ADULT SAFEGUARDING OBSERVED

HOW SOCIAL WORKERS ASSESS AND MANAGE RISK AND UNCERTAINTY

JEREMY DIXON

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List of abbreviations

ADASS	Association of Directors of Adult Social Services
ADSS	Association of Directors of Social Services
AEGIS	Aid for the Elderly in Government Institutions
ARC	Association for Residential Care
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
ICT	information and communications technology
LGA	Local Government Association
NAPSAC	National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities
NHS	National Health Service

The problem of adult safeguarding

Introduction

I qualified to be a social worker in England in 1998. During my time in training, nobody used the term 'adult safeguarding'. The concept, as it is understood now, did not exist. This situation is very different from where we find ourselves today. Adult safeguarding is now seen as a central part of social work practice in England. The Care Act 2014 sets out the legal duties of local authorities, and social workers are often acutely aware of the law and policy. Adult safeguarding training is a core part of the social work curriculum. Also, there is increased public understanding of adult abuse and neglect (Yoeli et al, 2016). In the present day, it can be hard to understand why adult safeguarding was not seen as important for so long. And the ever-rising rate of adult safeguarding referrals and enquiries seems to attest to the fact that it is a problem of some scale (NHS Digital, 2022). This raises the question of how we got here and how safeguarding came to be understood in its current form.

In this chapter, I consider how adult safeguarding has come to be viewed as an issue needing a policy response. Adult safeguarding or adult protection systems have evolved in several countries, including England, Wales, Scotland, Ireland, Canada and Australia (Donnelly et al, 2017) although here I limit myself to an analysis of the situation in England. While others have examined how adult safeguarding policy has evolved in relation to care homes and hospitals (Manthorpe and Stevens, 2015), my analysis is broader in range, focusing on all aspects of adult safeguarding. I begin by setting out a history which highlights how policy has developed, identifying campaigns, public inquiries, political discussion and policy developments from the 1960s to the Care Act 2014 and beyond.

Abuse and neglect exist in all societies and are sometimes referred to as being 'as old as time itself'. However, as Blumer (1971) states, some harms are identified as social problems, while others are not. Because of this, we need to understand how particular issues within society come to be seen as problems in need of policy response. In this chapter, I adopt what is known as a social constructionist position, meaning that I focus on how meaning and knowledge about adult safeguarding have evolved. To provide some structure for the first part of my chapter, I set out what Best (2013) (drawing on Blumer, 1971) describes as a 'natural history' of social problems.

According to Best (2013), social problems go through six stages. First, 'people make claims that there is a social problem, with certain characteristics, causes and solutions' (Best, 2013, p 19). Claims may be made by activists or by experts, who are referred to as 'claims-makers'. Second, the issue may gain media coverage. Here, claims-makers may seek press coverage to alert the public to the issue and to exert pressure on policy makers. Third, claims may lead to a public reaction where members of the public learn about a claim and form opinions about it. Fourth, policymaking takes place, with policies or laws being created by government to address the claims that have been raised. Fifth, state agencies engage in social problem work to implement these policies. In the sixth and final stage, different parties respond to policy outcomes. This may involve individuals pointing out the shortcomings of current arrangements and proposing change. When examining these claims, it is important to consider the resources that claims-makers have, such as money, status or power, as those with more power are more likely to get their views heard. We also need to consider the rhetoric which claims-makers use. In other words, what kinds of language or argument are used to describe the issue and persuade people that it is problematic?

The history I present in this chapter draws on library research and analysis of policy documents. I show that what we have come to understand as adult safeguarding has emerged as the result of multiple claims by different groups of people. I begin my history in the 1960s, focusing on concerns raised about the treatment of people with mental health problems who had been placed in psychiatric hospitals.

The 1960s: Barbara Robb's campaign

This history begins with an examination the abuse and neglect of older people in long-stay hospitals. Public attention was drawn to the issue through the book *Sans Everything: A Case to Answer* (Robb, 1967). The book became a bestseller (Hilton, 2017b) and consisted of chapters by hospital visitors, nurses and social workers which described the degrading treatment of older adults in seven hospitals. *Sans Everything* was part of a wider campaign to draw attention to the mistreatment of adults in hospital, led by Barbara Robb, a psychotherapist by profession.

Barbara Robb first became aware of the mistreatment of older people in 1965 when visiting Amy Gibbs, a patient who had been admitted to Friern Hospital, a psychiatric unit in London. Amy's deterioration since her admission in 1963 and the conditions at Friern shocked Robb, leading her to document them in a diary (Hilton, 2017a). Robb was particularly concerned by a practice known as 'stripping', which was common in 1960s long-stay hospitals. This involved removing patient's personal possessions, including their glasses, dentures and hearing aids, on the basis that it was easier to treat

passive patients than active ones (Hilton, 2017a). Robb's conversations with Amy and the relatives of other patients highlighted a range of accusations, such as nurses hitting patients for being incontinent, threatening them and taunting them. Furthermore, Amy was frightened about complaining about the treatment, telling Robb that the nurses had threatened to put her 'out into the street' (Robb, 1967, pp 82–3).

Robb had more power than the typical activist, being friends with several influential members of society, such as Lord and Lady Strabolgi and Audrey Harvey, a citizens' rights campaigner. Robb kept a diary of events, which she asked other visitors to corroborate. This was sent to Minister of Health Kenneth Robinson, via Lord Strabolgi, who also made suggestions about how care might be improved and gave a speech in the House of Lords (Hansard, 1965). Following this, the Ministry of Health arranged for Robb to meet the head of mental health at the ministry, Dr Geoffrey Tooth. However, Robb was disappointed to find that the issues had not been investigated, with Tooth advising her not to raise a complaint in case 'something brutal' occurred to Amy (Hilton, 2017a, p 81).

Robb's dismissal by the head of mental health led her to engage in activism by forming Aid for the Elderly in Government Institutions (AEGIS) in October 1965 (Hilton, 2017a). One of AEGIS' first activities was to submit a letter to *The Times* newspaper, signed by several lords, bishops and professors. The letter highlighted the practice of stripping, alleged that the Ministry of Health mishandled complaints and called on others to come forward with further examples of poor care or mistreatment. Robb then published *Sans Everything* (1967), documenting Amy Gibbs' mistreatment and also giving evidence of abuse in other hospitals.

Accusations in *Sans Everything* and the *News of the World* newspaper prompted the government to act by commissioning seven hospital inquiries (Hilton, 2017a), though the regional hospital boards were allowed to appoint their own inquiry committees. The reports from these inquiries adopted a 'doctor knows best' mentality, writing off complainants as uneducated or simple-minded and attributing poor care to a few 'bad apples' (Butler and Drakeford, 2003, p 37). The Minister for Health concluded that the allegations in *Sans Everything* were 'totally unfounded or grossly exaggerated' (cited in Hilton, 2017a, p 208). This response backfired, being viewed as a whitewash by the press and increasing public support for AEGIS.

Following the ongoing press attention on the treatment of older adults in hospitals, Minister for Health and Social Security Richard Crossman adopted a different approach, ordering a full inquiry into the conditions at Ely Hospital, a large institution for people with learning disabilities (Fyson et al, 2004). This was chaired by Geoffrey Howe, QC. Howe's inquiry noted that care within the hospital was 'old fashioned, unduly rough and

[of] undesirably low standards' (Department of Health and Social Security, 1973, p 24), that staff who complained were victimised and that leadership was poor. However, as Butler and Drakeford (2003) note, much of the mistreatment was seen as the result of unsophisticated nursing techniques. Statements by a key whistle-blower, which later became available through the Public Record Office, presented a starker picture of violence. One excerpt notes that:

> In Ward 23, there is a charge nurse named John Edwards who everyone considers to be a sadist. He has an assistant named Kay who falls into the same category. A young patient named Kevin is constantly going into the kitchen which is out of bounds. He is regularly beaten by the two nurses. On one occasion Edwards took him to his office and beat him. I heard the screams. (Cited in Butler and Drakeford, 2003, p 50)

The findings of the inquiry were embarrassing for the Labour Government, leading it to launch the Hospital Advisory Service (Hilton, 2017a). This organisation was independent from the Department of Health, though clinically led, and examined the service offered by hospitals (although it did not examine individual complaints). Actions by AEGIS also contributed to the development of an NHS ombudsman, which encouraged the NHS to develop more transparent complaints procedures.

In summary, several points can be noted about claims of adult abuse in this period. For a claim to be effective, claims-makers had to put forward a persuasive argument. These claims may consist of grounds (information and evidence about the condition), warrants (appeals to values) and conclusions (recommendations for future policy or practice; Best, 2013). AEGIS' claims appealed to the new public values emerging in the 1960s, namely autonomy and public ownership of the NHS (Hilton, 2017a). While ministers initially tried to discredit AEGIS' claims, continuing press coverage and fear of what the public might think drove the Ely Hospital inquiry, leading to the establishment of the Hospital Advisory Service and a revised system for hospital complaints.

The 1970s: early concerns about 'granny battering'

The beginning of the 1970s saw a change of government, with the Conservative Party defeating Labour. Once in power, the government commissioned a committee to review the hospital complaints system (Hilton, 2017a). The committee identified that further reform was needed, and this led to a 26-point code focusing on how complaints should be managed. Following these changes, the issue of abuse in hospitals fell off the political agenda and was gaining little public or press attention.

The 1970s did, however, see the emerge of claims about the abuse of older people in the community, initially described as 'granny battering' or 'granny bashing'. These concerns need to be seen in context of the coverage about child abuse and 'baby battering' that was prevalent at that time. Medical concerns about 'battered baby syndrome' arose in the 1960s but came to public attention through the Maria Colwell inquiry (Parton, 1979). Maria Colwell, at 7 years old, was killed by her stepfather after being returned home following a period in foster care. The case attracted much press attention, and this was instrumental in child abuse becoming recognised as a social problem (Parton, 1979). While adult abuse did not receive the same degree of attention in the press, psychiatrists began to speak about it in professional publications in the United Kingdom (Burston, 1975; Baker, 1981). These concerns are neatly encapsulated in a letter by B.J. Burston, a psychiatrist, to the *British Medical Journal*:

> Sir,—Hardly a week goes by without some reference in the national press or medical journals to baby-battering, and I think it is about time that all of us realized that elderly people too are at times deliberately battered. I have personal knowledge of cases in which it has been possible to confirm that elderly patients have been battered by relatives before admission to hospital and in which there has been no doubt that the battering was deliberate. In other cases assault at home has been suspected but could not be confirmed. This leads one to wonder how many of the elderly who 'fall down frequently, doctor' do so because they are assaulted. […] Perhaps general practitioners in particular and casualty officers especially should become as conscious of granny-battering as they are now aware of baby-battering. Community nurses, health visitors, and social workers should also have this aspect of 'caring for the elderly' drawn to their attention. (Burston, 1975, p 592)

Psychiatrists hypothesised that several factors might account for 'granny battering', including the higher rates of abuse in society more generally, the ageing population and the lack of support for those who experienced abuse (Walshe-Brennan, 1977; Baker, 1981). Drawing on the accounts of nurses, Walshe-Brennan (1977) suggested that the problem was worsening and that doctors tended to disbelieve reports of abuse. However, coverage in UK medical journals fizzled out (until the 1990s).

Claims-makers seek to draw attention to an issue by adopting the language of other social problems to 'piggyback' onto existing concerns (Best, 2013). Use of the term 'granny bashing' was a clear attempt to align adult abuse with child abuse and to argue that both should receive professional attention. While references to these letters and articles are frequently cited in histories of

adult abuse, they had very little impact in the press or on public perceptions, being limited to academic or clinical journals, which few people read. However, the 1980s would see the emergence of new claims-makers who would be more successful in raising concern about the issue.

The 1980s: concerns about old-age abuse and the abuse of people with learning disabilities

The early 1980s saw the issue of 'granny battering' picked up by Mervyn Eastman, a practising social worker in London (see Eastman, 1980, 1982; Eastman and Sutton, 1982). His first article, 'The battering of Mrs. Scarfe', published in *New Age* defined 'granny battering' as 'the systematic physical abuse of an elderly person by a relative' (cited in McCreadie, 1993, p 8). Eastman noted a lack of research in this area, which he saw as discouraging professionals from recognising the issue. Nonetheless, he set out a series of signposts which might indicate the possibility of abuse having taken place. These included dependence on a relative, poor family communication, history of repeated falls, bruising and cramped housing conditions. Perhaps more unusual for the modern reader, the issue of 'role reversal' was set out as a warning sign. This was seen to occur in cases where a person who had been cared for by the older adult was now caring for them, leading to resentment on the part of the carer. Later articles by Eastman expanded the definition by noting that abuse could be physical, emotional, psychological (Eastman and Sutton, 1982) or sexual (Eastman, 1982). Eastman later wrote that the term 'granny battering' was disparaging, and his book reframed the problem as 'old age abuse' (Eastman, 1984).

While calls by Eastman for more attention to the issue were ignored by government, Age Concern England (now Age UK) became concerned and commissioned a review of research (see McCreadie, 1993). This highlighted that there was no agreed definition of abuse, that most research studies on the issue were small in scale and that the current levels of abuse and its causes remained unknown. Age Concern England published Eastman's book *Old Age Abuse* (1984) and established a consultative group to review the law in relation to 'vulnerable elderly people' (Greengross, 1986). The charity argued that current laws were scattered and ill-used. This was because workers had a low level of awareness about existing laws, but also because the laws were unwieldly or difficult to apply to the cases that practitioners had experience with. The group considered establishment of specific powers, including the duty to consider the case of a vulnerable adult or their carer, and also argued that there should be greater public awareness of elder abuse and clearer referral procedures. A multidisciplinary conference was held by the British Geriatrics Society in 1989, and this highlighted growing academic interest in the issue (Tomlin, 1989).

The 1980s also saw concerns arise about the abuse and neglect of people with learning disabilities. The context of this concern was community care policies, through which people who had been housed in long-stay hospitals were moved into supported or independent housing. These policies were first introduced in the 1960s, but had stalled due to the lack of coordination between health trusts and local authorities (Bartlett and Sandland, 2014). The Conservative Government sought to revive community care policies (see Department of Health, 1989), with 'normalisation' or 'normal life' philosophies being promoted (Alaszewski, 1999). Such policies held that individuals should be empowered to gain control over their lives through being given the right to engage in jobs or relationships. While few commentators doubted normalisation policies were a good thing, concerns were expressed about the vulnerability of people with learning disabilities. For example, a paper published in 1987 by Hewitt, a police officer, expressed worry about how those with learning disabilities would fare in the community. He wrote:

> people with mental handicaps are very vulnerable. They are very trusting, mostly quite honest and have a love some might envy. What is so odious, is that those in positions which give them advantage will sometimes abuse it. There must be justice and we can all do something to see that it is upheld. (Hewitt, 1987, p 131)

Although Hewitt's characterisation of people with learning disabilities seems clumsy now, he highlighted several worries which were echoed by others. Studies in the late 1980s highlighted that people with learning disabilities were being victimised in community homes (Williams, 1993), and Hewitt's concerns reflected growing worries among the public and professionals that such issues were being ignored. The case of Beverley Lewis brought these worries into focus. Beverley was a young deaf-blind Black woman with learning and physical disabilities who lived with her mother. In February 1989, she was found dead on the family sofa, weighing just four stone and wrapped in newspaper. Press reports noted that access to Beverley had been refused repeatedly by her mother, who had mental health problems (Simcock and Manthorpe, 2014). The inquest reported death by natural causes and no agencies were blamed. However, the family went on to make their dissatisfaction with the inquest known. In national television and radio interviews, they blamed the social worker leading the case and identified poor communication between agencies (Simcock and Manthorpe, 2014). These issues would be picked up by activists and politicians in the 1990s.

In summary, the 1980s saw a greater number of claims being made about adult abuse than had been the case in the 1970s. What is notable about this decade is that a wider range of claims-makers emerged. Claims were

initiated by 'experts', in the form of social workers and police officers voicing concerns from practice. Claims about elder abuse gained the backing of national charities, providing a larger platform. Press coverage of the abuse of Beverley Lewis also brought the issue of adult abuse to public attention, a pattern which would be repeated with inquiries in the next decade.

The 1990s: early guidance and the Law Commission reviews

The beginning of the 1990s saw the introduction of the National Health Service and Community Care Act 1990, passed by the Conservative Government under Margaret Thatcher. The Act, which received royal assent on 29 June 1990, was significant for making a split between purchasers and providers, for creating an internal market within the NHS and for changing local authority functions. However, it provided little provision for defining, assessing or managing abuse and neglect. Section 47 gave local authorities a duty to conduct an assessment where they became aware that a person needed services due to actual or potential abuse or neglect, but gave little direction beyond this.

Although the National Health Service and Community Care Act 1990 made little provision for adult abuse, the Department of Health did commission a review of research evidence (McCreadie, 1991). This supported the message that little was known about the context or prevalence of adult abuse. However, research by the Social Services Inspectorate the following year looked at levels of abuse within two local authorities (Sutton, 1992). Within this study, 64 cases of elder abuse were identified by social workers, including physical, psychological and financial abuse. Professional responses were viewed as uncoordinated, with workers unsure how to proceed. In addition, academic research began to emerge which highlighted the scale of elder abuse. A survey of adults aged 60 and over in Great Britain asked participants whether they had been abused by a family member or relative (Ogg and Bennett, 1992). It found that 5 per cent of older adults reported psychological abuse, 2 per cent reported physical abuse and 2 per cent reported financial abuse.

Growing awareness of adult abuse led professionals to come together to campaign on the issue. In 1993, the pressure group Action on Elder Abuse (now Hourglass) was formed. Supported by Age Concern England, its mission was to 'prevent abuse in old age by promoting changes in policy and practice through raising awareness, education, promoting research and the collection and dissemination of such information' (cited in Penhale and Kingston, 1995, p 225). Concern about the issue of adult abuse spread beyond professionals, and family groups began to lobby on the issue. For example, Voice UK, formed by parents who discovered that their daughter had been raped by a member of staff while in residential care, aimed to effect change

through highlighting examples of bad practice and advocating for changes to the legal system (Horrocks, 2000).

Also in 1993, two documents were published aiming to address adult abuse, but these lacked bite. First, the Social Services Inspectorate issued professional guidance in the form of *No Longer Afraid: The Safeguard of Older People in Domestic Settings* (Department of Health and Social Services Inspectorate, 1993). The definition of abuse given in the document built on previous ones by acknowledging that abuse could be temporary as well as systematic. However, as workers had no statutory powers to manage elder abuse, they were forced to address it through existing assessment and care management procedures (Biggs, 1996). The second document came out of a two-day workshop funded by the NHS and the Social Services Inspectorate and hosted by the Association for Residential Care (ARC) and the National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities (NAPSAC). The workshop covered the issue of sexual abuse of people with learning disabilities. This led to practice guidance suggesting how sexual abuse should be tackled in residential care settings (ARC and NAPSAC, 1993). However, the guidance was published by ARC and NAPSAC rather than by the government, leading critics to question whether local authorities would act on their suggestions (Hardiker, 1994).

Following an internal inquiry into the Beverley Lewis case by Gloucester Social Services, the pressure group Sense (a group supporting people with complex disabilities) called for a public inquiry into the case (Simcock and Manthorpe, 2014). This call was rejected by the Parliamentary Under-Secretary for Health, Stephen Dorrell (Hansard, 1990). However, the government did ask the Law Commission[1] to consider and advise on the coroner's view that law in this area should be clarified. The Law Commission's (1995) report on mental incapacity expressed growing concerns about elder abuse and the abuse of disabled people. It noted that many organisations had identified the need for legal powers to deal with crisis situations. It stated:

> To the basic question of whether any reform of these emergency powers was needed our consultees responded with a resounding affirmative. The existing law[2] was said to be ineffective in protecting elderly, disabled and other vulnerable people from abuse and neglect, and inadequate in its approach to issues of autonomy and individual rights. It appeared to be counter-productive, being so draconian that it was rarely used. (Law Commission, 1995, para 9.1)

Its final report on mental incapacity (Law Commission, 1995) also expressed concern about 'vulnerable people'. It proposed that local authorities should be given new powers to investigate abuse and neglect of vulnerable adults. It also recommended that local authorities should be given short-term

powers to assess whether a person was at risk and, where professionals were obstructed, powers to enter and remove the person.

At the time of this review, several independent inquiries made the issue of adult abuse more visible. In 1996, the Beech House inquiry drew attention to the issue of elder abuse in hospitals, focusing on the systemic abuse of 13 older adults with mental health problems at Beech House in London (Camden and Islington Community Health Services NHS Trust, 1999). The inquiry found that staff had punched and slapped patients, given them cold baths and restrained them inappropriately. It also highlighted poor clinical standards, acceptance of ulcers and pressure sores, unauthorised absences from the ward by staff and dishonest record-keeping. The Longcare inquiry (Buckinghamshire County Council, 1998) received even broader coverage due to the number of people involved and the protracted period over which it was undertaken (Stanley and Manthorpe, 2004). It focused on abuse against people with learning disabilities in two residential homes owned and managed by Gordon Rowe, an ex-social worker. While the inquiry report was discrete about the details of the abuse, press reports revealed that residents had been indecently assaulted, raped, injured with scissors and made to lie on cold, wet grass as a punishment (Smith and Clement, 2003; Fyson et al, 2004). The resulting press scandal led to questions in Parliament with Paul Boateng (then Parliamentary Under Secretary of State for Disabled People) stating:

> We take the issue of abuse very seriously. We are determined to send a clear and unambiguous message that abuse in residential care will not be tolerated. The promulgation of good practice based on respect for the individual, and the importance of being able to identify and remedy actual or potential abuse, is a vital part of the Department's funding strategy, as is its work on developing a credible and comprehensive regulatory framework based on national regulatory standards. (Hansard, 1997)

The government's response to the Law Commission report suggested that it was edging toward giving professionals powers to address adult abuse and neglect (Lord Chancellor, 1997). It accepted its recommendations on creating new compulsory powers and sought views on their practicalities. However, following the consultation, the government decided not to proceed. No reasons for this decision were given (see Joint Committee on the Draft Mental Incapacity Bill, 2003).

The 1990s saw greater recognition of the issue of adult abuse. While the National Health Service and Community Care Act 1990 had failed to address the issue, the decade saw an increase in claims-makers highlighting adult abuse as a social problem. As in the 1980s, many of these claims were made

by welfare professionals. However, the number of groups campaigning on the issue was starting to grow, with professionals and family carers becoming more organised and public inquiries making the issue more visible. While we can't be sure how the public reacted to these reports, concerns about abuse were beginning to filter down to policy makers. While the government was resistant to providing professionals with legal powers to respond to adult abuse, the 2000s would see significant steps taken to address the issue within policy.

The 2000s: publication of *No Secrets* and debates on the future of safeguarding

The beginning of the 2000s saw the government following up on policy from the 1990s. First, the government introduced new measures to regulate residential care settings outside of the NHS. National minimum standards were introduced under the Care Standards Act 2000, which came into effect in July of that year. Second, *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse* (Department of Health, 2000) was published. This guidance was significant in outlining a national approach to adult protection, providing guidance to social services departments (who were identified as 'lead agency'), NHS trusts, health authorities and the police. Agencies were instructed to collaborate closely on developing local codes of practice and to take steps to prevent abuse from occurring. The document defined abuse in relation to 'vulnerable adults' as 'a violation of an individual's human and civil rights by any other person or persons' (Department of Health, 2000, para 2.5). This definition included acts of both commission and omission, covering physical, sexual, psychological and financial abuse, neglect and discrimination.

Following the publication of *No Secrets* (Department of Health, 2000), local authorities set to work at putting the policy in place. Research studies found that local authorities and other agencies adopted the definitions of abuse given in *No Secrets* and most had multi-agency procedures in place by 2001 (Sumner, 2002; Filinson, 2007). However, several problems were evident. Local authorities reported that they did not have the resources to apply *No Secrets* effectively (Mathew et al, 2002). Survey research by the Practitioner Alliance against Abuse of Vulnerable Adults also found that key areas of practice within the guidance were not being consistently addressed (Filinson, 2007).[3]

In 2002–03, the issue of adult abuse received parliamentary attention once more when the Joint Committee on the Draft Mental Capacity Bill (2003) reviewed the proposed legislation. The report was critical of the progress made through *No Secrets* (Department of Health, 2000) and cited evidence

from witnesses to support this. In the report, Graham Collingridge from the Association of Directors of Social Services (ADSS) stated that the government had provided no extra resources when implementing the guidance and noted wide variations in practice across local authorities. Also a leading judge, Master Lush, representing the Court of Protection, stated that the police were reluctant to become involved in adult abuse cases. And John Williams, a professor of law, said that social workers and health professionals were frustrated by a lack of power to intervene, even where they were aware that abuse was taking place. He opined that existing policy, 'tolerates financial abuse, tolerates physical abuse, and basically there is nothing that can be done' (Joint Committee on the Draft Mental Incapacity Bill, 2003, para 259). In response to these concerns, the Joint Committee recommended that, 'statutory authorities should be given additional powers of investigation and intervention in cases of alleged physical, sexual or financial abuse of people lacking the capacity to protect themselves from the risk of abuse' (2003, para 266).

In its response to the Scrutiny Committee of the Mental Capacity Bill, the government resisted calls to introduce new safeguarding powers (Department for Constitutional Affairs, 2004). They argued that the *No Secrets* guidance (Department of Health, 2000) already required local authorities to liaise with other agencies to protect vulnerable adults. They also stated that adult protection should not be addressed under mental incapacity legislation, because 'it is right that this [*No Secrets* guidance] extends beyond adults who lack capacity to all vulnerable adults' (Department for Constitutional Affairs, 2004, para 15). New legal powers were viewed as unnecessary on the grounds that Section 47 of the National Assistance Act 1948 already provided a duty to investigate and gave compulsory powers. In making this argument, the government ignored the arguments by the Law Commission (1995) that these powers were unsuitable in most cases and rarely used in practice.

The issue of adult abuse also received government attention in 2003–04 with the report of the House of Commons Health Committee on Elder Abuse (2004). The report opened with evidence from Gary Fitzgerald, Chief Executive of Action on Elder Abuse. This read:

> Mr Fitzgerald pointed out that many people would be familiar with case of Victoria Climbié, a child tortured and murdered in the care of a relative, but that few knew about Margaret Panting, a 78-year-old woman from Sheffield who died after suffering 'unbelievable cruelty' while living with relatives. After her death in 2001, a post-mortem found 49 injuries on her body including cuts probably made by a razor blade and cigarette burns. (House of Commons Health Committee on Elder Abuse, 2004, para 1)

The committee made a wide range of recommendations to address elder abuse. These included broadening the definition of abuse to include those who did not receive support services, multidisciplinary research to establish the scale of abuse, training to enable workers to recognise abuse, better regulation of care staff and better advocacy services. The government responded by highlighting initiatives it had already implemented, namely the Modernisation of Adult Social Services Research initiative to improve data collection on elder abuse; the Care Standards Act 2000, The Care Homes Regulations 2001 and the Domiciliary Care Agencies Regulations 2002 (HM Government, 2004).

Despite the government's reluctance to introduce new measures, several bills were coming into legal effect which would have an impact on the prevention and management of adult abuse. The Mental Capacity Act 2005, implemented in 2007, was relevant in three respects (Filinson, 2007). First, it was established that a person should not be treated as unable to make a decision merely because they make an unwise decision. Where individuals were judged to lack capacity, professionals were instructed to act in their best interests, meaning that neglect should be addressed. Second, the Act established the Office of the Public Guardian. This promoted the use of lasting powers of attorney and enduring powers of attorney, which encouraged individuals to state who should act on their behalf should they lose capacity. In promoting these provisions, the government hoped that cases of financial abuse would be reduced. Third, Section 44 of the Act made the ill treatment or wilful neglect of a person who lacked capacity an offence – a power designed to prevent abuse.

Existing law and guidance on managing adult abuse was supplemented in 2005 by *Safeguarding Adults: A National Framework of Standards for Good Practice and Outcomes in Adult Protection Work*, published by the ADSS (2005). The ADSS had recognised in 2004 that the *No Secrets* guidance (Department of Health, 2000) needed further development, and it developed a series of good practice standards in conjunction with government departments, intended to be used as an audit tool. The guidance was notable for introducing the term 'safeguarding adults' in preference to 'vulnerable adults', which was used previously (Law Commission, 1995; Department of Health, 2000). Several arguments were made in favour of this. First, the term 'vulnerable adults' could be misinterpreted, as it focuses on vulnerability of the person experiencing abuse rather than focusing on the perpetrator of abuse. Second, the criteria which had been adopted in the government's Fair Access to Care Services criteria (DHSC (Department of Health and Social Care), 2002) focused on 'risk to independence and wellbeing' as the key criteria for eligibility, making the concept of vulnerable adult redundant. Third, policy now enabled adults to access care of their own choosing. In recognition of these changes, safeguarding adults was defined as 'all work which enables

an adult "who is or may be eligible for community care services" to retain independence, wellbeing and choice and to access their human right to live a life that is free from abuse and neglect' (ADSS, 2005, p 5). This shift in language appeared to be widely accepted by those in the sector, with a later government consultation finding that 90 per cent of respondents favoured the phrase 'adult at risk' (Department of Health, 2008b).

The newly named ADASS continued to campaign for the improvement of adult safeguarding, arranging a series of workshops in 2007 with the Commission for Social Care Inspection, which lobbied for further legal powers to be introduced (Johnson, 2008). The demands of ADASS had been prompted by new research into adult abuse, funded by Comic Relief and the Department of Health (Johnson, 2008). The research was the first nationally representative study of elder abuse in the UK (O'Keeffe et al, 2007). The study sampled 2,100 people living in private households aged 66 and over. It found that 2.6 per cent of respondents in private households (including sheltered housing) reported that they had experienced mistreatment from a family, friend or care worker in the last year. When a broader measure of mistreatment was used, which included neighbours and close acquaintances, the level of mistreatment was 4 per cent. Types of mistreatment reported included neglect (1.1 per cent), financial abuse (0.7 per cent), psychological abuse (0.4 per cent), physical abuse (0.4 per cent) and sexual abuse (0.2 per cent). Care homes and hospitals were excluded, and the study was unable to access people affected by dementia.

Following the publication of the national study on elder abuse (O'Keeffe et al, 2007), the Minister for Care Services, Ivan Lewis, announced a review of *No Secrets*. In the consultation document, the government claimed that there were three reasons for holding the review (Department of Health, 2008a). First, it was important to establish whether *No Secrets* was appropriate for the current policy environment. Personalisation, which had been introduced with the aim of increasing self-assessment and management and providing eligible people with direct payments through which they could purchase their own care (HM Government, 2007), topped this list. Second, the report noted that stakeholders and researchers had reported deficiencies in the existing safeguarding system. Specifically, it was noted that implementation had been slow and inconsistent, that joint working was patchy and that some partners had been unwilling to 'come to the table' (Department of Health, 2008a, p 6). Third, they conceded that there had been calls for new statutory powers and that there was a need to examine the case for legislative change. Looking at responses to the consultation, 60 per cent of respondents supported new powers to enter a premises where there were suspicions that a vulnerable adult was being abused, although only 22 per cent felt that this should apply where an individual had mental capacity (Spencer–Lane, 2014).

In summary, the period of 2000–09 saw a high degree of activity in relation to debates around adult abuse or safeguarding. These debates followed on from concerns in the 1990s, with the government issuing guidance on protecting vulnerable adults through *No Secrets* (Department of Health, 2000). This guidance had set national standards, accelerating procedures already in place in some local authorities. However, implementation was uneven across the country. The report of the Joint Committee on the Draft Mental Capacity Bill (2003) and the report of the House of Commons Health Committee on Elder Abuse (2004) provided two high-profile forums in which the problem of adult abuse could be debated, and a range of claims-makers appeared before both. These individuals and organisations were largely united in their view that not enough was being done to address abuse and that further legal powers were needed. While the government initially resisted these claims, the findings of the national study on elder abuse (O'Keeffe et al, 2007) prompted them to revise their position, leading to national consultation (Department of Health, 2008a, 2008b) which would inform the Care Act 2014 in the next decade.

2010 and beyond: high-profile scandals, the Care Act 2014 and after

In 2010, the Department of Health and the Welsh Assembly Government agreed to review the adult social care system, and the Law Commission was tasked with reviewing the legal frameworks (see Law Commission, 2010). Formal efforts to shape safeguarding responses came about as part of that review, which took place over a three-year period. Safeguarding practice was also influenced by the LGA, the ADASS and the Social Care Institute for Excellence, who promoted the Making Safeguarding Personal initiative throughout the decade. The first Making Safeguarding Personal toolkit was published in 2010 (Ogilvie and Williams, 2010) with the aim of aligning safeguarding with other adult care initiatives, most notably personalisation, and ensuring that people experiencing a safeguarding enquiry were given choice about how their case was being managed (see Redley et al, 2015).

McAdam (2000) argues that at certain points in time, cultural opportunities arise in which the public becomes more willing to listen to claims-making. While the problem of adult abuse had been discussed within government committees in the 1990s and some adult abuse cases had received press attention, the level of coverage had been limited. Press coverage of the public inquiry into the Mid Staffordshire NHS Foundation Trust would be of a new order, receiving regular attention in 2010–14 (BBC, 2014). Mistreatment at this hospital came to light due to high mortality figures, discovered by the Healthcare Commission (now the Care Quality Commission – CQC) and due to campaigning by the pressure group Cure the NHS (Holmes, 2013).

The founder of Cure the NHS was Julie Bailey, whose mother had died at Stafford Hospital. Bailey recalled that she and her family had become aware that Stafford Hospital was unsafe when her mother was admitted there in 2007, their concern being so high that they had refused to leave her side. Following her mother's death, Bailey made complaints to the hospital's chief executive and director of nursing and to her local MP. Finding her concerns dismissed, she wrote a letter of appeal to the *Staffordshire Post* asking if other families had witnessed similar treatment. In an interview in 2009, she stated:

> Many of the letters we received were from relatives who only had themselves to provide the care, too fearful to leave their loved ones. … Many had been full time carers now forced to watch as their loved one's body broke down. Dressings left unchanged and sores left to fester, nurses too busy to attend to even the basic of nursing needs. Many wrote how they watched their loved ones shrinking before them from lack of nourishment and care. (Cure the NHS, nd)

The incoming Conservative Government announced a public inquiry, to be chaired by Robert Francis, QC. Held during 2010 and 2011, it identified multiple examples of neglect and treatment (Francis, 2013). Patients were reported to have been left in urine-soaked sheets, treated roughly and given the wrong medication. Some were reported to have been so dehydrated that they had been reduced to drinking water from flower vases (BBC, 2019). The extent of the publicity was so high that it prompted a parliamentary response from Prime Minister David Cameron, rather than the health secretary as is normally the case. Drawing on the Francis report, Cameron argued that a culture had evolved in which 'patient care was always someone else's problem' and where managers ignored evidence of bad practice (Gov.uk, 2013).

While the Mid Staffordshire inquiry was in hearing, further abuse was revealed through the BBC's flagship documentary programme *Panorama* (BBC, 2011). The documentary came about after Terry Bryan, a nurse working at a Winterbourne View private hospital for people with learning disabilities, highlighted concerns to the BBC. Bryan had previously reported his concerns to the CQC but felt they had been ignored. The documentary adopted an undercover format, with the reporter getting a job as a healthcare worker at the hospital and secretly filming events. His footage showed patients with learning disabilities being slapped, taunted and dragged across the floor, and one person was shown being dragged into a shower fully clothed (Flynn, 2012). The prosecution of staff was reported widely in the newspapers, and the charity Mencap used the documentary to campaign for the closure of similar hospital assessment units.

The government responded to growing concerns about adult safeguarding through the Draft Care and Support Bill (HM Government, 2012). This led

to the Care Act 2014, which was enacted in May of that year. Notably, in England, the government decided not to give practitioners new powers of entry. This decision was based on responses from the consultation on power of entry, which found that while the proposed measures were popular with professionals, they were unpopular with members of the public (Department of Health, 2013, para 32). Sections 42–47 of the Care Act 2014 provided a framework for how local authorities and other agencies should safeguard people at risk of abuse and neglect. Local authorities were given the lead responsibility for coordinating safeguarding, with each local authority instructed to establish a Safeguarding Adults Board in its area. The crux of local authority duties was contained within Section 42 of the Act, which required local authorities to consider whether there was reasonable cause to suspect if an adult had care and support needs, was experiencing, or at risk of, abuse and neglect and because of their needs was unable to protect themselves. In these cases, local authorities were given a duty to 'make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case … and, if so, what and by whom' (Care Act 2014, Section 42(2)). The Act also instructed Safeguarding Adults Boards to conduct safeguarding adults reviews where specific failings in care were suspected, replacing the previous system of adult safeguarding case reviews. Part 2 of the Care Act 2014 focused on promoting new care standards in response to the Mid Staffordshire inquiry. The Act added to the 'duty of candour' in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This requires providers who are regulated under the CQC to be open and transparent with service users, their families and advocates where a 'notifiable safety incident' occurs.[4] The Act also increased the powers of the CQC, establishing three chief inspector roles focusing on hospitals, adult social care and general practice.

Several criticisms were made about the safeguarding powers within the Care Act 2014. Luke Clements, a professor of law, argued that the Act gave local authorities 'very little in terms of substance, to enhance their safeguarding powers' (2018, p 48). He noted that the Act did not define abuse, except through stating what financial abuse may involve (although definitions of abuse were included in the revised *Care and Support Statutory Guidance*) (DHSS, 2022). Gary Fitzgerald (2016), the chief executive of Action on Elder Abuse, observed that Section 42 of the Care Act 2014 was ambiguous, leading to differences in interpretation across local authorities. He argued that the descriptions of self-neglect given in the revised statutory guidance were unhelpful saying:

> It tells us that self-neglect may not prompt a section 42 enquiry and that this will depend 'on the adult's ability to protect themselves by controlling their own behaviour'. An adult deemed able to protect

themselves would not qualify for a safeguarding enquiry. But given that self-neglect is a behavioural condition, it is difficult to understand, let alone apply, such guidance. (Fitzgerald, 2016)

Research has also indicated that social workers continued to favour being given a statutory power of entry in adult safeguarding work, although they recognised that such powers might impact negatively on relationships with adults at risk and their families (Stevens et al, 2020).

From the beginning of the Care Act 2014 coming into force, concerns were expressed about the levels of safeguarding referrals. A 2016 *Community Care* article (McNicoll and Carter, 2016) reported on a LGA 'stocktake' which indicated that 103,900 referrals were made in the first 12 months of the Care Act 2014 coming into effect – this was reported as 'a substantial increase' on the previous year. Gary Fitzgerald said:

> If these figures are accurate, they represent a major increase in adult safeguarding intervention, and that must be welcomed because of what it means for victims. However, it is worth exploring the detail further as it is difficult to see how safeguarding teams effectively doubled their workloads at a time of substantial cutbacks. (Cited in McNicoll and Carter, 2016)

Despite criticisms from legal commentators, the new safeguarding powers were viewed in a positive light by those from the practice community. This may have been because the *Care and Support Statutory Guidance* (DHSC, 2022) gave a strong endorsement of the social work role (Whittington, 2016). Specifically, it viewed social workers as vital to safeguarding adults, recognising their ability to work with individuals in complex situations and to supervise safeguarding enquiries and lead safeguarding (paras 14.81). Additionally, the guidance endorsed the Making Safeguarding Personal approach, which had been driven by the LGA and ADASS, and it highlighted the role of principal social workers in applying it. In line with the guidance, the LGA and ADASS continued to promote the Making Safeguarding Personal initiative, conducting 'temperature checks' to assess its implementation and designing a new outcomes framework (Cooper et al, 2016).

Nonetheless, safeguarding duties under the Care Act 2014 pose a significant challenge for local authorities that are tasked with deciding whether the concerns they receive meet the criteria for a safeguarding enquiry. Government-collated statistics show that the number of safeguarding concerns received by local authorities (where a local authority is notified about a risk of abuse or neglect which could instigate a safeguarding enquiry) has risen steadily over the years. This number totalled 364,605 in the 12-month reporting period for 2016–17, and the figure reached 541,535 in

2021–22 (NHS Digital, 2022). Some research has suggested that the COVID-19 pandemic has been responsible for an increase in referrals in recent years (LGA, 2021). While this may be the case, the NHS Digital statistics indicate a rise in safeguarding referrals year on year since 2016–17. In 2020–21, 498,260 safeguarding concerns were received in England (equivalent to 1,121 per 100,000 adults). Of these, 152,270 resulted in a Section 42 enquiry, while 16,690 resulted in what NHS Digital calls an 'other enquiry' (where the adult did not meet all of the Section 41 Part 1 criteria, but where the local authority deemed it necessary to conduct a safeguarding enquiry; NHS Digital, 2020).

In summary, this period saw adult safeguarding placed on a statutory footing through the Care Act 2014. While the government had already begun consultations on a new adult safeguarding system in 2008, the Mid Staffordshire and Winterbourne View inquiries kept the abuse and neglect of adults in the public consciousness. The level of public attention to the issue made it difficult for the government to duck further reforms, with the Care Act 2014 providing powers designed to enable professionals to make enquiries into abuse in the community and enable new care standards in hospital. While groups like the ADASS had campaigned for greater statutory powers, these were withheld in England, though they were granted to practitioners in Scotland and Wales. Government statistics indicate a steep increase in safeguarding referrals. Reactions from the social work leaders and professionals suggest the Care Act 2014 was positively received by the profession, although whether that will remain the case is an open question.

Conclusion

This chapter, charting developments from the 1960s to the Care Act 2014 and after, has highlighted how the abuse and neglect of adults came to be seen as a social problem. According to Best (2013), claims-makers commonly seek media coverage to publicise their claims, which then filter down to the public and policy makers. This pattern can be seen in some parts of my social history but is less evident in others. Barbara Robb and AEGIS were successful in placing the problem of elder abuse on the political agenda. However, this attention was much more muted in the 1970s, with claims being limited to concerned medical practitioners in their professional journals. Adult abuse and neglect received some press attention throughout the 1980s, 1990s and 2000s, mainly though coverage of inquiries. Press attention then became more sustained from 2010, with the abuse and neglect of adults receiving regular press attention and a high degree of coverage. However, these cases did not act as a catalyst for the current safeguarding system. This work had already started through the *No Secrets* guidance (Department of Health, 2000)

and the reviews of law and policy by the Law Commission and government committees which took place throughout the late 1990s and 2000s.

Best (2013) contends that claims-making leads to reactions from both the public and policy makers. While one would imagine that the public would disapprove of adult abuse and neglect, public surveys or research on this issue are rare, and it is difficult to know what public perceptions on the issue were or how they have evolved. Nonetheless, the evolution of national policies can be traced through an examination of policy documents. Claims-making in the 1960s led politicians to establish complaints procedures in the 1960s and 1970s. Those in the 1970s and 1980s led to *No Secrets* (Department of Health, 2000). Lobbying by professionals for new legal powers then led to the Care Act 2014.

According to Best's model, once policies have been made, agencies engage in social problem work. Policy makers set expectations which must be carried out, institutions frame expectations, and organisations employ workers to deal with the problem and monitor their work. This results in some individuals seeking attention from problem workers, and observers witnessing and commenting on these interactions. This may be commentated on by the media, who develop idealised versions of social problem work.

The final stage in the evolution of social problems, according to Best (2013), is policy outcomes. Several types of outcome are possible. Critics may argue that policies are ineffective or make the problems worse. Debates may occur as to how policy outcomes should be measured or judged. As I observed in the previous section, the duties and powers given to social workers under the Care Act 2014 were broadly welcomed by social work bodies. There has also been very little critical debate of these policies within the academic community. This stands in stark contrast to the situation in the child protection system, where criticism of legal frameworks by some practitioners and academics has been vociferous (Jones, 2018; Featherstone et al, 2019). There is also a shortage of literature focusing on how social workers view such work.

In the next chapter, I turn to the topic of social work and risk before exploring how social workers manage decisions about risk and safeguarding in my empirical chapters.

Notes

Chapter 1

1   The Law Commission is a government-commissioned independent body responsible for reviewing English law and suggesting policy change.

2   The document referred to the National Assistance Act 1948 and the Mental Health Act 1983. Section 47 of the National Assistance Act 1948 allowed for the 'removal to suitable premises of persons in need of care and attention'. This needed to be authorised by a magistrate and could be used for those who were seriously ill, living in squalor or not receiving proper care and attention. The Mental Health Act 1983 (as amended by the Mental Health Act 2007) allows for people with a mental disorder to be detained and assessed or treated in hospital where the conditions in the legislation are met.

3   Research focusing on how *No Secrets* was applied is set out in greater detail in the next chapter, focusing on social workers understand and manage risk.

4   This falls under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. See Kelly and Quick (2019) for further details. The Care Quality Commission (Registration) Regulations 2009 also state that providers must report specific harms to the CQC, including abuse or allegations of abuse.

Chapter 3

1   As noted in Chapter 1, the guidance lists several types of abuse: physical abuse, domestic violence, sexual abuse, psychological abuse, financial or material abuse, modern slavery, discriminatory abuse, organisational abuse, neglect and acts of omission, self-neglect, domestic abuse and financial abuse (DHSC, 2022, para 14.17). This list is not intended to be exhaustive and other types of abuse or neglect may be considered.

2   The use of the term 'threshold' was omitted from LGA guidance in 2018. This change was made 'to avoid any inference that an individual must "pass a test" or "reach a threshold" to get safeguarding support' (LGA, 2019, p 6).

Chapter 4

1   Current guidance states that the concept of wellbeing should be applied broadly (DHSC, 2022, para 1.5). Section 1(2) of the Care Act 2014 states that wellbeing relates to any of the following: '(a) personal dignity (including treating of the individual with respect); (b) physical and mental health and emotional well-being; (c) protection from abuse and neglect; (d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided); (e) participation in work, education, training or recreation; (f) social and economic well-being; (g) domestic, family and personal relationships; (h) suitability of living accommodation; (i) the individual's contribution to society.'

2   Section 1(3(b)) of the Care Act 2014 states that local authorities must give regard to 'the individual's views wishes, feelings and beliefs'. As such, the principle overlaps with the safeguarding principle of empowerment, which is concerned with '[p]eople being supported and encouraged to make their own decisions' with informed consent (DHSC, 2022, para 14.13).

3   An adult's needs meet the eligibility criteria if '(a) the adult's needs arise from or are related to a physical or mental impairment or illness; (b) as a result of the adult's needs the adult is unable to achieve two or more of the outcomes specified in paragraph (2); and (c) as a consequence there is, or is likely to be, a significant impact on the adult's well-being' (The Care and Support (Eligibility Criteria) Regulations 2015, Section 2(1)).

Chapter 5

1   CQC reports rate homes under four different categories. Providers may be rated as 'outstanding', 'good', 'requires improvement' or 'inadequate'.

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