capacity. The deputy may be a family member, friend, Director of Social Services, a professional (a solicitor

or accountant, for example) or another appropriate person. When acting within the powers given by the Court, a deputy can make a lawful decision. In addition to appointing a deputy, the Court of Protection may also decide on behalf of the person who lacks capacity (to have medical treatment, for example, or whether to dispose of assets). Normally, the Court will make a specific order where there is a single issue to be decided and appoint a deputy when there is an ongoing need to make decisions such as the need to protect the finances of the person against abuse. As with an LPA, if a practitioner is concerned about the way in which a deputy is exercising their powers, they should report it to the Office of the Public Guardian which has a supervisory role over LPAs and the work of deputies.

How should it be used?

Capacity is relevant in two ways. First, the lack of capacity may be the basis of abuse, such as when an abuser financially exploits a person without capacity. In addition, it is a criminal offence for a person to ill-treat or wilfully neglect somebody who lacks capacity, or whom the person reasonably believes lacks capacity. Second, capacity is important in deciding how the safeguarding policies and procedures operate. A person with capacity has considerable control over how far an enquiry goes. They can refuse to co-operate, and this may make the process more difficult. The range of options available is greater if the person lacks capacity under the MCA 2005; these include, making decisions in the best interests of the person and the use of a Deprivation of Liberty authorisation.

Deciding whether somebody has capacity or whether a course of action is in his or her best interests is complex. Professional judgment is important and practitioners need to be sure that their decision is one that would command the respect of a group of their peers. Wherever possible (and especially in relation to very important decisions) opinions should be discussed with other practitioners.

What are its limitations?

The MCA 2005 does not give a power to intervene in the lives of people who have capacity, but who are frail and vulnerable. The authorisation to act under the 'best interests' test only exists where the person lacks capacity at the material time and in relation to the material matter. However, if the person has capacity but is 'vulnerable', the use of the inherent jurisdiction may be considered (See Chapter 6).

The 'best interests' test does not mean that we should always do what the practitioners think is desirable. Other factors, such as previously expressed wishes or the views of carers may lead to another conclusion.

Points to remember:

- The five principles – they are legal principles and not just good ideas and must be followed as a matter of law.
- Any judgements made under the MCA 2005 must be ones that would gain the support of a responsible body of your peers.
- All decisions must be compatible with the person's human rights.

- Do not make assumptions about people's capacity based on age, manner of dress, way of life, or anything other than the test in the MCA 2005.
- Assessments of capacity should be reviewed.

Chapter 4: Deprivation of Liberty

Introduction

Our liberty or freedom is something we take for granted. Depriving somebody of their liberty normally only happens following a conviction for a criminal offence and a sentence of imprisonment. However, there are other circumstances when a person may lawfully be deprived of their liberty. Under the Mental Health Act 1983 (MHA 1983), for example, people can be detained for assessment or for treatment if they meet the criteria in the Act.

Following a case originally known as the ‘Bournewood case’ and subsequently (when it went to the European Court of Human Rights) as *HL v UK*, depriving people who lacked capacity of their liberty in a care home or hospital became a matter of national concern. Article 5 European Convention on Human Rights (ECHR) provides that nobody shall be deprived of their liberty ‘save in the following cases and in accordance with a procedure prescribed by law’. One of the cases in the Article is that the person is ‘of unsound mind’. In *HL v UK*, which pre-dated the Mental Capacity Act 2005 (MCA 2005) coming into force, the European Court of Human Rights held that the old common law test of acting in the best interests of a person without capacity was too arbitrary and lacked sufficient safeguards, especially when compared with the safeguards under the MHA 1983; it therefore breached Article 5 ECHR. There followed a period of consultation and eventually new sections were inserted into the MCA 2005 which introduced what are known as the ‘Deprivation of Liberty Safeguards’ (DoLS). Although they are not aimed primarily at safeguarding, they may be relevant in cases where an older adult at risk lacks capacity. Depriving people of their liberty without an authorisation under DoLS is unlawful, unless some other lawful authority exists.

It is difficult to say precisely what amounts to a deprivation of liberty; it is different from restraint, which under certain circumstances may be lawful. The distinction between a deprivation and restraint is one of fact and will depend upon all the circumstances of the case. Locked doors without the possibility of leaving, inappropriate sedation, and even the culture of the home or hospital (nobody dares to ask to go out) may be enough. Section 64 of the MCA 2005 says that under the Act a ‘deprivation of liberty’ has the same meaning as in Article 5 ECHR.

The European Court of Human Rights said in the *HL v UK* case:

“...the key factor [in deciding whether it is a deprivation of liberty] is that the healthcare practitioners treating and managing [the patient] exercised complete and effective control over his care and movements’ and he ‘was under continuous supervision and control and was not free to leave.”

The United Kingdom’s Supreme Court discussed deprivation of liberty in *Cheshire West*, a joint appeal involving two separate cases. The first case involved a 38-year-old man (P) with cerebral palsy and Downs syndrome who was unable to look after himself and required twenty-four-hour care. He needed help with all activities of daily living; occasionally he would put pieces of his incontinence pad into his mouth. To prevent this, he wore a body suit as well as having finger sweeps of his mouth to remove any material. Regular intervention was needed to cope with his challenging behaviour. The second case involved two sisters, MIG and MEG, who were at the time 18 and 17 years respectively. They had a background of family neglect and abuse and as children were placed in foster care by the local authority. By the time of the first

court hearing, MIG was still living at her foster mother's home. She made no attempt to leave, her bedroom door was not locked, and she attended local education facilities. If she had tried to leave home, however, her foster mother would have restrained her to prevent her from doing so. MEG was living in an NHS unit. She had behavioural problems requiring staff intervention; carers went with her wherever she went. She received tranquillising medication, although she had never tried to leave the unit. Both MIG and MEG fell outside of the DoLS procedure as they were not in a care home or hospital.

The Supreme Court had to decide whether P, MIG and MEG were deprived of their liberty. The approach of the Court of Appeal was based on the idea of 'relative normality'. In relation to P, the Court of Appeal said that the appropriate comparator is 'the kind of lives that people like him would normally expect to lead'. The reality is that P was living a life which is as 'normal' as it can be for someone in his situation, and therefore he was not being deprived of his liberty. It was not appropriate to compare P's life with that of a healthy adult who would be regarded as being deprived of his or her liberty in these circumstances.

The Supreme Court disagreed and found that all three were deprived of their liberty, albeit with their best interests at heart. A person with a disability has the same right to liberty as anyone else; if it was a deprivation for a non-disabled person, it is a deprivation for a person with a disability. The key question was whether the person is under continuous supervision and control and is not free to leave. The person's compliance, the relative normality of the placement, and the purposes behind it are not relevant to the objective question of whether it was or was not a deprivation. Lady Hale in the Supreme Court put it this way:

“If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage.”

This is often referred to as the 'acid test'.

The consequence of Cheshire West is that many more people are deprived of their liberty than was previously thought. The fact it is irrelevant that the person is compliant is a notable change and has led to a significant backlog in applications for DoLS being processed and to many people being detained without authorisation. The case is also important in that it recognised that if the state is responsible for the care arrangements giving rise to the deprivation, it does not matter where the deprivation is taking place. DoLS under the MCA 2005 only applies to care homes and hospitals. The effect of Cheshire West is that authorisation is also required if the state (that is the local authority or Health Board) has arranged for the care involving a deprivation provided in supported living or in the person's own home, as was the case for MIG and MEG. In such cases, an application to the Court of Protection is necessary to authorise the detention.

What does the law say?

DoLS provides the procedure by which authorisation is given to deprive a person of their liberty, either in a care home or in a hospital. It is important to emphasise that DoLS are designed to provide safeguards for people who are being deprived of their liberty and not simply as a means by which people may be detained.

Criteria for a DoLS

The DoLS process is complicated and involves several participants:

- The relevant person – the person being deprived of their liberty (or who may be deprived of their liberty in the near future).
- The Managing Authority – this is the hospital or care home where the relevant person is at the time of the application, or where it is intended that they be taken. The Managing Authority has responsibility for making an application for a deprivation of liberty authorisation to the Supervisory Body.
- The Supervisory Body - this is the local authority in the case of deprivation of liberty in a care home and the Health Board in the case of a hospital. They receive the application from the Managing Authority, and they grant or refuse the authorization based on the assessments.
- The Independent Mental Capacity Advocate (IMCA) - the IMCA service is available for an adult where, in the words of the MCA 2005:

‘...there is no person, other than one engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate for them to consult...’

The use of IMCAs is discussed in Chapter 2.

- The Best Interests Assessor (BIA) – the BIA undertakes the best interest assessment. The BIA must consult with ‘interested persons’. These are:
 - partner (spouse or civil partner);
 - children or stepchildren;
 - parents and stepparents;
 - brothers and sisters, half-brothers and sisters and stepbrothers and sisters;
 - Grandparents;
 - Court appointed deputy;
 - Donee of a Lasting Power of Attorney (LPA).

The BIA decides whether people who lack capacity are deprived of their liberty and, if so, whether deprivation is in their best interests, necessary to prevent harm to them and proportionate to the risk or likelihood of that harm.

Under the MCA 2005, the Supervisory Body must undertake six assessments.

Age assessment: Is the person aged 18 year or over?

The mental capacity assessment: does the person lack the capacity to consent to the arrangements made for their care? (the MCA 2005 test applies – see Chapter 2).

Mental health assessment: is the person suffering from a mental disorder under the MHA 1983?

Best interest assessment: three issues must be decided.

a. Is the person being deprived, or about to be deprived, of their liberty?

b. If so, is it:

i. in the person's best interests; and

ii. necessary to prevent harm to self?

c. Is the actual or proposed deprivation of liberty a proportionate response to the likelihood of the harm and the seriousness of that harm?

No refusals assessment: to establish whether an authorisation would conflict with other existing authority for decision making (for example, an LPA or the Court of Protection's jurisdiction).

Eligibility assessment: to establish whether the relevant person should be covered by the MHA 1983 or a DoLS under the MCA 2005.

This is the 'standard procedure'. Conditions may be attached to a standard authorisation, including recommendations on contact, the person's culture, or other major issues related to the deprivation of liberty which, if not addressed, would mean that the deprivation is not in the person's best interests.

A standard authorisation should last for the shortest period possible. If the circumstances that precipitated the DoLS are resolved, the authorisation should end. It is also incumbent on the care home and hospital to make every effort to no longer deprive the person of their liberty; this can be achieved by, for example, organising outside visits, maximising the person's ability to move around within the setting, encouraging visitors and access to fresh air.

There is also provision for urgent authorisations. If the person needs to be deprived of their liberty as a matter of urgency, the Managing Authority can give itself an urgent authorisation, which provides interim authorisation while the standard authorisation application is made. An urgent authorisation cannot be made unless an application is also made for a standard one at the same time. An urgent authorisation will only last for up to seven days, although the Supervisory Body may extend it in exceptional circumstances.

The Cheshire West case said that an authorisation to deprive a person of their liberty is needed where deprivation takes place outside of a care home or hospital. For example, a person may be deprived of their liberty as a consequence of a package of care provided in their own

home by the local authority, or may be in supported living arrangements. These fall outside of the DoLS under the MCA 2005 process and an application must be made to the Court. The procedure is set out in what is known as a Practice Direction issued by the Court. A special form (COPDOL11) must be used and legal advice will be necessary.

The Liberty Protection Safeguards replacement for DoLS – Spring 2020

The Mental Capacity (Amendment) Act 2019 amends the MCA 2005 provisions on DoLS by replacing them with the Liberty Protection Safeguards (LPS). The expectation is that the LPS will be introduced in Spring of 2020, although this may be subject to delay. The LPS process does not implement all of the recommendations in the Law Commission’s report on DoLS, although it does make significant changes that address some of the issues raised in Cheshire West. It also seeks to simplify the process.

For the purposes of an LPS the definition of a deprivation is the one adopted by the European Court of Human Rights which is reflected in the ‘acid test’ in Cheshire West. Unlike a DoLS, an LPS will not be restricted to a deprivation in a care home or hospital; it will include living arrangement in the community where the state (the local authority or Health Board) is responsible. There are no restrictions on the type of setting where an authorisation can be put in place. The arrangements may include the transport of the cared-for person to, from or between particular places.

An LPS has to be authorised by the ‘responsible body’. The responsible body is:

- NHS hospitals - the ‘hospital manager’ - .
- For Continuing Health Care outside hospital, the relevant Health Board.
- In all other cases, the local authority (this includes private hospitals).

Before the responsible body can authorise a deprivation, it must undertake consultations in order to identify the wishes and feelings of the person who will be subject to the LPS. It must consult with the following, unless it is impracticable or inappropriate to do so:

- the cared-for person;
- anyone named by the person as someone to be consulted;
- anyone engaged in caring for the person or interested in their welfare;
- a donee of a lasting power of attorney or a deputy appointed by the Court of Protection; and
- any appropriate person and IMCA.

The responsible body must consider the appointment of an IMCA or an appropriate person. An IMCA should be appointed if the cared-for person has capacity to consent to the appointment and has requested that one be appointed. If the cared-for person lacks capacity to request that an IMCA be appointed, the responsible body should appoint one unless satisfied that it would not be in his or her best interests. An IMCA will not be appointed if the responsible body is satisfied that there is an ‘appropriate person’ who would be suitable to represent the cared-for person. The appropriate person must consent and must not be engaged in providing care of support for the cared-for person in a professional capacity. However, the person will not be

considered suitable if the cared-for person has capacity to consent to representation but does not give consent. If the cared-for person lacks that capacity, the person will still be unsuitable if the responsible body is satisfied that representation by that person will not be in the cared-for person's best interests.

Three conditions need to be satisfied for an LPS:

1. the cared-for person must have a mental disorder within s.2 MHA 1983;
2. the arrangements are necessary to prevent harm to the cared-for person and proportionate to likelihood and seriousness of the harm;
3. the person lacks capacity to consent to the arrangements (but they may have capacity to make other decisions).

Who assesses whether the cared-for person meets the conditions? Under DoLS it was the best interests assessor. The LPS is different; a person from the responsible body will undertake the assessment. He or she must not be directly involved in the care and support of the cared-for person. However, if the deprivation of liberty will take place in a care home, the local authority, if it felt it to be appropriate, could ask the manager of the care home to undertake the assessments and report their findings to the local authority in its capacity as the responsible body.

In some cases, the assessments must be undertaken by an Approved Mental Capacity Professional (AMCP). In the following cases an AMCP must undertake the assessments:

1. the arrangements provide for the cared-for person to live or to receive care and treatment in a particular place and it is reasonable to believe that he or she does not want to live there, or to receive care or treatment there;
2. the arrangements provide for the cared-for person to receive care or treatment mainly in an independent hospital; or
3. the case is referred by the responsible body to an AMCP and he or she accepts the referral.

An AMCP will have received specialist training on the MCA 2005.

If the conditions have been met, the responsible body will make the authorisation. It is possible that the deprivation may take place in more than one setting, which adds to the flexibility of the LPS. The first authorisation may last for up to twelve months, although the responsible body may specify a shorter period. It may be renewed. On the first renewal it may be for a period of up to twelve months; any subsequent renewal may be for up to three years. When seeking renewal the responsible body must be satisfied that the conditions continue to be met, and that it is unlikely that there will be any significant change in the cared-for persons condition. It must also carry out the necessary consultations.

However, if the cared-for person is in a care home, the care home manager must provide the responsible body with a written statement that the conditions for the authorisation continue to be met, and that there is unlikely to be any change in the cared-for person's condition. He or she must also undertake the necessary consultations. If satisfied, the responsible body can renew the authorisation.

An authorisation must be reviewed on a regular basis. The Court of Protection will have overall supervision of the LPS.

How should it be used?

DoLS should only be used in exceptional cases – a least restrictive form of intervention should always be considered. It may be necessary to use DoLS to remove a person from an abusive environment, or to prevent their return to one from a care home or hospital. It will be necessary to work closely with the Managing Authority, providing them with necessary information to enable them to make the decision whether to seek an authorisation.

It is important, as always, to balance several different human rights – home, family, private life and protection from inhuman or degrading treatment. DoLS should not be routinely used, in the absence of other legislation, as a means of depriving people of their liberty in order to protect them from abuse. The criteria are detailed and must be satisfied before a deprivation can be authorised.

What are its limitations?

- DoLS only applies where the person lacks capacity and meets the other requirements of the MCA 2005 – it is not a general procedure available in all cases of older people at risk of abuse. Outside of the MCA 2005, the inherent jurisdiction may be considered. (see Chapter 6)
- DoLS does not authorise medical treatment.
- DoLS does not apply to people who may be deprived of their liberty in their own home. – if the state is responsible for the deprivation, authorisation should be sought from the Court of Protection.
- The Liberty Protection Safeguards will eventually replace DoLS. A Code of Guidance will be published along with any necessary regulations. Implementation is expected to be in Spring 2020.

Points to remember

- DoLS and LPS are intended as a safeguard for the person and not a free-standing right to deprive people of their liberty.
- All the assessments must agree that a DoLS authorisation is necessary.
- If there is an LPA or a health and welfare deputy, the deprivation can only be authorised by the DoLS if they are supportive and this matter is within the scope of their authority. As always, the deprivation must be in the best interests of the person.
- Deprivation can take many forms.
- The fact that the person is compliant does not mean that it is not a deprivation.
- In emergencies, it may be possible to temporarily restrain a person to protect them from serious harm; any restraint must be proportional and of limited duration.
- Ongoing restraint will most likely be a deprivation.

Chapter 5: Confidentiality and Data Protection

Introduction

One area of confusion in adult safeguarding is how to manage personal and sensitive information about people. When working with adults at risk of or experiencing abuse or neglect, practitioners are told many things by the person, friends, carers, families and other practitioners. How are they to handle such information? Myths have developed surrounding confidentiality and data protection, not least the idea that information can never be shared. The expectation under the safeguarding law and procedure is that information is shared. As with child protection, the lesson from case reviews is that failing to share information often leads to tragic consequences.

Although ‘confidentiality’ and ‘data protection’ are often used interchangeably, they are different. Confidentiality describes a duty between, for example, a social worker or a lawyer and their client where the expectation is that information is not shared with another unless there is a legal basis for doing so; we do not expect our doctor to randomly share information about our health. Data protection, as the name suggests, is about the way in which personal information held about individuals is protected when it is ‘processed’ (for example, collection, holding, organising, consulting, disclosure, and destruction) so that its use is fair and lawful.

Information given to a practitioner is not provided on a personal basis: they receive the information as a practitioner and most often as an employee. It is not a personal confidence with the information provider.

What does the law say?

Confidentiality

Some relationships are based on a legal duty of confidentiality. Doctor and patient is the most often cited example, but the duty extends to others including social care workers, nurses, lawyers, priests and volunteers. A confidential relationship exists where there is an expectation on the part of the provider that information will be treated confidentially, a duty that is often embedded in professional codes of practice. The reason for the duty is that people would be unwilling to talk to practitioners (often about personal and private matters) unless reassured that what is said is treated confidentially. It is safe to assume that information provided or obtained by professional health, law enforcement or social care workers as part of the safeguarding process, is subject to the duty. However, establishing the duty is only one part of the process.

Even if information is given as part of a confidential relationship and entitled to respect, the law does not require the practitioners to keep it to themselves. What it does expect is that confidential information is not shared socially or publicly with people who do not have a professional need to know. However, this does not mean that the information cannot, or indeed should not, be shared with others as part of the safeguarding process. Just as there is a public interest to keep information confidential, there is a competing public interest to share information, when necessary, to protect the client, other adults or children, or another practitioner.

It is difficult to be precise about what information is protected by the duty of confidentiality as the law on confidentiality is not found in an Act of Parliament; instead, it is a law that has been developed by the judges. One judge said that the information must have:

“ ... the necessary quality of confidence about it, namely, it must not be something which is public property and public knowledge.”

It is therefore wise to err on the side of caution and treat all personal information about the client as confidential. For example, the fact that you have been to visit a client deserves protection by the duty, even though you do not intend to publicly disclose the purpose or the result of the visit. A common-sense test is helpful – or the ‘reasonable man’ test as lawyers describe it. Would a ‘reasonable man in the shoes of the recipient of the information ... have realised that upon reasonable grounds the information was being given ... in confidence.’ The ‘reasonable man’ or, more appropriately, the ‘reasonable person’ is one who exercises average care and skill in their judgment; his or her opinions are used in law to decide on liability. One judge referred to him or her as the person ‘on the Clapham omnibus’.

As mentioned, the confidential nature of information given under the safeguarding procedure does not mean that it goes no further than the professional to whom it was given. One thing that practitioners cannot do is to guarantee to a client that what they say will ‘go no further’; the information will have to be properly recorded and kept on file and concerns about safeguarding issues must be reported. Very importantly, the information will be shared within the team including practitioners from other agencies. The Guidance issued by the Welsh Government on adult safeguarding emphasises the qualified nature of the duty:

‘Practitioners are under a duty of confidentiality. This is important in maintaining confidence and participation in services. However, the duty of confidentiality is not absolute and may be breached where this is in the best interests of the individual, or the wider public interest.’ (Working Together to Safeguard People: Volume 6 – Handling Individual Cases to Protect Adults at Risk, para 44)

This will, of course, affect the relationship between the practitioner and the client. The Guidance emphasises the importance of practitioners being open with people where they may need to share information with other practitioners or authorities such as the police. It is therefore essential that this is made clear at an early stage so that the client can make an informed choice about whether to give information. The difficulties that such conversations may involve should not compromise the need to protect any adult at risk.

When is it necessary to share confidential information with others?

The provider of the information may give consent to sharing the information. Any consent must be informed and the provider must be made aware of the information’s potential use, including any individuals or organisations with whom it may be shared.

Under s.128 Social Services and Well-being (Wales) Act 2014 (SSW(W)A 2014) a ‘relevant partner’ of a local authority must inform it if they think a person in its area is an adult at risk (or where the person is in another local authority’s area, to inform that other authority). A local authority must also inform another local authority (in Wales or England) if an adult they suspect to be at risk is living or moving to the area of that other authority.

There may be an overriding public interest in disclosing the confidential information to others even if the provider does not consent. This overriding public interest may involve, for example, saving an adult at risk or some other person from death or serious injury.

It is unacceptable to withhold safeguarding information on the basis that it is the ‘property’ of your agency and must not be shared with others. The purpose behind sharing information is that those working under the safeguarding procedures obtain a broadly based and multidisciplinary assessment of the person’s situation. It is also important because a seemingly insignificant piece of information may when put alongside similar information from other practitioners, identify a high risk. It is unacceptable that one professional keeps the information to themselves on the basis it is given in confidence.

Human Rights

As seen in Chapter 1, Article 8 of the ECHR protects ‘private life’, amongst other things. Private life includes the right to have sensitive and confidential information held by public authorities to be respected and not unlawfully shared. The European Court of Human Rights recognised this in the 1993 case of *Z v Finland*. The personal data under discussion in the case were medical records; the same principle applies to information relating to adult safeguarding. The Court said:

“In this connection, the Court will take into account that the protection of personal data, not least medical data, is of fundamental importance to a person’s enjoyment of his or her right to respect for private and family life as guaranteed by Article 8 of the Convention. Respecting the confidentiality of health data is a vital principle in the legal systems of all the Contracting Parties to the Convention. It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general.”

However, as we have seen the Article 8 right is a qualified right that allows interference if certain conditions are satisfied. Any sharing of such information must meet the criteria in Article 8(2) ECHR to be lawful. (See Chapter 1).

The Data Protection Act 2018 and the European General Data Protection Regulation (GDPR)

Like health and safety legislation, urban myths have grown up around data protection. Data protection law does not prevent the sharing of information but regulates the way in which certain types of data may be ‘processed’. Significant amounts of personal information are held by public and private bodies, both electronically and in traditional forms such as manual files. Without proper regulation on how this information is to be used by the holder, information could be stored and used without any security being in place and used for purposes other than that intended by the information provider. In adult safeguarding the careless storage and use of sensitive information may place the person at extra risk, as well as being an invasion of their human rights. Data protection law is therefore partly designed to protect the individual when data is stored and used by another person or organisation.

Parliament has recently passed the Data Protection Act 2018 (DPA 2018). In addition, as a European Union regulation, the GDPR has, since 25 May 2018, direct effect in all member

states. This currently includes the United Kingdom. Transitional arrangements for the possible exit from the European Union mean that it will continue to apply post Brexit. The DPA 2018 takes advantage of the opportunity in the GDPR for individual states to adapt the regulation within their own country, which means that the current law is found both in the DPA 2018 and the GDPR. Article 1 of the GDPR recognises that that the ‘protection of natural persons in relation to the processing of personal data is a fundamental right’. As seen in Chapter 1 on Human Rights, rights often involve delicate balancing exercises and the rights in the GDPR are no exception. Article 4 GDPR confirms this:

‘The processing of personal data should be designed to serve mankind. The right to the protection of personal data is not an absolute right; it must be considered in relation to its function in society and be balanced against other fundamental rights, in accordance with the principle of proportionality.’

Together, the DPA 2018 and the GDPR protect individual rights in the processing of personal data by:

- Requiring personal data to be processed lawfully based on the person’s consent or for some other lawful basis.
- Giving the ‘data subject’ the right to obtain information about the processing of their personal data and the right to require inaccurate information to be corrected.
- Giving the Information Commissioner the duty to enforce the law. Complaints and concerns over the use of personal data are made to the Commissioner.

Note the following key definitions:

- **Personal data**: information on any ‘identifiable living individual’. The identified or identifiable person is known as the data subject.
- **Identifiable living individual**: the question is whether based on all the information held, the person can be distinguished from other people. The most obvious example is the person’s name, although you may be able to identify a person without knowing their name. However, it may also include an identification number, location data and any online identifier (such as an email address or username). It may be that identifying the person requires some information additional to that currently held.
- **Processing**: this includes collecting, recording, and storing information. It also includes adapting or altering it, using it, disclosing it, and erasing it. Note that it goes further than sharing information.
- **The data controller**: the natural or legal person, public authority, agency, or another body which decides the purposes and means of processing of personal data.

Understanding and following what are known as the **data protection principles** are fundamental to the DPA 2018 and the GDPR. When processing personal data, practitioners must adhere to the principles.

The new principles require that the processing of personal information must meet the requirements of:

Principle 1 – lawfulness, transparency and fairness: The GDPR identifies six lawful bases for processing. These include the consent (see below) of the data subject; a legal obligation to process the information; where it is necessary to save life; or where it is necessary to perform a task in the public interest or for an official function (provided the task or function has its basis in law). It is essential that before processing personal data the appropriate legal basis is identified.

Principle 2 – purpose limitation: the reason for processing the personal data must be made clear, and it must be for a legitimate reason. Processing is only allowed for the purposes for which the information was collected.

Principle 3 – data minimisation: the personal data must be adequate (and no more), relevant to the reason for retention, and not excessive.

Principle 4 – accuracy: the personal data must be accurate (any errors must be corrected or deleted without delay) and up to date.

Principle 5 – storage limitation: the information must not be kept longer than is necessary.

Principle 6 – integrity and confidentiality (security): the personal data must be processed securely to prevent its unlawful use or loss.

To ensure accountability, the data controller is responsible for compliance with the data protection principles and they must be able to demonstrate compliance.

Article 6 of the GDPR identifies a number of lawful bases for processing personal information – these include the following:

- **Consent:** the individual has given clear consent for you to process their personal data for a specific purpose.
- **Legal obligation:** the processing is necessary for you to comply with the law.
- **Vital interests:** the processing is necessary to protect someone's life.
- **Public task:** the processing is necessary for you to perform a task in the public interest or for your official functions, and the task or function has a clear basis in law.

The GDPR has much to say on consent as a way of meeting the lawfulness requirement in Principle 1. It imposes higher standards for consent than under the earlier law. People must be given a real choice and positively consent rather than consent being the default. It must be an informed consent and any questions or queries must be honestly answered. Any third-party data controllers who will rely on the consent – another public authority, for example – should be identified. Blanket consent is not enough; specific consent is necessary. People must also be able to easily withdraw consent and consent must never be a precondition for the provision of a service. Practitioners should ensure, and be able to prove, that consent is given freely.

Practitioners' employers must have policies, procedures and protocols in place to ensure data protection law compliance. However, practitioners must be aware of the general framework

within which they work. An understanding of the data protection principles and how they apply to adult safeguarding is important.

How should it be used?

All the time. Respecting confidentiality and protecting data is crucial. Information gathered as part of the safeguarding process must be handled sensitively and with due regard to the rights of the provider. However, this is not a reason for not sharing with other practitioners.

What are its limitations?

There are no limitations as such as both confidentiality and data protection impose clear legal obligations, albeit these require practitioners to exercise professional judgement.

Points to remember

- Never give an undertaking of absolute confidence – there is an obligation to share information with other practitioners, including the police.
- Always make the person aware that you cannot keep information to yourself before they tell you their account of what has happened – they can then decide whether to disclose.
- Effective investigation of cases of suspected abuse or neglect depends upon the full exchange of information between the relevant practitioners.
- Information you receive must not be shared outside of the professional environment.
- Deal with all the information that you receive in accordance with the data protection principles.

Chapter 6: Adult Safeguarding under the Social Services and Well-being (Wales) Act 2014

Introduction

Before the Social Services and Well-being (Wales) Act 2014 (SSW(W)A 2014) adult safeguarding (or protecting vulnerable adults) relied on In Safe Hands, which was statutory guidance. Although this guidance recognised the importance of agencies working together and sharing information, it was recognised as being no longer fit for purpose. A new approach was therefore required to make sure, amongst other things, that adult safeguarding complied with the European Convention on Human Rights (ECHR). Whilst the Law Commission recommended that local authority social services should have the lead co-ordinating responsibility for adult safeguarding, including a duty to 'investigate', it left it to the Welsh and Westminster governments to decide whether any new legislation should include powers of compulsion, such as those in the Adult Support and Protection (Scotland) Act 2007.

Placing adult safeguarding on a statutory basis is an important achievement as it is now on a par with child protection. However, the experience and knowledge gained by adult safeguarding practitioners working within In Safe Hands should not be lost. The SSW(W)A 2014 provides a statutory framework and as with all legislation it does not give practitioners easy answers but provides a context within which professional judgements are made and implemented. Professional experience and good decision making are as important as they always have been.

The inherent jurisdiction

Before outlining the SSW(W)A 2014 it is worth noting the inherent jurisdiction of the High Court. The inherent jurisdiction is a principle of law that a superior court can hear any matter that comes before it, unless a statute or rule limits that authority or grants exclusive jurisdiction to some other court or tribunal. It is a form of default jurisdiction which may be useful in safeguarding cases.

As discussed in Chapter 3, before the Mental Capacity Act 2005 (MCA 2005) the judges developed the law on capacity and best interests as there was no legislation and it was necessary to act in order to protect a vulnerable adult. Since the MCA 2005, all capacity cases are dealt with under the Act; the inherent jurisdiction has been displaced in relation to capacity. However, there are other groups of people who may have capacity but are vulnerable. The courts have developed the inherent jurisdiction to cover vulnerable adults who fall outside of the MCA 2005. In a 2006 case called **Re SA**, Munby J developed the concept of the vulnerable adult. He said:

“A vulnerable adult who does not suffer from any kind of mental incapacity may nonetheless be entitled to the protection of the inherent jurisdiction if he or she is, or is reasonably believed to be, incapacitated from making the relevant decision by reason of such things as constraint, coercion, undue influence or other vitiating factors.”

An example of the use of the inherent jurisdiction in cases where capacity is not an issue is the 2012 case of **A Local Authority v DL**. The case involved an older couple, who both had mental capacity but were subject to coercive and controlling behaviour by their son. The court held that it could use the inherent jurisdiction to help ‘liberate the autonomy’ of the vulnerable older couple, something confirmed in later cases where the Court of Appeal held that this was compatible with Article 8 of the ECHR right to a private life. It enabled the couple to enjoy this right without being controlled by their son.

The use of the inherent jurisdiction is possible in safeguarding cases if there is a gap in the legislative framework. If the facts fall within the MCA 2005, the Mental Health Act 1983 or the SSW(W)A 2014 then it cannot be used. Law made by Parliament or the Assembly is supreme. However, outside of the statutory framework, the inherent jurisdiction may be available in high risk cases.

An overview of safeguarding under the SSW(W)A 2014

Part VII of the SSW(W)A 2014 imposes a duty on local authorities to make enquiries, or cause them to be made, when they have reasonable cause to suspect that an ‘adult at risk’ is experiencing (or at risk of) abuse or neglect. Section s.126(1) defines adult at risk; it is linked to the adult’s need for care and support under the SSW(W)A 2014. Upon completion of the enquiries, the local authority must decide what, if any, action to take.

To support the safeguarding process, the SSW(W)A 2014 introduces a new order called an Adult Protection and Support Order (‘APSO’). This allows an ‘Authorised Officer’ to enter premises to assess whether an adult is an adult at risk and in need of support. An APSO is made by a justice of the peace upon an application by the Authorised Officer. The SSW(W)A 2014 specifies the conditions, purposes and the procedure for applying.

All local authorities and ‘relevant partners’ have duties to report cases of suspected abuse and neglect to the appropriate local authority. Section 162(4) defines ‘relevant partner’. It covers police, other local authorities, the Secretary of State, probation, Health Boards, NHS Trusts, Welsh Ministers, and any others included in regulations.

The SSW(W)A 2014 establishes a National Independent Safeguarding Board to give support and advice, as well as six regional Safeguarding Boards for adults and for children. Practitioners can identify their own regional board using the interactive map at <http://safeguardingboard.wales/find-your-board/>. The SSW(W)A 2014 includes the possibility of combining children and adult boards.

These are the specific reforms introduced by the SSW(W)A 2014 found in **Part VII – Safeguarding: Adults at Risk**. However, safeguarding is not to be compartmentalised. The need to safeguard adults at risk is pervasive throughout the social care provisions in the SSW(W)A 2014. This resonates with the message that safeguarding is everybody’s concern and not just the concern of safeguarding teams.

To support the operation of the SSW(W)A 2014, the Welsh Government published statutory guidance, Social Services and Well-being (Wales) Act 2014 – Working Together to Safeguard People. Practitioners should be familiar with the following Volumes:

- Introduction and Overview (Guidance Volume 1)
- Adult Protection and Support Orders (Guidance Volume 4)
- Handling Individual Cases to Protect Adults at Risk (Guidance Volume 6)

Volumes 2, 3 and 5 deal with Child Practice Reviews, Adult Practice Reviews and Handling Individual Cases to Protect Adults at risk. These are outside the scope of this Guidance.

Definitions

Adult: The SSW(W)A 2014 defines an ‘adult’ as a person aged 18 years or over (s.3(2)).

Abuse: The SSW(W)A 2014 and the Guidance define ‘abuse’ as:

**‘physical, sexual, psychological, emotional or financial abuse’
(s.197(1))**

The Guidance gives examples of abuse or neglect:

- physical abuse - hitting, slapping, over or misuse of medication, undue restraint, or inappropriate sanctions.
- sexual abuse - rape and sexual assault or sexual acts to which the vulnerable adult has not or could not consent and/or was pressured into consenting.
- psychological abuse - threats of harm or abandonment, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks, and coercive control, (coercive control is an act or pattern of acts of assault, threats, humiliation, intimidation, or other abuse used to harm, punish or frighten the victim).
- neglect - failure to access medical care or services; negligence in the face of risk- taking; failure to give prescribed medication; failure to assist in personal hygiene or provide food, shelter, clothing; and emotional neglect (Guidance Volume 1, para 26).

Abuse can take place in any setting; it may be in a person’s home, an institution, or any other place.

Adult at risk: Section 126(1) defines an ‘adult at risk’ as follows:

An ‘adult at risk’ is an adult who:

- i. is experiencing or is at risk of abuse or neglect,
- ii. has needs for care and support (whether or not the authority is meeting any of those needs), and
- iii. as a result of those needs is unable to protect himself or herself against the abuse or neglect or the threat of it.

The definition includes a person at risk of abuse or neglect. Early intervention and prevention are essential: there is no need to wait for abuse or neglect to happen.

The definition does not include self-neglect. People who self-neglect may be eligible for an assessment of their need for care and support, although they have a right to refuse depending on certain conditions being met. (see s.20).

When assessing whether a person is an adult at risk of abuse or neglect, practitioners must have regard to the:

- frailty or vulnerability of the adult at risk;
- extent of the abuse or neglect;
- length of time and frequency of its occurrence;
- impact on the person; and
- risk of repeated or escalating acts involving this person or others. (Guidance Volume 1, para 25).

Financial abuse: This includes having money or other property stolen, being defrauded, put under pressure in relation to money or property or having money or other property misused (s.197(1)). The Guidance provides possible indicators of the financial abuse of people needing care and support:

- unexpected change to their will;
- sudden sale or transfer of the home;
- unusual activity in a bank account;
- sudden inclusion of additional names on a bank account;
- signature does not resemble the person's normal signature;
- reluctance or anxiety by the person when discussing their financial affairs;
- giving a substantial gift to a carer or other third party;
- a sudden interest by a relative or other third party in the welfare of the person;
- bills unpaid;
- complaints that personal property is missing;
- a decline in personal appearance that may show that diet and personal requirements are being ignored; and
- deliberate isolation from friends and family giving another person total control of their decision-making (Guidance Volume 1, para 26).

Local authority: A local authority means 'the council of a county or county borough in Wales'. (s.197)

Neglect: The SSW(W)A 2014 defines neglect as:

'... a failure to meet a person's basic physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being (for example, an impairment of the person's health...).' (s.197)

Examples of neglect given in the Guidance include:

‘...failure to access medical care or services, negligence in the face of risk-taking, failure to give prescribed medication, failure to assist in personal hygiene or the provision of food, shelter, clothing; emotional neglect.’ (Guidance Volume 1, para 26).

(This is a non-exhaustive list)

Reasonable cause to suspect: The phrase ‘reasonable cause to suspect’ features in s.126 (‘adults at risk’ and the duty to make enquiries), s.127 (APSOs), s.128 (duty to report adults at risk) and s.130 (duty to report children at risk). This is a low standard of proof. It does not require establishing the fact on a balance of probabilities, even less beyond all reasonable doubt. Whilst certainty is not required, there must be information available that would satisfy an objective observer that the fact or facts exist. In supporting a reasonable cause to suspect, practitioners must summarise the information underlying their assessment, explain why he or she considers objectively that it meets the threshold for intervention, and prepare a short statement of the risks for the adult if nothing is done. (Guidance -Volume 1, para 84).

Relevant partner: Although aimed at social services, the SSW(W)A 2014 imposes some duties on ‘relevant partners’. A relevant partner is defined as:

- the local policing body and the chief officer of police for a police area within the local authority area;
- any other local authority with which the authority agrees that it would be appropriate to co-operate;
- the Secretary of State regarding his or her functions under sections 2 and 3 of the Offender Management Act 2007 in relation to Wales;
- any provider of probation services that is required by arrangements under section 3(2) of the Offender Management Act 2007 to act as a relevant partner of the authority;
- a Health Board for an area within the area of the authority;
- an NHS trust providing services in the authority’s area;
- the Welsh Ministers when discharging functions under Part 2 of the Learning and Skills Act 2000; and
- such a person, or a person of such description, as regulations may specify. (s.162(4)).

Safeguarding within the broader context of the SSW(W)A 2014

One of the general functions of local authorities under the SSW(W)A 2014 is the duty to ‘seek to promote’ the well-being of people who need care and support and carers who need support (s.5(a) & (b)). Although this is a general duty rather than an individual one, it is important to ensure that everyone’s well-being is promoted. ‘Well-being’, as defined by the SSW(W)A 2014, includes protection from abuse and neglect. In addition, the other elements of the well-being definition in s.2(2) of the SSW(W)A 2014 are affected if the person is experiencing abuse or neglect, such as physical, mental and emotional well-being. Similarly, domestic and family

relationships, securing rights and entitlements, and suitability of living accommodation are all adversely affected if the person is being abused. Being safe is a key part of well-being and central to the SSW(W)A 2014's philosophy; it is a human right.

Another general function of a local authority under the SSW(W)A 2014 is to provide or arrange provision of a range of preventative services (s.15). Included in the list of possible services are those designed to prevent people from suffering abuse or neglect. Part 2 of the Code of Practice (General Functions) states that prevention is at the heart of the Welsh Government's programme of change for social services (para 155). Although social services are the key agency in providing preventative services, Part 2 emphasises that the culture must be embedded across the whole local authority including environment, transport, housing, education and leisure. Although the duty to provide rests on local authorities, the SSW(W)A 2014 requires that Health Boards 'have regard' to the importance of preventative services (s.15(5)).

Local authorities have a duty to assess a person where it appears he or she has needs for care and support (s.19). To address an earlier uncertainty in the law, s.20 clarifies that an adult may refuse an assessment. However, that right to refuse may be overridden, where the local authority suspects that the person is experiencing or at risk of experiencing abuse or neglect (s.20(3)). In such a case, the duty to assess remains, although the ability to do the assessment can be compromised by the adult's presenting unwillingness to take part. Coercive or controlling behaviour by the harmer may prevent the person making an independent and informed decision.

Section 32 of the SSW(W)A 2014 introduces statutory eligibility criteria. The details of the criteria are found in the **Care and Support (Eligibility)(Wales) Regulations 2015**. Where the local authority is satisfied that an adult has needs for care and support, it must decide whether those needs meet the eligibility criteria. The first requirement of the criteria is that the need arises from the adult's physical or mental health, age, disability, alcohol or drug dependency, or similar circumstances. Secondly, the need must relate to one of seven factors, which include protection from abuse or neglect. Thirdly the adult must not be able to meet the need either alone, with the care and support of willing others, or with help from community services. Finally, the adult must be unlikely to achieve one or more personal outcomes without local authority support. Abuse and neglect are an integral part of the eligibility criteria.

If the local authority decides it is necessary to meet the needs of the person in order to protect them from harm or abuse, or neglect, it is unnecessary to apply the eligibility criteria. It must not be applied if it would cause delay in responding to a safeguarding concern. A local authority must meet those needs which it considers necessary to protect the adult. This is an overriding duty and applies irrespective of any application of the eligibility criteria. (Social Services and Well-being (Wales) Act 2014: Part 4 Code of Practice (Meeting Needs, paras 38-39).

Duty to make enquiries – s.126

If a local authority 'has reasonable cause to suspect that a person within its area (whether or not ordinarily resident there) is an adult at risk', it has a duty to make, or 'cause' to be made, enquiries. The following points should be noted:

- **The threshold for engaging the duty is 'reasonable cause to suspect'**. As noted above, this does not need irrefutable knowledge that abuse occurred, or that there is convincing evidence it occurred. The question is whether the facts known to the local authority would cause a reasonable person, knowing the same facts, to reasonably

conclude that the adult is an adult at risk.

- **The duty applies to any person physically present within the local authority area.** It does not matter whether they are ordinarily resident. So, for example, a person living in holiday accommodation is covered. However, if the person is ordinarily resident in another local authority area and their presence is only transient, the s.128 duty to report to his or her ordinarily residence authority may be considered more appropriate, unless there is an immediate need to intervene.
- **The duty is to make ‘enquiries’.** It is not a duty to investigate. Enquiries are information gathering and not full-scale investigations.
- **The local authority may make the enquiries or may ask another person or organisation to do so.** If somebody else conducts the enquiry, the local authority is still responsible, and it is not relieved of its duties under the SSW(W)A 2014: This includes any duties it has in relation to the appointment of an advocate. The local authority decides the nature of the enquiries they are asking others to undertake. A relevant partner may undertake the enquiry if it is thought more appropriate, such as where health expertise could be helpful. As a relevant partner, they must comply unless it would be outside their remit. A third sector organisation could undertake the enquiry if thought appropriate.

The enquiry

It is important to identify the date on which the local authority feel that the duty to make enquiries is triggered. The local authority should record the reasons for the enquiry and the form it is taking. Normally an enquiry should be completed within seven days of that date, but sometimes it may take longer. In such cases, the reason for the additional time should be recorded and this information may assist Adult Safeguarding Boards in monitoring performance. The Guidance emphasises that enquiries should not be rushed, but delay should be avoided wherever possible.

The form enquiries take should be whatever the local authority ‘thinks necessary to enable it to decide whether any action should be taken and ... if so, what and by whom.’ An enquiry must be proportionate to the level of concern and be compliant with the ECHR (Guidance Volume 1, para 38). If it is clear at an early stage of the enquiry that the person is not an adult at risk, then it must end, and that decision must be recorded. However, the person may need other services that are available, or may need signposting to third sector providers.

The Guidance refers to three phases of an enquiry:

1. screening – to check general factual accuracy of the referral;
2. initial evaluation – collecting reviewing and collating information; and
3. determination – given the outcome of the above, what, if anything, should be done?
This may include a single or multi-agency investigation (Guidance Volume 1, para 39).

It is important to consider what an enquiry should cover. One important issue is whether the person thought to be an adult at risk agrees to take part. If he or she refuses, they cannot be compelled; there are no powers of compulsion. This does not, however, relieve the local authority of its duty. Unlike a refusal of an assessment for social care (other than where abuse

or neglect is suspected or there is incapacity), refusal to take part does not end the duty. However, the ability of the local authority to fulfil its duty will be compromised by a refusal.

Unfortunately, the refusal may result from coercive conduct by the harmer. The fact that the duty remains in place may be helpful in trying to identify whether coercion is present. Coercive control in an intimate or family relationship may now amount to a criminal offence under s.76 of the Serious Crime Act 2015. An APSO may be appropriate in cases where there is serious cause for concern about the adult and access to them is being refused by the suspected harmer.

Besides consent or refusal, the Guidance lists several factors that should be considered when undertaking an enquiry. These are:

- the wishes and feelings of the adult at risk;
- the possibility that the adult thought to be at risk is not making decisions freely;
- whether there is a need to involve an advocate under any statutory or voluntary advocacy scheme;
- the need to carry out the enquiry sensitively and with the minimum distress to the person and others (for example, carers and family members);
- whether the harmer has any needs for care and support;
- whether the harmer is providing care or support for another adult at risk or child who may be at risk; and
- the need for the local authority to work closely with and involve other agencies who may assist with the enquiries and contribute to achieving the identified outcomes of the enquiries. (Guidance Volume 1, para 38)

Relevant partners must share information as part of their safeguarding responsibilities, including enquiries. (s.128). A failure to share is a common criticism found in reports from Serious Case Reviews and the law recognises information sharing in safeguarding cases is important. Paragraphs 28 and 29 of the Guidance provide guidance on how and when information should be shared and who should be consulted (Guidance Volume 1). The Data Protection Act 2018, the General Data Protection Regulation and the common-law duty of confidentiality accept that there may be a compelling public interest in sharing sensitive personal information (see Chapter 5) and the protection of adults at risk and of children from abuse, neglect or harm provides justification for sharing. Information should be shared under the Wales Accord on the Sharing of Personal Information (WASPI), an information sharing framework for the public, independent and third sectors.

The Statutory Guidance requires that the report of an enquiry should include the following:

- the identities of the individual who identified the concern and the individual who took the decision to start the enquiry;
- the identity and relevant details of the person who is the subject of the enquiries;
- a summary of the evidence on which the 'reasonable cause to suspect' was founded;

- the identity of the person or persons and, if relevant, the agency who conducted the enquiries;
- the chronology of the enquiries;
- a list of people who supplied information during the enquiries;
- a list of people interviewed during the enquiries;
- a list of documentary evidence reviewed during the enquiries;
- statement that those making the enquiries consider that the person is or is not an adult at risk. Where the finding is that the adult is not an adult at risk, a statement should be included saying why this conclusion was reached. Consideration should be given to identifying any future concerns that may arise and the need for Information, Advice and Assistance;
- a statement on whether an assessment under the MCA 2005 or the MHA 1983 has been or should be carried out. If such an assessment has been carried out, the outcome should be included in the record; and
- a statement of the findings of the enquiries that led to the conclusion (if that is the case) that the adult is an adult at risk (Guidance Volume 1, para 42).

The report should also include a record of any abuse that the person may be experiencing together with any supporting evidence including the following:

- nature of the abuse;
- length of time the person has been subjected to abuse;
- wishes and feelings of the adult at risk;
- frequency and intensity of the abuse;
- alleged harmer and the relationship, if any, to the adult at risk;
- impact of the abuse on the adult at risk;
- any other person in the household who may be an adult at risk or a child;
- whether the alleged harmer provides care and support for the adult at risk or for any other known adult at risk. If so, the nature and intensity of such care;
- the nature of any support and help the adult at risk may receive from a carer or relative other than the alleged harmer;
- the identity of any other agencies or third sector organisations who are aware or involved in working with the adult at risk; and
- such other matters as those making the enquiries consider should be included in the care and support plan.

It is essential that the conclusion to the report states whether the person is an adult at risk and, if so, what action should be taken, when, and by whom.

Where a local authority has a duty to meet care and support needs under the SSW(W)A 2014, it must prepare a care and support plan (s.54). The SSW(W)A 2014 requires that the conclusions of any enquiries must be recorded in the adult's care and support plan (126(3) and Regulations made under s.54 (the Care and Support (Care Planning) (Wales) Regulations 2015) confirm that the plan must contain a record of the conclusion of any enquiry. This is re-emphasised in paragraph 87 of Part 4 of the Code of Practice (Meeting Needs). Where a care and support plan has been refused, or is not required as needs can be met through other means, the finding should still be recorded in the case record. The Care Plan may also incorporate any protection plan in place.

Adult Protection and Support Orders – APSOs

During the debate on the Social Services and Well-being (Wales) Bill, there was discussion on the extent to which adult safeguarding should include powers of intervention. Should powers of access and powers of removal be included? The Adult Support and Protection (Scotland) Act 2007 includes extensive powers of intervention alongside necessary safeguards to avoid their misuse or abuse. The Welsh Government resisted calls to include powers of removal in the original Bill, emphasising the importance of an individual with capacity being able to make his or her own decision and the need, in their view, not to override human rights. The Law Commission recommended the repeal of s.47 National Assistance Act 1948, thereby getting rid of the only power of compulsory removal.

The National Assembly's Health and Social Care Committee, in its **Stage 1 Committee Report** on the Bill, tentatively suggested that s.47 National Assistance Act 1948 should be retained if powers were not included in the Bill, but retention of s.47 in its original form would have caused significant problems regarding compliance with the European Convention on Human Rights. In response, the Government agreed to include a power of entry, namely the APSO. The power is found in s.127 of the SSW(W)A 2014. Interestingly, no similar provision is included in the English Care Act 2014.

As will be seen, an APSO has a specific set of purposes and these do not include a power to remove or ban an individual from the premises. Consideration should therefore be given to using some of the civil law domestic violence orders. These may be used instead of an APSO, or as part of action to be taken following the APSO. (See Chapter 9)

It was anticipated that APSOs will not be used that often and this has been the case to date. As they are an intrusion in a person's home, they must be proportionate to the objective being sought; a complex judgement is required of the Authorised Officer and justice of the peace on whether an order could leave the adult at greater risk.

What is an APSO?

An APSO is a civil order made by a justice of the peace after an application is made by an 'Authorised Officer'. It gives the Authorised Officer a power of entry, but only for the purposes listed in the SSW(W)A 2014.

The 'Authorised Officer'

The Authorised Officer plays a central role in applying for and carrying out an APSO. Responsibility for the APSO are placed on the Authorised Officer and not on the local authority. The role is a designated one and they have a degree of independence. The Adult Protection and Support Orders (Authorised Officer) (Wales) Regulations 2015 require that an Authorised Officer has completed 'appropriate training', although the nature of the training is not specified. However, the Guidance, (Guidance Volume 4) lists skills and attributes that should form the basis of a training programme:

- the ability to prepare and present, with legal assistance, an APSO application clearly and confidently to a justice of the peace;
- an understanding of the legal framework within which APSOs operate, including the implications of the Human Rights Act 1998, the Equality Act 2010, and the need to respect diversity;
- the ability to assess any risk to the person suspected of being an adult at risk before making the application and, if an APSO is made, once it has been executed;
- a high level of understanding of the context of abuse, abusive situations and neglect;
- an ability to identify coercive control and its effects on adults at risk;
- a clear understanding of the provisions of the MCA 2005 in particular assessments of capacity, best interests' assessment and the role of the Independent Mental Capacity Advocate;
- effective communication skills and the ability to identify any special communication needs that the person suspected of being at risk may have, and how their ability to communicate their wishes may be enhanced;
- the ability to be assertive and exercise control in difficult and challenging situations;
- the ability and willingness to challenge their own agency and other agencies when necessary; and
- an awareness of when an advocate is required and how to support the adult to secure an advocate (para 1.9).

As well as training and the possession of these skills and attributes, other restrictions are imposed on who may be an Authorised Officer. Normally, the Authorised Officer must be an officer of the local authority in whose area the suspected adult at risk is living. However, if that is not practical (for example, for reasons of illness or annual leave) an Authorised Officer from a local authority in the same Safeguarding Board area may act. If that is not practical, an Authorised Officer from another local authority in Wales may act. It must be emphasised that the above is a hierarchy; the expectation is that it will be the Authorised Officer from the local authority in whose area the person is living will act. In the highly unlikely event that appointing any of the above is not practical, the regulations require that an officer from the authorising local authority should be appointed, even though they will not have been trained.

Grounds for making an APSO

The justice of the peace must be satisfied,

- the Authorised Officer has reasonable cause to suspect that a person is an adult at risk;
- it is necessary for the Authorised Officer to gain access to the person to properly assess whether they are an adult at risk and to decide on what, if any, action should be taken;
- making an order is necessary to fulfill the purposes of an APSO; and
- exercising the power of entry will not result in the person being at greater risk of abuse or neglect. (s.127(4)).

It should be more than simply desirable or convenient to obtain an APSO. It must, in the words of the Guidance, be 'unavoidable or essential'. One of the most difficult judgements to be made firstly by the Authorised Officer and then the justice of the peace is that exercising the power of entry will not result in the person being at greater risk. Given the need for an APSO, it may not be possible to give satisfactory evidence to the justice of the peace that this is the case. (Guidance Volume 1, para 66).

What are the specified purposes of an APSO?

Section 127(2) of the SSW(W)A 2014 lists the three purposes of an APSO:

1. **To enable the Authorised Officer and any other person accompanying the officer to speak in private with person suspected of being an adult at risk.** As noted below, the role of the constable goes beyond gaining entry. The constable may be involved in enabling the interview to take place in private if the suspected harmer is obstructive.
2. **To enable the Authorised Officer to ascertain whether that person is making decisions freely.** Coercive or controlling behaviour is a feature of abuse. The Authorised Officer must assess whether the adult suspected of being at risk is deciding freely without any direct or indirect pressure from the suspected harmer. Practitioners must also guard against exerting pressure on the person to do something. It is always important to remember that this will be a stressful occasion for all concerned and there is always a risk that a practitioner may unintentionally suggest something the adult feels obliged to accept. Advocates can play an important role in enabling the adult to make their decision freely.
3. **To enable the Authorised Officer to properly assess whether the person is an adult at risk, and to make a decision on what, if any, action should be taken.** Section 126(2) imposes a duty on local authorities to decide whether action should be taken following the making of enquiries. Although it is not clear from the SSW(W) A 2014, local authorities should record the outcome of an APSO on any care and support plan in the same way.

Once these purposes have been achieved, the justification for the order disappears.

Preparation for an APSO

In deciding whether to make an application, an Authorised Officer should discuss with the local authority's legal department how to prepare the case, the nature of the evidence required, and the giving of evidence at the hearing.

The intrusive nature of an APSO, and the potential for it to place the adult at greater risk, calls for very careful planning ahead of the application; liaison with the police is essential to ensure clarity around what their role will involve - will they enter the premises, or simply be on hand if needed? The police may also have information to support the application, which should be shared with the Authorised Officer and the justice of the peace. However, planning should not be confined to the police. Housing, education, the Fire and Rescue Service, children's services, environmental health and other individuals and agencies may have helpful information. As noted above, s.128 imposes a duty on relevant partners to report to the local authority if they have reasonable cause to suspect that an adult at risk appears to be within the authority's area.

Those involved in the APSO must understand its purposes and their role in the process. Roles should be identified ahead of time, although these may have to change depending upon what is found upon entry. One useful suggestion in the Guidance is for the Authorised Officer to draw up a balance sheet identifying risks and benefits. This may be a useful exercise for the Authorised Officer and the justice of the peace. (Guidance Volume 1, para 63).

What is included in an APSO?

An APSO must specify the premises to which it relates. 'Premises' are not defined in the SSW(W)A 2014. However, a broad definition is found in the guidance on APSOs. 'Premises' include:

- domestic premises – a house, flat or similar;
- residential care homes;
- nursing homes;
- hospitals; or
- any other buildings, structures, mobile homes or caravans in which the person is living. (Guidance Volume 4, para1.13).

This is a wide definition and it is important to note that it includes care homes, nursing homes and hospitals. The person need not be permanently living in the premises. It is enough if he or she has lived there for a period and it does not matter whether they have any legal interest in the premises. It is also important to note that the definition does not include secure premises, prisons or youth detention accommodation. (s.185(6)).

The APSO must include a condition that the Authorised Officer may be accompanied by a police constable. Prior knowledge may suggest that a constable's presence will not be necessary; if so, the reasons must be recorded.

Police involvement may or may not be critical; it depends on individual circumstances. Any police involvement is not confined to gaining entry. Section 127(7) of the SSW(W)A 2014 says they are there to enable all the purposes of the APSO to be fulfilled, and not just obtaining entry.

So, for example, the police constable may be called upon to make sure that the Authorised Officer can speak in private to the person, perhaps by getting the alleged harmer to leave the premises while the assessment is underway. It also includes ensuring that the person is speaking freely and not being intimidated by the alleged harmer. The police constable may use 'reasonable force if necessary' to ensure that the purposes of the APSO are fulfilled.

The APSO should also specify the period it is to be in force, although no specific time limits are mentioned in the SSW(W)A 2014 or Guidance. The duration must be proportionate and not extend beyond the time necessary for the purposes of the APSO to be achieved. An APSO cannot give an ongoing power of entry held in reserve to be used at some future unspecified time.

It is not clear from the SSW(W)A 2014 whether APSOs can authorise more than one entry. The Guidance takes a broad interpretation and presupposes that more than one entry under a single APSO is allowed, which makes sense for several reasons. At the time of making the application and granting of the APSO it may be unclear whether the suspected adult at risk has any communication needs, requires a mental capacity or mental health assessment, or has any special need arising out of a disability or otherwise; this may only become apparent after the initial visit. There is also a discretion to include other conditions. The SSW(W)A 2014 provides examples:

- **Restricting the time at which the power of entry may be exercised:** Given this is not an emergency power, good practice dictates the time of entry is reasonable and appropriate. A strong justification for the power being exercised during the night would be needed. The justice of the peace may impose a specific condition as to timing - for example that it should be exercised in the afternoon. More broadly, the justice may place an overall time limit within which the APSO power must be used. Linked to this is the issue of multiple entries. As noted above, the Guidance assumes that more than one entry is allowed. However, if the justice has concerns about the excessive use of multiple entries, a condition may be included restricting that number.
- **Providing for the authorised person to be accompanied by another specified person:** At the time of the application for an APSO, it may be clear that specialist expertise is necessary to achieve the purposes. For example, the Authorised Officer may be aware the person has a specific communication need, or the person has known mental health needs. It may therefore be sensible to include a condition in the order that the Authorised Officer is accompanied by a specialist practitioner, such as an Approved Mental Health Professional (AMHP). The rationale for including a specialist should be made in the application.

In many cases, it will not be possible to anticipate who should accompany the Authorised Officer as little may be known of the adult. In these circumstances, the Guidance suggests that 'as far as is possible' such people should be identified in the application (Guidance Volume 4, para 2.16). The fact a person is specified in the order does not mean they must be involved. It may become clear after the first visit that they are not required. Examples of people who may be included in the order include:

- the key worker (social worker or health care worker);
- domiciliary care worker;
- advocate (statutory or non-statutory);

- family member or close friend;
- best interest assessor;
- general practitioner; or
- AMHP under the MHA1983. (Guidance Volume 4, para 2.15)

This is not an exhaustive list and the role of those who accompany the Authorised Officer will vary depending upon individual circumstances. The Guidance anticipates that their roles will include ensuring that any interview with the person suspected of being at risk is conducted fairly, assisting with communication, providing expert knowledge and experience on specific matters, advocating for the person, sharing their knowledge of the person, and building a rapport with the person. An advocate may also be needed. Specialist advocates include Independent Mental Capacity Advocates, Independent Mental Health Advocates, Independent Domestic Violence Advisors and non-statutory advocates. They may play a crucial role in ensuring that the adult can express their feelings and wishes. (Guidance – Volume 1, paras 76-7).

It will not always be possible to identify what expertise will be required ahead of time. It may transpire after the first visit that highly specialised expertise is required, which was not anticipated at the time of the application. Under s.127, the power of entry is restricted to the Authorised Officer and a constable, and to ‘any other specified person accompanying the officer in accordance with the order’. Does this restrict the persons who may accompany the Authorised Officer to those mentioned in the APSO? Whilst it suggests that the power to enter is restricted to those identified on the order, there is no reason why on a later visit an additional person could not go with the Authorised Officer with the consent of the occupier. If consent is refused, the lawful basis for the additional person’s entry to the property is unclear and Authorised Officers should be aware of the possible need to negotiate entry of a person not named in the order.

Granting a power of entry is a serious matter and principles of natural justice should apply insofar as they are not inconsistent with a person’s safety. Consideration should therefore be given to giving notice to the occupier(s) of the premises and the adult suspected of being at risk that an application is being made for an APSO.

Annex B to the Guidance Volume 4 includes the application form for an APSO. Applicants are required to state why notice to the occupier and person suspected of being at risk is or is not given. Any concern that notice would expose the adult suspected at being at risk of further harm is a reason to withhold it. The Guidance requires that the rationale for the decision is outlined on the form. An Authorised Officer must consider what type of notice should be given if it is thought necessary and be assured that it will not expose the adult to further risk or interfere with the assessment. Notice may be written, via telephone or face-to-face (Guidance Volume 1, para 68).

Implementation of the APSO

Before using the APSO, it is essential that consideration is given to the exit strategy. The absence of powers of removal or banning orders mean that it is likely that, if the person is an adult at risk, they will stay in the premises with the harmer. As far as it is possible, consideration must be given ahead of time to the information given to those affected by the APSO, and what will happen next. The safety of the adult is the priority. Decisions on action to be taken must be made quickly where the adult is identified as being at risk following the APSO. In the extreme,

the police may be able to use their powers of arrest, but it should not be assumed that this will always be possible. Indeed, it is unlikely other than in high risk cases. The powers available to the police include s.17(1)(e) and s. 24 Police and Criminal Evidence Act 1984, common law powers such as arrest for breach of the peace and a Domestic Violence Protection Order under the Crime and Security Act 2010.

The SSW(W)A 2014 requires that on entering the premises the Authorised Officer must state the object of the visit, produce evidence of the APSO, and explain to the occupier how to complain about the exercise of the power.

The APSO will likely be just the beginning of safeguarding intervention. It may lead to the revision or preparation of a care plan, a formal investigation or police action. On the other hand, there may be no cause for concern, and it may turn out that the reasonable suspicion was unfounded.

At all times, it should be remembered that safeguarding is an integral part of the whole SSW(W) A 2014 and its commitment to well-being.

How should it be used?

The powers and duties under the SSW(W)A 2014 provide the statutory framework for safeguarding and practitioners should be familiar with them. For those working within safeguarding teams, the framework will be foremost.

However, it is important to remember that safeguarding is everybody's concern and that all practitioners should be aware of the framework and feed in any concerns that they may have. The use of APSOs is very rare. This may be because it is difficult for Authorised Officers and justices of the peace to satisfy themselves that an APSO will not place the person at greater risk from a revengeful harmer.

As seen in Chapter 8, other powers of access exist; the safeguarding provisions of the SSW(W) A 2014 are not the complete answer and a lot will depend upon the professional skills and the experience of frontline practitioners. Within the framework, practitioners are required to make difficult judgements. Good teamwork across different disciplines and the sharing of information are therefore essential. All decisions must be underpinned by the HRA 1998. The duty to make enquiries places a very clear responsibility on local authorities to respond to concerns.

What are its limitations?

Arguably the lack of powers of removal or banning orders limit the effectiveness of the SSW(W) A 2014, although this is a contentious point.

Points to remember

- Safeguarding is everybody's business.
- All decisions under the framework must be human rights compliant.
- An interdisciplinary approach is essential.
- Information must be shared.

Chapter 7: Criminal Justice

Introduction

This chapter considers the role of the police and the criminal justice system in the investigation of suspected cases of abuse or neglect. It outlines some of the criminal offences that may have been committed. The chapter also reviews how decisions to prosecute are made and what provision is made for vulnerable witnesses in the courtroom. Criminal prosecutions are not always going to lead to the best outcome, but this does not mean that the police role is unnecessary or that prosecutions are never appropriate. Criminal law options and civil law options should be discussed with the older person.

What does the law say?

The Criminal Law

Many, almost certainly most, cases of abuse and neglect involve criminal behaviour. The fact that it takes place within a family relationship or friendship, and possibly in private space, does not deprive it of its criminal character. An assault in a person's home by a relative is as much a criminal offence as it would be if it took place in the street or in a care home or hospital. It is important to emphasise the criminal nature of abuse or neglect. Doing so means that harmers may face prosecution. It also sends out the message to society that abuse and neglect are unacceptable and criminal.

A crime may be aggravated by the fact that it is driven by hostility or hatred based on personal characteristics. A hate crime is a criminal offence committed against a person or property motivated by an offender's hatred of the victim based on their race, colour, ethnic origin, nationality or national origins, religion, gender or gender identity, sexual orientation or disability. The hate-based nature of the crime is reflected in the sentence. An offence driven by hostility or hatred towards the victim based on age is not a hate crime, although an older person may fall within one of the other categories.

There is a wide range of general criminal offences arising out of abuse and neglect. They include the following:

Behaviour	Legal Basis
Using violence to secure entry to property	s.6(1) Criminal Law Act 1977
Physical violence, with or without weapons	s.39 Criminal Justice Act 1988
Actual bodily harm	s.47 Offences Against the Person Act 1861
Grievous bodily harm	s.18/20 Offences Against the Person Act 1861
Neglecting, abusing or ill-treating an individual whereupon the act has caused serious physical harm or death	s5 Domestic Violence Crime and Victims Act 2004

Using violence or threatening violence to prevent someone from dressing as they choose or forcing them to wear a particular make-up, jewellery and hairstyles	s47 Offences Against the Person Act 1861 s1-2 Protection from Harassment Act 1997
Violence resulting in death	Murder or manslaughter
Threatening with an article used as a weapon	s16 Offences Against the Persons Act 1861 s39 Criminal Justice Act 1988
Offensive/obscene/menacing telephone calls, text messages, letters, emails, online messages	s127 Communications Act 2003 s1 Malicious Communications Act 1988
Harassment and stalking	s1-2A, 4A Protection from Harassment Act 1997
Persistent verbal abuse	s.1-2 Protection from Harassment Act 1997
Locking someone in a room or house or preventing him or her from leaving or preventing someone from seeking aid (for example, medical or social care)	False imprisonment
Tying somebody up	s39 Criminal Justice Act 1988 s 47 Offences Against the Person Act 1861 Common law offence: false imprisonment
Preventing someone from visiting relatives or friends	False imprisonment
Racial abuse	s31 Crime and Disorder Act 1998
Blackmail	s21(1) Theft Act 1968
Threatening to cause criminal damage	s2 Criminal Damage Act 1971
Harming or threatening to harm a pet	s1 and 2 Criminal Damage Act 1971 Animal Welfare Act 2006
Enforced sexual activity	s.1 Sexual Offences Act 2003 – rape Various sexual offences under the Sexual Offences Act 2003

Secret or enforced administration of drugs	<p>s.39 Criminal Justice Act 1988 (common assault)</p> <p>s.47 Offences Against the Person Act 1861 (actual bodily harm)</p> <p>s.18/20 Offences Against the Person Act 1861 (grievous bodily harm)</p> <p>s.23 Offences Against the Person Act 1861 (administering poison)</p> <p>s.67 Medicines Act 1968</p>
Theft, robbery, burglary	Theft Act 1968
Obtaining property by deception	s.2 and 3 Fraud Act 2006

Practitioners should be aware of the range of possible offences they may encounter. The abuse of older people takes many forms and we should avoid the risk of narrowing down the range of available offences.

Some offences are aimed specifically at people who are, for whatever reason, at risk because of their personal situation or a condition that they may be living with. These include the following:

Wilful neglect or ill treatment

Under s.127 MHA 1983 it is an offence for a person employed by a hospital or care home to ill-treat or wilfully neglect a patient receiving treatment for a mental disorder as an inpatient or as an outpatient, within the hospital or home. It is also an offence to ill-treat or wilfully neglect a mentally disordered person subject to guardianship under the Act. The guardian or any other person having custody or care of the patient may commit this offence – there need not be a legal obligation to care.

Under s.44 MCA 2005, it is an offence to ill-treat or wilfully neglect a person who lacks capacity, or whom the harmer reasonably believes to lack capacity. The offence may be committed by somebody who has the care of the person.

The Criminal Justice and Courts Act 2015 (CJCA 2015), following a recommendation by the Francis inquiry into events at Mid-Staffordshire hospital, extends the range of offences of ill-treatment and wilful neglect . It now goes alongside the offences under the MHA 1983 and the MCA 2005 and applies more generally to health and social care services. The CJCA 2015 creates two new offences:

- **The care worker offence:** Under s.20 it is an offence for a person who has the care of another individual as a care worker to ill-treat or wilfully neglect that person. A care worker is defined as a person who is a paid worker providing health care for an adult or a child or provides social care for an adult. Informal or family carers do not fall within the definition. There are some limitations on what is meant by paid work. For example, if somebody

only receives reasonable expenses for caring, they are not a paid worker.

- **The care provider offence:** This offence is intended to hold to account care providers such as owners of care homes. There are three elements to the offence, all of which must be proved for a successful prosecution:
 - that a person who cares for a patient or resident as part of the care provider's arrangements for the provision of health or social care, ill-treats or wilfully neglects that patient or resident;
 - the care provider runs the service in a way that amounts to a 'gross breach' of a legal duty of care owed to the person; and
 - if the breach did not take place, the ill-treatment or wilful neglect would not have taken place, or it would be less likely to have occurred.

The following definitions are helpful:

Ill-treatment: This must be deliberate and may take place through acts or omissions, or both. It is unnecessary to prove that the ill-treatment resulted in actual harm, although normally that would be the case. The offence is aimed at the behavior of the person rather than the consequences. The care worker must either appreciate that their behavior is ill-treatment or be reckless as to whether it is ill-treatment.

Wilful neglect: To be wilful the harmer must either deliberately do the act(s) knowing that there is a risk that the person may suffer harm or does the act(s) not caring whether there such a risk. Neglect includes a failure to provide adequate food, clothing, medical assistance or warmth.

Gross breach: Note that the care provider offence under the CJCA 2015 refers to a 'gross breach' and not just a breach. It is a gross breach 'if the conduct alleged to amount to the breach falls far below what can reasonably be expected of the care provider in the circumstances.'

In all the above, ill-treatment and wilful neglect are two separate offences.

Interestingly, under the CJCA 2015 a person found guilty under the care worker offence may receive a sentence of up to five years or twelve months, depending on which level of court hears the case. A care provider found guilty will receive a fine and possibly either a remedial order or a publicity order.

These offences are aimed at the worst form of treatment within care and health settings and not at failings that are inadvertent without any intention or recklessness. However, such failings must be addressed as part of a lessons learned exercise.

Harassment and putting people in fear of violence

Since its introduction in 1997, the Protection from Harassment Act (PHA 1997) has been amended and new offences have been added. Some examples of the type of behaviour covered by the revised Act are listed above. The Act creates the following offences:

Harassment: This section contains two offences:

1. X must not engage in a course of conduct amounting to harassment of Y if X knows, or ought to know that it is harassment. A 'course of conduct' is conduct towards Y on at least two occasions. Usefully, the PHA 1997 also enables the victim of harassment to take civil action against the harmer. This action is subject to the lower standard of proof required in civil cases – a balance of probabilities rather than beyond all reasonable doubt.
2. X must not engage in a course of conduct involving harassment of two or more people, which X knows or ought to know involves harassment of them, in circumstances where X intends to persuade them either not to do something they are entitled or required to do, or to do something they do not have to do. A 'course of conduct', involves conduct on at least one occasion in relation to each person.

Conduct includes speech. Harassment can involve causing the person alarm of distress. Whether a person 'ought to know' their conduct is harassment is based on whether a reasonable person having the same information would think the course of conduct amounts to harassment – the so called 'reasonable person' test.

Stalking: Under this offence X must have engaged in harassment (see above) and, in addition, the conduct must amount to stalking. Examples of acts that amount to stalking include following a person; contacting or attempting to contact them by any means; loitering in any place; interfering with property in the possession of the person being stalked; and watching or spying on that person. A justice of the peace may give a constable a power of entry to collect evidence for a possible trial.

Putting a person in fear of violence: For this offence there needs to be a course of conduct as defined above. That course of conduct by X must put Y to fear that violence will be used against them. X knows or ought to know that the conduct will cause Y to fear violence. In deciding whether X ought to know the consequences of the conduct, the reasonable person test will again apply.

Stalking involving fear of violence or serious alarm or distress: The course of conduct by X must amount to stalking as defined above. It must either cause Y to fear on at least two occasions that violence will be used against him or her or cause Y serious alarm of distress which has a substantial effect on Y's usual day to day activities. In deciding whether X ought to know the consequences of the conduct, the reasonable person test will apply.

The court can impose a restraining order on a person convicted of an offence under the PHA 1997. This is in addition to any sentence imposed. The order protects the victim from further conduct amounting to harassment or causes fear of violence. Exceptionally, the court can make an order against a person found not guilty when necessary to prevent future harassment. As this may interfere with that person's human rights, the courts have held that it is only used when genuinely necessary to protect another person.

Using these laws provides scope for preventative work. If the harmer is told that their behaviour either causes fear or amounts to harassment, it will place them on a warning. It will be difficult for them to argue that they did not know the consequences of their actions; it may lead to them modifying their behaviour.

Coercive or controlling behaviour

The Serious Crimes Act 2015 (SCA 2015) introduced the offence of coercive or controlling behavior in an intimate or family relationship. Coercive or controlling behavior is a pervasive feature of domestic abuse and the abuse of older people. Even though the evidence may not be strong enough to satisfy the criminal standard of proof, controlling or coercive behavior must always be considered and investigated in all safeguarding cases.

The elements of the offence are:

1. X repeatedly or continuously engages in behavior towards Y that is controlling or coercive;
2. at the time, X and Y are personally connected;
3. the behaviour has serious effect on Y. X's behaviour has a serious effect on Y if it causes Y to fear, on at least two occasions, that violence will be used against Y, or it causes Y serious alarm or distress which has a substantial adverse effect on Y's usual day-to-day activities; and
4. X knows, or ought to know that the behaviour will have a serious effect on Y (the reasonable person test applies in deciding whether X ought to know).

What does 'personally connected' mean? It means one of two things. Firstly, X and Y are in an 'intimate personal relationship'. It is not clear what 'intimate' means in this context. The term is used in other legislation and it is for the courts to decide whether a relationship falls within the definition; it may or may not involve a sexual relationship. Intimate in this sense includes close, personal, and private relationships. It does not include platonic friendships or casual sexual or physical intimacy. Secondly, personally connected has a wider meaning and includes where X and Y live together and are either members of the same family or have previously been in an intimate personal relationship. Family has a wide meaning and includes being married or previously married, being in or previously being in a civil partnership, being relatives, agreeing to marry each other, or having entered a civil partnership agreement.

There is a defence in the SCA 2015. In relation to causing serious alarm or distress which has a substantial adverse effect on day-to-day activities it is a defence to show:

1. X believed that he or she was acting in Y's best interest; and
2. the behaviour in all the circumstances was reasonable.

This defence does not apply where Y is put in fear of violence.

In deciding whether X ought to know that their behaviour would have a serious effect on Y, the test is whether a reasonable person in possession of the same information would know that the behaviour would have a serious effect on someone.

Collecting evidence of coercive or controlling behaviour is complex and it is necessary to look beyond the last incident, which may have been the one that brought the case to the attention of the adult safeguarding team. It involves looking at the history of the relationship and identifying a pattern of behaviour that is controlling or coercive. The prosecution guidance issued by the

Crown Prosecution Service (CPS) provides a non-exhaustive list of the type of evidence that is required:

- Copies of emails
- Phone records
- Text messages
- Evidence of abuse over the internet, digital technology and social media platforms
- Photographs of injuries such as defensive injuries to forearms, latent upper arm grabs, scalp bruising, clumps of hair missing
- 999 tapes or transcripts
- CCTV
- Body worn video footage
- Lifestyle and household including at scene photographic evidence
- Records of interaction with services such as support services, (even if parts of those records relate to events which occurred before the new offence came into force, their contents may still, in certain circumstances, be relied on in evidence)
- Medical records
- Witness testimony - for example the family and friends of the victim may be able to give evidence about the effect and impact of isolation of the victim
- Local enquiries with neighbours, regular deliveries, postal, window cleaner etc.
- Bank records to show financial control
- Previous threats made to children or other family members
- Diary kept by the victim
- Victims account to the police of what happened
- Evidence of isolation such as lack of contact between family and friends, victim withdrawing from activities such as clubs, or the harmer accompanying victim to medical appointments
- GPS tracking devices installed on mobile phones, tablets, vehicles etc.
- Where the harmer has a carer responsibility, the care plan might be useful as it details what funds should be used for

The CPS also suggests that the victims keep a diary of events (ideally in a bound book or timed by keeping an electronic record).

The burden and standard of proof in criminal cases

The presumption of innocence means that the burden (who must prove it) of proving that the accused is guilty of an offence is placed upon the prosecution. Normally, this will be the CPS. The standard of proof (the degree of proof needed) requires that the prosecution case must be proved beyond all reasonable doubt. This is a high standard of proof emphasising the importance of collecting good quality evidence to support the case. Percentages must not be applied by judges when explaining to juries what this test involves. Judges are vague and avoid trying to be specific. One judge (helpfully or otherwise) put it this way:

“The prosecution must make you feel sure beyond reasonable doubt. A reasonable doubt is a doubt that is reasonable. These are ordinary English words that the law does not allow me to help you with, beyond the written directions [he had already given them].” (Mr Justice Sweeney in the trial of Vicky Pryce)

In some situations, the defence in a criminal case has the burden of proof. For example, if the defence wishes to use the defence available under the SCA 2015, it must at least supply some evidence to support a belief that X was acting in Y’s best interests. It is insufficient simply to raise it as a defence without any supporting evidence. Once it has been raised to the satisfaction of the court, the prosecution then has the burden of proving beyond reasonable doubt that this was not the case.

The decision to prosecute

Using the criminal law is not a panacea; on its own it will not end abuse, but it has a role. Building a prosecution case often involves social care practitioners collecting evidence for the criminal proceedings. At some stage, they must cross the line from therapeutic to forensic work and this change in role must be recognised.

The decision to prosecute is taken by the CPS following an investigation by the police. The CPS will review the evidence. The CPS is one of the agencies involved in the safeguarding process. Although prosecution is not appropriate in all cases and a sensitive judgment is required, older victims of abuse are entitled to the protection of the criminal law; the right to justice is a human right.

When reviewing the evidence and deciding whether to prosecute, the CPS use a two-stage test, known as the Full Code Test.

Stage 1

The evidential test: is there sufficient evidence to provide a ‘realistic prospect of conviction’? The admissibility and reliability of the evidence is assessed. Will the witness ‘stand up at trial’? The assumption that all older people make bad witnesses because of perceived frailty, poor memory, borderline capacity or simply older age is ageist. Any unjustified assumptions about the ability of the individual to present evidence must be challenged. Many older people make good witnesses. Whilst they may not enjoy the process (witnesses rarely do) and it may cause them some stress, that is not in itself a reason for denying them justice under the criminal justice system.

Stage 2

Is a prosecution needed in the public interest? Do the public interest factors against prosecution outweigh those in favour? In deciding this, the circumstances of the older person are relevant. Where the victim is vulnerable, it is more likely that a prosecution is required in the public interest. This is particularly so where the harmer was in a position of trust. The CPS Code requires prosecutors to consider whether the offence was motivated by any form of discrimination based on, for example, disability or age. Consideration must also be given to the possibility that a prosecution may have an adverse effect on the victim’s physical or mental health, but this must be measured against the seriousness of the offence. The views of the victim and his or her family should be considered where appropriate. Although the CPS considers the views of the victim and family, it has a broader public duty to enforce the law; decisions to prosecute are therefore complex.

If a person is to give evidence in court, they must be a 'competent witness'. The test of competence states:

'(A) person is not competent to give evidence in criminal proceedings if it appears to the Court that they are unable to understand questions put to them as a witness and give answers to them which can be understood.' (Section 53(3) Youth Justice and Criminal Evidence Act 1999)

Competence and mental capacity are different things. A person who lacks mental capacity for certain decisions may be a competent witness and able to understand questions put to them and provide understandable answers. The CPS should involve social and health care practitioners at an early stage of any competency decision. Again, unsubstantiated assumptions must be challenged. Such discussions will also be an opportunity to identify any special measures that may help the person give evidence. These are discussed below. Health and social care practitioners should also be proactive in providing the CPS with information.

Recently updated guidance on prosecuting crimes against older people has been published by the CPS and can be found at <https://www.cps.gov.uk/publication/policy-guidance-prosecution-crimes-against-older-people-0>

The criminal justice system

Once a decision to prosecute is taken, it is important to consider how the older person can be best supported through the process. Practitioners involved in the investigation (collection of evidence, interviewing the older person or providing witness statements) must be careful not to compromise the case by being accused of coaching the witness. Voluntary groups, such as Victim Support, provide support and an advocate may also be helpful. In preparing for court, practical problems must be resolved, such as how the older person is going to get to the court and whether the court is easily accessible if there are problems with mobility. In addition, the older person will probably never have given evidence before and will need information on what is going to happen.

For most people, giving evidence in court is hard and stressful. In recognition of the fact that some people may be especially vulnerable when giving evidence, 'special measures' were introduced to support some groups of witnesses. However, any support must be balanced against the defendant's right to a fair trial and this must be respected when any support is given to witnesses; it is a question of balancing the rights of the witness with the rights of the defendant.

For some time special measures were available to assist children to give evidence in criminal proceedings. The Youth Justice and Criminal Evidence Act 1999 (YJCEA 1999) extended these to some adults. Special measures are available to eligible adults when presenting evidence at criminal trials where their vulnerability may affect the quality of their evidence. The special measures are not available to all adults. Very importantly, they are not available to a defendant.

Before the court grants permission to use them, the witness must meet the conditions in the YJCEA 1999. An older person may be eligible for special measures in the following circumstances:

Vulnerable witnesses: Where the court decides that the quality of the evidence is likely to be diminished because:

- the person has a mental disorder within the MHA 1983, or has some other significant impairment of intelligence and social functioning; or
- the person has a physical disability or is suffering from a physical disorder.

OR

Intimidated witnesses: Where the court concludes that the quality of the evidence is likely to be diminished by reason of fear or distress – several factors are relevant, including:

- The nature of the alleged circumstances surrounding the alleged offence
- The age of the witness
- Social and cultural background of the witness
- Any behaviour towards the witness by the defendant, a member of his or her family, or any person likely to be an accused or witness

The CPS Guidance on Special Measures states that complainants in sexual assault cases are automatically intimidated witnesses. Victims of serious crime such as domestic abuse, hate crime, attempted murder, kidnap and false imprisonment, and wounding or causing bodily harm with intent might also be regarded as intimidated witnesses.

Social care and health care practitioners may have to provide evidence based on their professional knowledge of the person to support an application to the court for special measures.

Special measures consist of:

- Screening the witness from the accused.
- Video-recorded evidence-in-chief.
- Evidence by live link.
- Evidence given in private.
- Removal of wigs and gowns.
- Allowing the witness to use communication aids.
- Video-recorded pre-trial cross-examination and re-examination (not yet in force, although it is being piloted).
- Intermediaries – an approved intermediary to help a witness communicate with legal representatives and the court.

The judge must give the jury such warning as is necessary to ensure that the use of the special measures by the witness does not prejudice the accused. The use of some of these measures may make the bringing of a prosecution more likely.

How should it be used?

Although it is not always appropriate or realistic to use the criminal law, it is important to remember that abuse very often constitutes a criminal offence. The nature of the conduct does not change because it involves an older person. An abuser should be made aware that their conduct may constitute a criminal offence. The decision to use the criminal law is a complex one and will involve a number of different agencies, including the police and the CPS.

Close inter-agency working and the sharing of information is essential. Where the older person lacks capacity to make the decision, there are concerns about delaying the involvement of an Independent Mental Capacity Advocate (IMCA) until the investigation is nearly completed. There may be a feeling that the IMCA would compromise the process and risk accusations of coaching the witness, thus reducing the likelihood of a prosecution. However, the early involvement of an IMCA is critical as many decisions taken early in the investigation may determine the outcome. The involvement of the IMCA during the investigation helps ensure that someone is advocating for the victim and that options are explored - the use of special measures, for example. IMCAs may also help in facilitating communication with the victim. Although the person lacks capacity, they still have the right to access the criminal or civil justice processes. Early involvement of an IMCA may help achieve this in the case of victims lacking capacity.

What are the limitations?

The criminal law is not a panacea. It depends upon getting the forensic side of safeguarding right. There is a risk in the older person co-operating with a prosecution only for the case to fail because of an error in the investigative process. In some cases, using the criminal law may make matters worse.

Points to remember

- Not all older people are especially vulnerable within the criminal justice system. Many will cope with it as well as any other witness or victim.
- Stereotypical views of older people must be challenged – it is the individual that matters.
- Within the criminal justice system, there are competing interests. The interests of victims and witnesses are important. However, we must not lose sight of the importance of being fair to the accused. They are entitled under the ECHR to a fair hearing.
- The police have special powers and expertise that are invaluable. The fact that the police are involved does not mean that they will take over the safeguarding process in every case – it may be considered better in some cases if they are in the background and called upon if necessary. However, if a prosecution is a possibility then the police will be involved, and their investigation may have to take priority.
- Working with the CPS is important; they have difficult decisions to make.
- Practitioners should be prepared to advise the CPS, particularly over the use of special measures.

Chapter 8: Powers of Access and Arrest

Introduction

One obstacle to investigating abuse and neglect is gaining access to the person - only when the practitioner gets to see the person can an informed judgement be made about their safety and what outcome they want. The law in Wales and England places emphasis on property rights. If the suspected abuser is the owner or tenant, they may obstruct entry. Even if the adult at risk is the owner or tenant, someone may put pressure on them to refuse access to social services or health services. Respect for property rights and the home is important and included in the rights protected under the European Convention on Human Rights. However, there are situations where there is an urgent need to get access to an adult at risk.

Research for the Department of Health in England found that when faced with difficulties in getting access to an adult suspected of being at risk, practitioners can draw on a range of skills to overcome resistance. This may include building a rapport with the person denying access. Practitioner skills are invaluable and, in most cases, 'hinderance' can be overcome, albeit after a period of time. Difficulties arise when this does not work, or when there is a need for immediate access. At this point legal powers may be necessary.

What does the law say?

The law provides for several ways in which access to an adult at risk can be achieved in the face of opposition.

Under s.17(1)(e) Police and Criminal Evidence Act 1984 (PACE 1984), a police officer may enter and search premises for the purpose of saving life or limb, or preventing serious damage to property. The power is not linked to suspicion of a criminal offence and can be used at the discretion of the police officer; it does not require a warrant.

Other powers of entry exist. Under the Mental Health Act 1983 (MHA 1983), a magistrate may issue a warrant authorising a constable to enter premises (using force if necessary) where it is believed a person thought to be suffering from a mental disorder has been or is being ill-treated, neglected or not kept under 'proper control', or is living alone and unable to care for themselves. The warrant authorises the constable to remove the person to a 'place of safety' so they can be assessed under the MHA 1983, or where an arrangement for treatment or care can be made. The basis of an application will be information provided by an Approved Mental Health Professional (AMHP).

An application to the magistrates' court for a warrant to enter premises may also be made when a person is authorised under the MHA 1983 to take (or retake) a patient to a particular place and admission to the premises where the patient is or has been is refused, or a refusal is anticipated. The warrant authorises the constable to enter the premises, by force if necessary, and remove the patient.

Section 115 of the MHA 1983 gives AMHPs the power to enter and inspect premises in which a mentally disordered patient is living if they have reasonable cause to believe that the patient is not under proper care. The power can only be exercised at 'reasonable times' and it does not apply to hospitals. Whilst the AMHP does not have power to force entry, refusal may amount to an offence under s.129 MHA 1983, which covers obstructing authorised persons in the exercise

of their powers. In these circumstances, a warrant under s.135 could be sought from the magistrates.

Powers of entry under sections 115 and 135 MHA 1983 are only available where a person has, or is thought to have, a mental disorder as defined by the MHA 1983; they are not generally available powers.

Under s.34 Regulation of Social Care Services Act 2016 a Care Inspectorate Wales (CIW) inspector may, for the purposes of carrying out an inspection, enter any premises used for the purpose of providing 'regulated services'. However, this does not include a private dwelling house unless the occupier consents. Upon entry, the inspector has powers including assessing the well-being of people living there or receiving care there. There are powers to access documents and records and to remove them if thought necessary. There is also a power to interview a person in private, provided they give consent. The person receiving the service may also be medically examined if they consent. This applies where the inspector thinks that it is 'necessary or expedient' in assessing care and support, and well-being. The person conducting the examination must be a registered medical practitioner or nurse.

Other powers exist which may be of assistance, although they are not specifically designed for safeguarding cases. These include:

- s. 287 Public Health Act 1936: this gives local authorities the power to enter premises in relation to possible breaches of the Act. A warrant may be obtained from the magistrates' court in the case of refusal or anticipated refusal.
- Public Health (Control of Disease) Act 1984: A number of provisions under this legislation cover people with infectious diseases.
- It is worth remembering that landlords often have a power to enter property.

The SSW(W)A 2014 went part of the way towards introducing legal powers of access into adult safeguarding in the form of Adult Protection and Support Orders (APSOs). The inherent jurisdiction may also be used to obtain access. These are discussed in Chapter 6.

Arrest

Arrest may also be an appropriate intervention to protect a person at risk. Under s.24 PACE 1984, a police officer may arrest without a warrant anyone:

- who is about to commit an offence;
- who is in the act of committing an offence; or
- whom he or she has reasonable grounds for suspecting to be about to commit an offence.

However, this can only be done if one of a number of conditions is met. One of these conditions is 'to protect a child or other vulnerable person' from the person being arrested.

In limited circumstances described in s.24A PACE 1984, a person other than a police constable may arrest without a warrant anybody in the act of committing an indictable offence (in general terms, a serious offence that would usually be tried in the Crown Court) or whom they have reasonable grounds for suspecting is committing an indictable offence. Similarly, if an indictable

offence has been committed, a person other than a constable may arrest anyone who is guilty of the offence or whom they have reasonable grounds for suspecting to be guilty of the offence. The power is exercisable if it is not reasonably practicable for a constable to make the arrest. It must be to prevent the person causing physical injury to self or another person, suffering personal injury or making off before a constable arrives. This power of citizen's arrest should be used only in the most extreme of circumstances and provided that the person exercising the power is assured of his or her own safety. Caution is necessary!

How should it be used?

The above powers are intrusive, and consideration must be given as to whether they are proportionate. Where applications have to be made to the magistrates, they must be supported by evidence and legal advice is necessary. Some of the powers outlined are not designed for cases of suspected abuse or neglect and care must be taken not to fit people into a particular piece of legislation simply because it enables you to get access. For example, the public health legislation must not be misused. Similarly, the mental health provisions must only apply to those who genuinely come, or are thought to come, within the MHA 1983.

The basic rule in law is that there is no general power of entry for social care and health care practitioners. Police powers are useful, but they depend upon a good working relationship with the police. At all times, practitioners must have regard to their own personal safety and must never place themselves at unacceptable risk.

What are its limitations?

- There may be difficulties in obtaining the evidence necessary to use these powers.
- The autonomy of the person must be respected.
- Force should never be used by social care and health care practitioners to detain somebody or to gain entry to premises.
- Powers of entry and arrest are only short term – they provide only a limited opportunity for intervention.

Points to remember:

- Sharing information will improve the evidence base and enable informed decision to be made about the need to use these powers.
- Where possible and safe, informal methods of obtaining access should be tried.

Chapter 9: Domestic Abuse

Introduction

The abuse of older people is very often domestic abuse. Where the harmer is an intimate partner or a family member rather than a stranger or a professional carer, it is domestic abuse. The cross-Government definition of domestic abuse refers to it being:

‘Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality.’

It includes, but is not limited to, psychological, sexual, financial, and emotional abuse. Older people who experience this type of abuse should be able to access the justice options available to younger victims; the fact that they are older, does not mean that it becomes exclusively a safeguarding matter.

Awareness of domestic abuse has increased over the years and there have been several legal initiatives providing justice options for victims. It would be wrong to suggest that these initiatives have fully addressed domestic abuse; they have not. However, they do present a number of options that should be considered in cases of domestic abuse of older people in addition to any safeguarding measures that may be considered.

Before looking at the relevant law, it is worthwhile noting two important parts of the domestic abuse support framework. First is the Multi Agency Risk Assessment Conference (MARAC), a victim-focused information sharing, and risk management meeting attended by key agencies, which deals with high risk cases. MARAC facilitates, monitors and evaluates information sharing so that necessary actions can be taken to increase public safety. It receives up-to-date risk information and assessments of the victim’s needs and links those to the provision of services for those involved in a domestic abuse case, namely the victim, any young children and the harmer. Second is the DASH risk assessment. DASH stands for domestic abuse, stalking and ‘honour’-based violence. A DASH risk assessment provides a tool for practitioners working with adult victims of domestic abuse to help identify who is at high risk and should therefore be referred to a MARAC meeting.

What does the Law say?

Over the years Parliament and the National Assembly for Wales have introduced legislation and other initiatives to tackle domestic abuse.

The Family Law Act 1996

The Family Law Act 1996 introduced two types of orders designed to protect those who experience domestic abuse. The first is an occupation order, which can be used to exclude the harmer from the home, or part of it. It is complicated by the need to identify the nature of the interest in the property of the victim and the harmer. It is helpful for the victim to seek legal advice on this matter. The second is a non-molestation order, an injunction that prohibits the harmer from using or threatening violence, or intimidating, harassing or pestering the victim. Again, victims should seek legal advice on whether they fall within the criteria for such an order.

A breach of a non-molestation order is both civil contempt of court and a criminal offence.

Proceedings under the Family Law Act 1996 are, unlike criminal proceedings, private law matters and must be financed by the person or through the Legal Aid Fund.

The Legal Aid Sentencing and Punishment of Offenders Act 2012 (LASPO 2012) made radical changes to the provision of Legal Aid. Earlier regulations under LASPO 2012 made it difficult for victims of domestic abuse to satisfy the gateway regulations for Legal Aid. Following a successful legal challenge the Westminster Government amended the regulations by including a more extensive list of evidence acceptable to the Legal Aid Agency. The amended regulations are found in Regulation 33 of The Civil Legal Aid (Procedure) Regulations 2012 as amended. There is no longer a time limit how far back evidence of abuse can go; previously it was five years. The types of information accepted as evidence of abuse have also been increased and now include statements from domestic violence support organisations and housing support officers. The Legal Aid Agency will consider the following evidence – P is the perpetrator:

1. Evidence that P has been arrested for a relevant domestic violence offence.
2. A relevant police caution for a domestic violence offence.
3. Evidence of relevant criminal proceedings for a domestic violence offence which have not been concluded.
4. A relevant conviction for a domestic violence offence.
5. A domestic violence protection notice issued under s.24 Crime and Security Act 2010 against P.
6. Police bail for a domestic violence offence.
7. A relevant protective injunction.
8. A copy of a finding of fact, made in proceedings in the United Kingdom, that there has been domestic violence by P.
9. An expert report produced as evidence in proceedings in the United Kingdom for the benefit of a court or tribunal confirming that a person with whom P is or was in a family relationship, was assessed as being, or at risk of being, a victim of domestic violence by P.
10. Letter or report from an appropriate health professional.
11. Multi-Agency risk assessment conference.
12. Letter from an independent domestic violence advisor.
13. Letter from an independent sexual violence advisor.
14. Letter from a local authority or housing association.
15. Letter from an organisation providing domestic violence support services.
16. Domestic violence support organisation refusal of admission to a refuge.

17. Evidence of Financial Abuse (for example, bank statements and text messages).

It will be necessary to check whether the older person is eligible for Legal Aid.

Clare's Law: The Domestic Violence Disclosure Scheme

Following the murder of Clare Wood by a man she met on Facebook, her father campaigned for a change in the law that would require the police to reveal whether a partner has any history of violence. There are two components to the scheme. First, is the right to ask. Under this procedure a member of the public can seek information held by the police on their partner. The police will carry out checks to find out whether relevant information exists. If such information does exist, it will be passed to the local MARAC where a decision will be made as to whether to make a disclosure. Second is the right to know. Right to know requests are triggered by the police where indirect information or intelligence held by them or a partner agency indicates that a person is at risk of harm from their partner. Again, the information is passed to the local MARAC where a decision will be made about whether to make a disclosure. In both cases, the MARAC will assess the application as to whether disclosure would be lawful and proportionate to protect the potential victim from harm.

Domestic Violence Protection Notices and Orders (DVPN and DVPO)

DVPNs and DVPOs were introduced by the Crime and Security Act 2010. A DVPN gives the police power to provide immediate protection to victims of alleged domestic abuse against the harmer where they consider that there are no other available enforceable restrictions. Examples of their use include where the police decide that 'no further action' is necessary following a referral, the suspect has received a caution, or has been bailed without conditions. The DVPN is only effective for forty-eight hours, during which time an application may, if needed, be made by the police to the magistrates' court for a DVPO. A DVPO give the police and magistrates the power to:

- enforce non-molestation of the victim;
- stop a defendant from contacting the victim;
- prevent a defendant from evicting/excluding the victim from premises;
- remove a defendant from premises; and/or,
- prevent a defendant from returning to premises for a period of up to 28 days.

The consent of the victim is not required for a DVPN or DVPO.

Restraining orders in criminal proceedings

In a criminal trial, when sentencing a person found guilty of an offence, a court may impose a restraining order under s. 5 Protection from Harassment Act 1997. This order protects the victim of the offence, or any other person, from conduct which amounts to harassment or which will cause fear of violence. A restraining order can also be made against a person who is acquitted. However, such an order can only be made if the court considers it necessary to protect a person from harassment by the defendant and evidence must be available for the court to be able to reach this view. Restraining orders can be for a specific amount of time or be indefinite, subject to any further order.

Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015

The Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 (VAWDASV 2015) is a Welsh Government initiative designed to achieve a more strategic and joined up approach to domestic abuse. VAWDASV 2015 creates the post of **National Advisor** to advise and assist the Government. She works with public services in Wales to promote best practice and review actions taken by local authorities, Health Boards, the Fire and Rescue Service, and NHS Trusts.

The purposes of the VAWDASV 2015 are set out in s.1 and seek to improve:

- arrangements for the prevention of gender-based violence, domestic abuse and sexual violence;
- arrangements for protection of victims of gender-based violence, domestic abuse and sexual violence; and
- the support for people affected by gender-based violence, domestic abuse and sexual violence.

Under VAWDASV 2015 the Welsh Government is rolling out its “Ask and Act” initiative. This involves a targeted enquiry to be used by public sector providers to identify violence against women, domestic abuse and sexual violence. The ‘targeted enquiry’ involves the recognition of indicators of violence against women, domestic abuse and sexual violence and acts as a prompt for practitioners to ask a person whether they have been affected by any of these issues. The initiative seeks:

- to increase identification of those experiencing violence against women, domestic abuse and sexual violence;
- to offer referrals and interventions for those identified which provide specialist support based on the risk and need of the client;
- to begin to create a culture across the public sector where addressing violence against women, domestic abuse and sexual violence is an accepted area of business and where disclosure is expected, supported, accepted and facilitated;
- to improve the response to those who experience violence against women, domestic abuse and sexual violence with other complex needs such as substance misuse and mental health issues; and
- pro-actively engage with those who are vulnerable and hidden, at the earliest opportunity, rather than only reactively engaging with those who are in crisis or at imminent risk of serious harm.

Practitioners must remember that older people can be victims of domestic abuse and should refer to the guidance published by the Welsh Government and the Older People’s Commissioner for Wales - **Information and guidance on domestic abuse: Safeguarding older people in Wales (see bibliography)**.

How should it be used?

Domestic abuse legislation and initiatives may play a significant role in protecting older people who experience domestic abuse. Liaison with the police is very important if it is thought that some of their powers will be helpful in protecting the older person. As far as private law options are concerned, it may be necessary to seek professional legal advice from a solicitor or an advice agency. The availability of Legal Aid may also be determinative in deciding whether this option is pursued.

What are the limitations?

Domestic abuse options provide limited protection and are only as good as the enforcement measures in place. They may provide temporary respite and, in some cases, a more permanent solution. However, they do not remove the need to support the older person even if a protective regime is in place. Although the changes to Legal Aid eligibility have improved access, not all older victims of domestic abuse will be funded. In the absence of Legal Aid, they may be unable to pursue options under the Family Law Act 1996.

Points to remember

- Older people experience domestic abuse.
- A significant amount of the abuse of older people is domestic abuse.
- The provisions noted above should be considered alongside any safeguarding measures.
- Older victims of domestic abuse should be provided with enough information on available options to enable them to decide how they want to proceed.

Case Studies

The following are case studies taken from the files of the Older People's Commissioner for Wales

Confidentiality and Data Protection

Mrs Llewellyn is 89 years-old, she has severe dementia and is deemed to lack mental capacity about decisions relating to her care and the use of social media (for example, Twitter, Instagram, Facebook). She is a resident in a local authority owned EMI care home.

The care home has a Facebook account.

The care home holds a community engagement event at the home which involves the residents. Photographs are taken which includes photographs and names of some of the residents, including Mrs Llewellyn. These photographs are posted on Facebook.

Mrs Llewellyn's son and daughter complain to the local authority that no consent had been obtained for their mother's images to be posted and that she lacked capacity to give such consent.

The local authority investigated the complaint and accepted that signed consent should have been acquired for all those who participated in the photographs and for those who lacked capacity, consent should have been sought from an attorney where an LPA existed.

The care home removed the images and reviewed its policy to ensure it was compliant with data protection requirements.

Domestic Abuse

Mrs Johnson is 86 years-old and lives in her own home with her daughter Lucy who is aged 48. Lucy is single and is in full-time employment and is fit and well.

At 3am in early December Mrs Johnson is discovered by local police sleeping in her car several miles away from her home. The weather is extremely cold and frosty (minus 40 C).

The police officers ask her why she is sleeping in her car at that time of the morning. She informed the officers that she feared her daughter and felt it was necessary for her to sleep in her car rather than her own home.

The officers did not ask any further questions as to why she was fearful and decided to notify the local authority as 'an adult at risk'.

Upon receipt of the referral, the local authority telephoned Mrs Johnson about the incident. They did not ask questions about the incident or suggest that she could seek support from local support services. The case was then closed.

Several months later, Mrs Johnson was seen by a neighbour on the driveway of her house. The neighbour then saw Lucy come out of the house and punch Mrs Johnson several times about her head and body as well as grabbing her hair, pulling her into the house.

The neighbour contacted the police dialling 999. The police arrived and entered the home. The daughter became violent towards the officers and had to be restrained and arrested and taken into police custody.

Mrs Johnson told the police she did not want to make a complaint against her daughter. She was immediately put into contact with an Independent Domestic Violence Advisor (IDVA).

Mrs Johnson disclosed to the IDVA that the abuse by her daughter had been a constant problem for over 20 years, that she had frequently slept out in her car and that she had also been physically abused on a regular basis.

She then agreed to make a statement. Her daughter was charged and was later sentenced for the assault on her mother receiving a custodial sentence.

In this case, opportunities for an early intervention had been missed. Neither the police nor social services asked questions that could have identified risks and the extent of the abuse. Nor was the offer of access to an IDVA or specialist support services initially considered.

‘Unwise decisions’

Mr Evans (aged 86) lent money to a friend and had previously lent money to other people; none of the money was returned. An outside agency became aware of the money lending during an assessment and raised concerns with the police who made a visit to Mr Evans to discuss concerns and a referral was made to adult safeguarding.

Mr Evans was angry that the police and safeguarding were contacted without his permission and stated he had capacity and was adamant he had the right to give the money.

The loans were not repaid.

Mr Evan’s was entitled to make this decision even though others may consider it to be unwise.

Lasting Powers of Attorney – financial abuse – access to justice

Alice Rees and her two sisters (Sylvia and Sandra) are registered attorneys under a Lasting Power of Attorney (LPA) for their mother’s property and finances. They can make decisions jointly or separately.

Alice understood that their role is to act in their mother’s best interests.

Her one sister (Sylvia) believed that the money their mother currently possessed was left following the death of their father and they felt it should be spent as their late father, who was financially generous to family members would have wanted, namely giving cash gifts to family members.

There was fundamental disagreement between Alice and Sylvia over how they should be acting.

Alice was advised to discuss matter with her sister (Sandra) and to report their concerns over Sylvia’s conduct as an Attorney to the Office of the Public Guardian.

Consent: Refusal to participate and mental capacity

Josie has an aunt (Betty) who is 94 years-old and lives in the other side of Wales (around 90 miles away).

Josie is her aunt's only relative; she does not have Power of Attorney.

Betty has capacity and lives independently in her own home with four care calls a day of each of half an hour duration. Betty recently had a fall and was admitted to hospital. A hospital discharge meeting took place and it was determined that she was able to return home.

Josie was unhappy that she wasn't informed of the meeting, she was advised by Social Services that Betty had not consented to her being in attendance.

Josie was concerned about Betty's safety and wanted to discuss more care calls with Social Services. She was advised that Betty has capacity and it was her right to refuse to allow her family to attend the meeting and not be involved in her hospital discharge process. If Betty did not want additional care, she could not be forced to have this.

Unwise decisions - self-neglect

John's mother (Pamela aged 87) had recently been in hospital. She had suffered a nasty fall which caused an injury to her head. Following tests, it was ascertained that she had had a previous stroke as well. Additional tests determined that she has alcohol related dementia (Korsakoffs).

Pamela was discharged from hospital against John's wishes and no care package was put into place.

John was concerned that his mother was being left for long periods at a time on her own. She would not eat. Pamela would not allow anyone to care for her and refused to take her medication.

John confirmed that Pamela has capacity to make decisions about her health and well-being, but he was concerned that her dementia will get worse.

John was advised that Individuals have the right to refuse a care package if they so wish. If an individual has mental capacity to make their own decisions then it is their right to do so, even if those decisions seem unwise to others around them. Whilst his mother has a diagnosis of dementia, she has been determined to have capacity.

Appendix 1: United Nations Principles for Older Persons

Adopted by General Assembly resolution 46/91 of 16 December 1991

The General Assembly ,

Appreciating the contribution that older persons make to their societies,

Recognizing that, in the Charter of the United Nations, the peoples of the United Nations declare, inter alia , their determination to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small and to promote social progress and better standards of life in larger freedom,

Noting the elaboration of those rights in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights and other declarations to ensure the application of universal standards to particular groups,

In pursuance of the International Plan of Action on Ageing, adopted by the World Assembly on Ageing and endorsed by the General Assembly in its resolution 37/51 of 3 December 1982,

Appreciating the tremendous diversity in the situation of older persons, not only between countries but within countries and between individuals, which requires a variety of policy responses,

Aware that in all countries, individuals are reaching an advanced age in greater numbers and in better health than ever before,

Aware of the scientific research disproving many stereotypes about inevitable and irreversible declines with age,

Convinced that in a world characterized by an increasing number and proportion of older persons, opportunities must be provided for willing and capable older persons to participate in and contribute to the ongoing activities of society,

Mindful that the strains on family life in both developed and developing countries require support for those providing care to frail older persons,

Bearing in mind the standards already set by the International Plan of Action on Ageing and the conventions, recommendations and resolutions of the International Labour Organization, the World Health Organization and other United Nations entities,

Encourages Governments to incorporate the following principles into their national programmes whenever possible:

Independence

1. Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
2. Older persons should have the opportunity to work or to have access to other income generating opportunities.
3. Older persons should be able to participate in determining when and at what pace withdrawal from the labour force takes place.
4. Older persons should have access to appropriate educational and training programmes.
5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
6. Older persons should be able to reside at home for as long as possible.

Participation

7. Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
8. Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
9. Older persons should be able to form movements or associations of older persons.

Care

10. Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
11. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
12. Older persons should have access to social and legal services to enhance their autonomy, protection and care.
13. Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

Self-fulfilment

15. Older persons should be able to pursue opportunities for the full development of their potential.
16. Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

Dignity

17. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.
18. Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

Appendix 2: Bibliography

Official Publications

National Protocols and Procedures

<https://www.cysur.wales/national-protocols-procedures/>

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<https://gov.wales/sites/default/files/publications/2019-05/working-together-to-safeguard-people-volume-i-introduction-and-overview.pdf>

Working together to safeguard people volume 3 – Adult practice reviews

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Working Together to Safeguard People - Volume 4 – Adult Protection and Support Orders

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