Helping or hindering in adult safeguarding: an investigation of practice

Martin Stevens, Stephen Martineau, Caroline Norrie and Jill Manthorpe

Social Care Workforce Research Unit

August 2017
Acknowledgements and disclaimer
We acknowledge funding from the Department of Health Policy Research Programme. The views expressed here are those of the authors and not the Department of Health. We are grateful to members of the Unit’s User and Carer Group who assisted with the development of this study and bring their experiences to inform and influence the work of the Unit. We thank those managers and practitioners who assisted in this study by completing the survey and being interviewed and all others who participated, especially the Advisory Group members.

About the Policy Institute at King’s
The Policy Institute at King’s College London addresses complex policy challenges with rigorous research, academic expertise, and analysis focused on improving outcomes. Our vision is to enable the translation of research into policy and practice by facilitating engagement between academic, business and policy communities around current and future issues in the UK and globally.

About the Social Care Workforce Research Unit
The Social Care Workforce Research Unit (SCWRU) at King’s College London is funded by the Department of Health Policy Research Programme and a range of other funders to undertake research on adult social care and its interfaces with housing and health sectors and complex challenges facing contemporary societies.

Project web page
kcl.ac.uk/sspp/policy-institute/scwru/res/capacity/helping-or-hindering.aspx
## Contents

<table>
<thead>
<tr>
<th>Section Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glossary</td>
<td>i</td>
</tr>
<tr>
<td>Executive summary</td>
<td>ii</td>
</tr>
<tr>
<td>1</td>
<td>Introduction</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Scope of the study</td>
<td>1</td>
</tr>
<tr>
<td>Study aims</td>
<td>1</td>
</tr>
<tr>
<td>Phases of the research</td>
<td>1</td>
</tr>
<tr>
<td>Legislative framework</td>
<td>2</td>
</tr>
<tr>
<td>Structure of the report</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Previous views and debates about hinder situations and legal powers</td>
</tr>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Analysis of responses to the Department of Health Consultation</td>
<td>4</td>
</tr>
<tr>
<td>Parliamentary debates</td>
<td>5</td>
</tr>
<tr>
<td>Managing difficult encounters – evidence from Adult Serious Case Reviews</td>
<td>6</td>
</tr>
<tr>
<td>Beyond the UK</td>
<td>7</td>
</tr>
<tr>
<td>Theoretical debates</td>
<td>8</td>
</tr>
<tr>
<td>Summary</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>Methods</td>
</tr>
<tr>
<td>Introduction</td>
<td>10</td>
</tr>
<tr>
<td>Phase 2 – Survey</td>
<td>10</td>
</tr>
<tr>
<td>Phase 3 – in-depth research in three research sites</td>
<td>11</td>
</tr>
<tr>
<td>Phase 3 site descriptions</td>
<td>14</td>
</tr>
<tr>
<td>Summary</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>How big a problem is hindering?</td>
</tr>
<tr>
<td>Introduction</td>
<td>16</td>
</tr>
<tr>
<td>Contextual factors influencing numbers of hinder situations</td>
<td>16</td>
</tr>
<tr>
<td>Numbers of cases</td>
<td>16</td>
</tr>
<tr>
<td>Costs of hinder cases</td>
<td>18</td>
</tr>
<tr>
<td>Characteristics of adults at risk and hinder cases</td>
<td>19</td>
</tr>
<tr>
<td>Summary</td>
<td>20</td>
</tr>
<tr>
<td>5</td>
<td>Contexts of hindering</td>
</tr>
<tr>
<td>Introduction</td>
<td>21</td>
</tr>
<tr>
<td>Reasons for hindering</td>
<td>21</td>
</tr>
<tr>
<td>Types of cases</td>
<td>21</td>
</tr>
<tr>
<td>Summary</td>
<td>26</td>
</tr>
<tr>
<td>6</td>
<td>Current approaches to gaining access in hinder situations</td>
</tr>
<tr>
<td>Introduction</td>
<td>27</td>
</tr>
<tr>
<td>Informal approaches to gaining access – negotiation</td>
<td>27</td>
</tr>
</tbody>
</table>
Informal approaches to gaining access – creative approaches where negotiation is unsuccessful 28
Current informal multi-agency approaches to gaining access when access is hindered 30
Information sharing 34
Summary 35

7 | Impact of the Care Act and use of current legal routes to effect access 36
Introduction 36
Impact of the Care Act 2014 36
Current legal provision 38
Summary 45

8 | Potential legal powers 47
Introduction 47
Views about a power of entry 47
Reasons for supporting a power of entry 48
Reservations about introducing new legal powers 50
Powers available in Scotland 52
Summary 55

9 | Discussion, conclusion and policy options 56
Introduction 56
How big a problem is hindering? 56
Current approaches to gaining access to an adult at risk in hinder situations 57
Current legal provision 58
Power of entry 60
Conclusion and policy options 61

References 63

Appendices – Research tools 67
Appendix 1: Online survey of adult safeguarding managers 68
Appendix 2: Interview guide for managers 82
Appendix 3: Interview guide for social workers 85
Appendix 4: Vignette interview guide 88
**Glossary**

**Adult at risk:** a person meeting the criteria set out in section 42 Care Act 2014.

**Assessment order:** in Scotland, a court order for the temporary removal of an adult to a place where it can be established whether or not the person is at risk.

**Banning order:** in Scotland, a court order that bans an individual from a specified place for a period not exceeding six months.

**Court of Protection:** specialist court in England and Wales created by the Mental Capacity Act 2005, which has jurisdiction over cases involving people without decision making capacity.

**Cuckooing:** where a third party moves in with a person with care and support needs and takes over the property, often financially and emotionally abusing the adult at risk.

**Deprivation of Liberty Safeguards (DoLS):** statutory provisions contained in the Mental Capacity Act 2005 which ensure that the deprivation of liberty of individuals lacking capacity is properly authorised.

**Domestic violence and abuse:** 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. (Home Office, 2016)

**Hindering:** where access to an adult at risk living in the community for the purposes of a safeguarding enquiry is obstructed by a third party, whether completely, intermittently, or through not allowing an interview to take place in private.

**Hoarding:** A hoarding disorder is where someone acquires an excessive number of items and stores them in a chaotic manner. The items can be of little or no monetary value and usually result in unmanageable amounts of clutter. Hoarding can interfere with everyday living and cause distress or negatively affect quality of life (NHS Choices website: [http://www.nhs.uk/Conditions/hoarding/Pages/Introduction.aspx](http://www.nhs.uk/Conditions/hoarding/Pages/Introduction.aspx)).

**Modern slavery:** under the Modern Slavery Act 2015, this refers to people trafficking, sexual exploitation, forced labour, and domestic servitude.

**Multi-Agency Risk Assessment Conference (MARAC):** a local multi-agency meeting focusing on information sharing in respect of victims/survivors of domestic violence and abuse.

**Multi-Agency Safeguarding Hub (MASH):** a group of practitioners, employed by their individual agencies (local authority, probation, health service, police etc.), who work closely in information sharing and promoting multi-agency working in safeguarding.

**Office of the Public Guardian:** created by the Mental Capacity Act 2005, this body protects people in England and Wales who may not have the mental capacity to make certain decisions for themselves, such as about their health and finance.

**Removal order:** in Scotland, a court order for the removal of an adult at risk to protect them from harm.

**Serious Case Reviews:** commissioned by local Safeguarding Boards to investigate how local professionals and agencies worked together to safeguard a vulnerable adult following an incident of abuse, harm or death if the Board identifies concerns about agencies' actions from which lessons may be learned. Since the Care Act 2014, they are now called Safeguarding Adults Reviews.

**Third party:** in the context of this study, this refers to a person hindering access to an adult at risk.
This study sought to examine current safeguarding practice in England where access to an adult at risk is obstructed by a third party. We refer to such obstructive behaviour as ‘hindering’. Our study focused on hindering of access to adults at risk and to occasions where an adult at risk is able to be interviewed, but this cannot be done with them on their own. It focused on these situations in respect of adults who are thought to have decision making capacity because there are powers permitting professionals to access a person lacking decision making capacity. We were also concerned with cases where professionals are unaware of the capacity of the adult at risk, because of problems in gaining access. Finally, our focus was on adults living at home (including sheltered and supported housing), because the regulatory body has powers of access to care settings. We sought to establish the current range of practice responses to situations of hindering, and practitioner views about the potential for any new powers.

The study took place following the implementation of the Care Act 2014 in April 2015 and focused on England. It was a multi-method study consisting of a literature review; analyses of the responses to the 2012 public consultation on the topic of powers of access, and of parliamentary debates on proposed amendments to introduce a power of entry into the Care Bill in 2013-14, and an analysis of Serious Case Reviews where access had been at issue; an online survey of adult safeguarding managers in England; and, interviews with adult safeguarding practitioners and older or disabled people and family carers in three English local authorities. The study was supported by members of the Social Care Workforce Research Unit’s User and Carer Advisory Group who offered valuable comments during the development of the study protocol and on its data collection instruments.

Phase 1: Previous views and debates about hinder situations and legal powers

Findings from Phase 1, a literature review, analyses of the responses to the 2012 public consultation on the topic of powers of access, and of parliamentary debates on proposed amendments to introduce a power of entry into the Care Bill in 2013-14, were presented in our Interim Report.

In our re-analysis of responses to the government’s Safeguarding Power of Entry Consultation in 2012, we found that the majority of respondents to the consultation generally reported that situations when a new power of entry would be required were seldom encountered, although a minority of respondents stated these situations occurred frequently.

Examples of situations where third parties appeared to be hindering access were given across the different categories of adults at risk and types of abuse. Respondents observed that the risks of excessive or inappropriate use of any new powers needed to be considered carefully. In support of its decision not to include a power of entry in the Care Act 2014, the Coalition Government argued that: there was no consensus on the topic; such a power may increase risk to individuals; overcoming such difficulties was part of the essence of social work; and current law provided sufficient protection.

The literature review summarised and synthesised current law in England, Scotland and Wales, the latter two countries having introduced a power of entry in 2008 and 2016 respectively, and explored some of the theoretical implications of these new powers. In Scotland, protection orders (for assessment, removal and banning) were also brought in, but have been rarely used. National data from Scotland are incomplete, but a survey of Adult Protection Committee reports that was conducted in early 2017 indicated around 100 had been used in the period 2012-14. Nearly all of these were banning orders, which prohibit someone from entering a property or area for up to six months.
Phases 2 and 3: National online survey and interviews in three English local authorities

Phases 2 and 3 of the study consisted of an online survey of Adult Safeguarding Managers in England (n=27) and in-depth interviews with 37 adult safeguarding social workers and managers in one London Borough and two county councils. We also interviewed disabled people, older people in need of care and support (n=6) and carers (n=5). This report presents the findings from Phases 2 and 3 of this study.

Findings

How big a problem is hindering?

None of the survey respondents or practitioner interviewees reported that data were collected specifically in relation to obstruction by third parties. Survey respondents who answered the question reported estimates of between 0 to 18 cases since April 2015 in their local authorities, though most of these reported five or fewer cases in this period. Social workers and managers interviewed also reported being aware of widely different numbers of cases since April 2015, ranging from 0 to 70. Generally, in these cases access was achieved, albeit it was often compromised by an inability to conduct a private interview. However, one social worker reported a case of complete obstruction, where access was only achieved by chance outside the house and another reported 15 unresolved cases. Several survey respondents and interviewees stressed the heavy demands placed on human resources from these cases, some of which ran for several years.

Why are third parties being obstructive?

Practitioner interviewees identified an array of scenarios. Sometimes parents or other family members were being arguably over-protective (often in cases involving an adult at risk with learning disabilities). Some third parties were thought to be fearful that the social worker would disrupt an established relationship. The obstructive third party might have his or her own mental health or addiction problems. Third parties might also be anxious that their opinion will not be heard; in some cases they were concerned about their own tenancy or immigration status. Cultural factors might be in play – for example, the third party objecting to a male social worker seeing a female adult at risk. As indicated by this variety in motivation, hindering was not always associated with abuse, according to interviewees. We identified seven types of risk accompanying obstructive behaviour:

- Poor care of the adult at risk (11)
- Abuse of the adult at risk (9)
- Risk management: where third parties are managing difficult situations and do not want social workers involved (3)
- Hoarding (3) creating potential health and safety or fire risks
- ‘Cuckooing’ where a third party (often unrelated to the adult at risk) moves in with a person with care and support needs and takes over the property, often financially and emotionally abusing the adult at risk. (5)
- Domestic violence (3): where the third party might be hiding domestic violence towards the adult at risk
- Modern slavery: where the third party might be hiding the fact that the adult at risk or other members of the household were being treated as slaves (3)

Without greater knowledge about the size and nature of the problem – and therefore the costs to local authorities – policy options may be limited; quantifying the issue, however, would involve further development work to define hinder situations and considering whether to add prevalence measures to annual statistical returns.
What approaches are social workers using to gaining access in these cases?

Social worker skills and informal relationships
Negotiation with the third parties was the most common approach reported in the survey: this might range from ‘soft’ styles aiming to develop rapport to a more assertive approach, sometimes with explicit reference to legal routes. Good ‘matching’ as part of social worker allocation to the family in question was felt to be important. Using different means of communication and working jointly with colleagues or professionals from different agencies were typical strategies used in these cases. Creative approaches to arranging interviews and identifying potential allies in the community (such as Age UK, or the RSPCA, housing or utilities representatives) were also important ways of securing access.

A multi-agency approach
In addition to the deployment of social worker skills, good multi-agency working was identified as essential in this aspect of safeguarding. Police, health, fire ambulance and housing services’ involvement was discussed at length in interviews and commented on by survey respondents. Relationships with banking staff were also mentioned. While individual practitioners were often willing to support social workers in gaining access (especially GPs), problems with finding time or giving this priority meant that availability was variable. Similarly, the police service was identified as potentially a very useful support, although again availability depended on local resources and informal relationships, as well as formal arrangements being in place, such as the presence of a multi-agency safeguarding hub (MASH).

Participants considered improved multi-agency information sharing would help in hindering cases. They also suggested more explicit powers/ responsibilities for multi-agency partners so that their support could be relied upon in certain circumstances.

Care Act 2014 and current law
The new status of safeguarding under the Care Act 2014 was deemed helpful, particularly in relation to encouraging other agencies in their duty to cooperate. Legal action, if possible, was a last resort because of cost implications and the risk of damage to relationships. Interviewees reported no involvement in the use of the Police and Criminal Evidence Act 1984 in hindering cases in the period under study, though five cases were reported by the survey respondents.

Social work interviewees reported problems of conducting mental capacity assessments unimpeded by third parties. Some stressed the importance of the private interview as a result. Recourse to the Court of Protection (COP) was an option used, rarely, by a number of interviewees in relation to hinder situations involving a person who had granted a lasting power of attorney (of any sort) to an individual under the Mental Capacity Act 2005 (MCA) or when best interests decisions about residence were being considered under the Act. Though the MCA was seen as providing useful statutory backing when dealing with problems of access to a person lacking capacity, Court of Protection applications were perceived by some social workers to take up much time and resources.

While the inherent jurisdiction of the High Court had not been used by survey respondents, it had been considered as a means of resolving access problems in all three interview sites, and two applications had been made. High Court cases also require a ‘massive’ amount of resources, which needed to be accepted as part of safeguarding responsibilities.

Domestic Violence Protection Orders (applied for by the police), which may involve the eviction of the perpetrator, were reported to be relatively easy to obtain, but not necessarily easy to enforce where both victim and perpetrator wish to breach the order. Four reports of the orders being used to resolve a hindering situation were mentioned by survey respondents. No cases of the new offence of controlling or coercive behaviour were reported, probably because this was in its early days and there was a view that caution was needed as to its applicability in cases where criminal prosecution might be counterproductive.

No instances of the use of section 135(1) Mental Health Act 1983 were reported by interviewees for a safeguarding purpose. There was no evidence of practitioners having used it, or knowing about it having been used, for anything other than a Mental Health Act assessment. However, two of the sites had arrangements whereby safeguarding for adults (except older adults) with mental health problems was managed by the local NHS Mental Health Trust, so this was not part of these participants’ responsibility.
**Power of entry**

Most survey respondents and interviewees were in favour of a power of entry for undertaking a private interview; most were also in favour of the introduction of assessment orders (temporary removal for assessment) and orders enabling the banning of a perpetrator. However, less than half were in favour of orders enabling authorities to remove an adult at risk.

Some interview participants in favour of a power of entry argued that such a power would strengthen the legal basis of safeguarding and provide legitimacy for action where someone has capacity, but there are strong concerns about their wellbeing. They also argued that such a power could shorten the process of negotiation. Many participants (those in favour as well as those who were against a power of entry) expressed reservations. These participants felt that: cases could generally be resolved with good social work; there would be a risk of negative impact on adults at risk and their families; the power of entry did not fit with social work practice and values; it could negatively affect social work relationships; it might infringe human rights; and, that current legal provision suffices.

The Scottish protection orders were seen by some as a useful complement to the power of entry. Again, some argued that existing powers were enough. Banning orders were seen as particularly useful in domestic violence and ‘cuckooing’ cases (takeover of a person’s accommodation). The ability to override an adult at risk’s refusal to consent in the Scottish legislation was seen as relevant, since the effect duress or coercion can have on decision making was widely acknowledged, though again there was concern that it ran counter to social work values.

**Conclusion and policy options**

While complex hinder situations appear to be rare, practitioners report that they are usually resolved by good social work and multi-agency working. Social workers appear creative in their approaches to gaining access to the adult at risk. However, in a small number of cases, gaining any access proves very difficult and sometimes impossible. Such cases can take up a great deal of time and resource, and also may mean that adults at risk suffer abuse or neglect for long periods. In these cases, many social workers appear to support the introduction of a power of entry, and some of the other powers available in Scotland. The similarities between these current findings and themes from the Department of Health (DH) consultation suggest that views have not altered substantially despite the changes of the Care Act 2014. The research highlights policy options for consideration (including some suggestions for further research), which are set out below.

**Policy options**

1. Wait for data from use of the legal powers in Wales and further data from Scotland before making firm policy decisions about further legal powers.

2. Undertake a public consultation through, for example, the Law Commission to consider legislation already proposed e.g. amendments to Care Act 2014. The consultation could seek views on
   a. Applying the approach adopted in Scotland to England (or that of Wales).
   b. How to improve the current legal routes to gaining access including speeding up legal processes.

3. Consider data collection and research to consider scale of problem, which would require:
   a. Commissioning further development work to define when to count a problem as a ‘hinder situation’.
b. Commissioning sample surveys to test out the measure and to produce estimates of prevalence.
c. Consideration of including a measure in annual statistical returns.

4. Offer further guidance or policy and procedures. Five areas in which guidance could be valuable were suggested by the research participants:

a. Practice approaches to gaining access, to complement the SCIE guide (SCIE, 2014), which sets out the legal routes (and updates it). In addition, SCIE’s ‘Safeguarding Questions’ (supporting the Care Act 2014) document could be expanded or other guidance, such as a ‘community of knowledge’ page with case studies, on ‘what’s worked for us’ and tips.
b. A decision tool for social workers to use in deciding when to escalate concern about a hinder situation and when a legal route to gaining access should be considered.
c. The Care Act 2015 section 6 duty to cooperate could be extended to give more structured powers (or responsibilities) to enable attendance and/or cooperation from professionals/agencies. This might include clearer criteria for involvement of the police and advising hospital staff and GPs on their role in supporting social workers to have private conversations with adults at risk in hospitals or in the community.
d. Guidance to the police and joint training with social workers on the remit and requirements for welfare checks.
e. Guidelines for co-ordination with banks in suspected financial abuse cases.
f. More training and skills development in the Mental Capacity Act 2005 for professionals working in agencies other than adult social care departments.

5. Consider widening the remit of when advocacy is appropriate in safeguarding cases to include provision in cases of apparent obstruction.

6. Consider the professional and organisational response to hindering in adult safeguarding in the context of intended human rights reform (now timetabled post-Brexit).
Introduction

This is the final report of ‘Helping or hindering in adult safeguarding: an investigation of practice’, a study commissioned from the Social Care Workforce Research Unit at King’s College London in July 2015, under the Department of Health’s (DH) Policy Research Programme. The Interim Report (Martineau et al, 2016), which was submitted to the DH in February 2016, reviewed the wider context of the topic. It examined recent developments in policy and law in this area, and included evidence of hindering in relation to social workers and other professionals in general (not just safeguarding enquiries) prior to the Care Act 2014 (CA). This chapter sets out the scope of the study and gives its aims and objectives. It then describes the phases of the research, sets out the current legal provision and outlines the structure of the report.

Scope of the study

Hindering, in the context of this study, refers to the actions of a third party who is obstructing local authority staff making safeguarding enquiries in respect of a community-dwelling adult (including people living in sheltered or supported accommodation) whose circumstances meet the criteria set down in section 42(1) CA. It is not limited to instances where staff are refused access to the dwelling, but also includes occasions where obstructive behaviour goes on within the home, for example where the third party refuses to leave the room where an interview or assessment is taking place.

In some of these situations, undue influence or duress are identified. In these cases it is considered that the behaviour of the third party makes it difficult or impossible for the adult at the centre of the enquiry to complain about the hindering activity (or, indeed, any possible abuse). For the purposes of the report, we will use the term ‘hinder situation’ to refer to all these cases.

A range of terminology is used in the literature on this topic, with the term ‘vulnerable adult’ being used in the courts, for example. In contrast to Scotland and Wales, where ‘adult at risk’ was given statutory definition, in England the Coalition Government eschewed the opportunity to do the same in the CA, and this approach was followed in the statutory guidance (DH, 2017). However, the term ‘adult at risk’ is increasingly used and in this report we use it to refer to the individual who meets the threshold criteria in section 42(1) CA. We refer to the person engaging in hindering as the ‘third party’ or ‘hinderer’.

The study focuses on instances when local authority staff are those making the enquiry, as opposed to another agency, such as the police, although often professionals and other staff from other agencies and organisations help in gaining access.

Study aims

The project aimed to:

1. Establish what evidence there is that social workers in England are being obstructed in their attempts to gain access to an adult about whom there is a concern in relation to possible abuse or neglect; and
2. Explore the policy and practice response in such situations.

Phases of the research

Phase 1 of the study consisted of a literature review, covering publications in English, with a formal start date of 2000; an analysis of part of the response to the government’s consultation on a new safeguarding power (DH, 2012); and, an examination of the relevant parliamentary debates, 2013-14, in the run-up to the enactment of the CA. Two articles have been published, one (Norrie et al, 2016a) about the analysis of the DH
consultation and one (Manthorpe et al, 2016) about
the parliamentary debates. An article exploring
the powers available under Scottish law has been
submitted for publication. This work forms much of
the background to the research and is described in
Chapter 2 of this report.

Findings of Phases 2 and 3 of the study are
presented in detail in this report. Phase 2 was a
survey of local authority safeguarding managers.
For Phase 3, three local authority sites were
selected: two counties and one London Borough.
Semi-structured interviews were undertaken
with social workers (n=22), team and service
managers (n=15), disabled and older people
(n=6), and carers (n=5).

Details of the methods used in the survey and
interviews follow in Chapter 3. In addition to this
report, articles are being written focusing on social
work practice in the face of obstructive behaviour,
practitioner experience of using current legal
provision, views of participants about a power of
entry and estimates of the number of cases being
brought to the attention of local authorities.

**Legislative framework**

The CA placed adult safeguarding on a statutory
footing in England for the first time. Sections
42(1) and (2) of the CA require a local authority to
make enquiries, or cause others to do so, if it has
reasonable cause to suspect that an adult in its area
(whether or not ordinarily resident there):

1. has needs for care and support (whether or not
the authority is meeting any of those needs);
2. is experiencing, or is at risk of, abuse or neglect;
and,
3. as a result of those needs is unable to protect
himself or herself against the abuse or neglect
or the risk of it (s 42(1) CA).

The local authority duty to enquire (s 42(2)
CA) arising from these circumstances was not
accompanied by any new powers (for example, a
power of entry), and this study encompasses both
hindering and the range of potential safeguarding
responses to it, in light of this absence. The
safeguarding provisions of the CA came into
force in England in April 2015, and the empirical
phases of this study (Phases 2 and 3) examined
local authority experiences of the phenomenon
of hindering from this date and attempted to gain
estimates of the number of cases.

The guide published by the Social Care
Institute for Excellence (SCIE), *Gaining access to an
adult suspected to be at risk of neglect or abuse* (SCIE,
2014) outlined the legal powers that may be of use
to local authorities in hindering situations. These
routes are set out in Box 1.

Two of the four nations of the UK have taken
a different legislative approach to this issue. In
Scotland, the Adult Support and Protection
Act (Scotland) 2007 (ASPA) introduced four
protection orders: assessment orders (i.e. take to
another place to determine whether the person is
an adult at risk); removal orders (take to a place of
safety); banning orders (exclusion of third party); and,
temporary banning orders (an emergency
measure for excluding the third party) (Scottish
Government, 2014). Social workers or other
professionals working on safeguarding cases can
apply to a Sherriff Court for any of these orders,
which are automatically accompanied with a
warrant for entry. In Wales, professionals can apply
to a justice of the peace for an ‘adult protection
and support order’, which gives a power to enter
in order to speak in private to a person suspected
of being an adult at risk. These orders were
introduced by the Social Services and Well-being
(Wales) Act 2014 (SSWA) (s 127). There is no legal
power of entry in Northern Ireland; no decision has
been made about whether this is required.

However, the Northern Ireland Commissioner
for Older People recommended a power of access
for the purpose of conducting a private interview
(Commissioner for Older People for Northern
Ireland, 2014). Guidance has been produced for
social workers and their managers about the law
in respect of seeking to gain access in England
(SCIE, 2014); for Wales (within Williams, 2014;
produced for the pre-SSWA context) and for
Northern Ireland (within Northern Ireland Adult
Safeguarding Partnership, 2012).

Phases 2 and 3 of the research asked
participants for their opinions about the value of
the powers available in Scotland which was the
situation most relevant to the English context at the
time of the study.

**Structure of the report**

Following this Introduction, Chapter 2 presents
an outline of the findings from Phase 1 of the
research, and some other research undertaken by
the authors, to provide some background to the
rest of the report. Chapter 3 describes the methods
used and samples achieved for Phases 2 and 3 of the study. The following four chapters present the findings of these phases. Chapter 4 examines how big a problem hindering represents, gives the findings about numbers of cases, views about different levels of seriousness of cases experienced and the characteristics of adults at risk and the third parties involved. Chapter 5 describes the context of cases, using the extended accounts of individual hinder situations and proposes a tentative typology of cases and reasons for hindering. Chapter 6 explores current practice responses to hinder situations by social workers and managers and identifies the benefits of and barriers to joint working in these cases. Chapter 7 describes the use of current legal routes to gaining access (as set out in Box 1 above), focusing on the frequency of use, decision-making and barriers to using these legal approaches. Chapter 8 presents participants’ views about the potential introduction of a power of entry where it is very difficult to gain access when undertaking safeguarding enquiries. It also explores views about the need for the further powers available in Scotland (as set out above). Chapter 9 presents a discussion of the findings and sets out some policy options arising from the study.

**Box 1: Current legal powers to gain access to an adult at risk in England (SCIE, 2014: 8–9)**

- ‘If the person has been assessed as lacking mental capacity in relation to a matter relating to their welfare: the Court of Protection has the power to make an order under Section 16(2) of the MCA [Mental Capacity Act 2005] relating to a person’s welfare, which makes the decision on that person’s behalf to allow access to an adult lacking capacity. The Court can also appoint a deputy to make welfare decisions for that person.
- If an adult with mental capacity, at risk of abuse or neglect, is impeded from exercising that capacity freely: the inherent jurisdiction of the High Court enables the Court to make an order (which could relate to gaining access to an adult) or any remedy which the Court considers appropriate (for example, to facilitate the taking of a decision by an adult with mental capacity free from undue influence, duress or coercion) in any circumstances not governed by specific legislation or rules.
- If there is concern about a mentally disordered person: Section 115 of the MHA [Mental Health Act 1983] provides the power for an approved mental health professional (approved by a local authority under the MHA) to enter and inspect any premises (other than a hospital) in which a person with a mental disorder is living, on production of proper authenticated identification, if the professional has reasonable cause to believe that the person is not receiving proper care.
- If a person is believed to have a mental disorder, and there is suspected neglect or abuse: Section 135(1) of the MHA, a magistrates court has the power, on application from an approved mental health professional, to allow the police to enter premises using force if necessary and if thought fit, to remove a person to a place of safety if there is reasonable cause to suspect that they are suffering from a mental disorder and (a) have been, or are being, ill-treated, neglected or not kept under proper control, or (b) are living alone and unable to care for themselves.
- Power of the police to enter and arrest a person for an indictable offence: Section 17(1)(b) of PACE [Police and Criminal Evidence Act 1984].
- Common law power of the police to prevent, and deal with, a breach of the peace. Although breach of the peace is not an indictable offence the police have a common law power to enter and arrest a person to prevent a breach of the peace.
- If there is risk to life and limb: Section 17(1)(e) of PACE gives the police the power to enter premises without a warrant in order to save life and limb or prevent serious damage to property. This represents an emergency situation and it is for the police to exercise the power.’
2 | Previous views and debates about hinder situations and legal powers

Introduction

This research was commissioned after the Care Act 2014 (CA) was implemented in April 2015. The DH consultation (2012) and parliamentary debates (2013-14) about whether to introduce a new power of entry for social workers were described in detail in the Interim Report and the outputs on this part of the research are published or in press (Manthorpe et al, 2016; Norrie et al, 2016a; Stevens et al, forthcoming and Manthorpe et al, 2017). This chapter presents a short account of this background to contextualise the findings of the primary research presented in this report.

Whether social workers (alone or with others) should have a power of entry in cases where individuals obstruct their access to adults at risk, who are believed to have decision-making capacity, during safeguarding enquiries remains topical (see, for example, Action on Elder Abuse, 2016). Furthermore, opinion remains divided on whether a new power of entry should be introduced for social workers working in such cases. Establishing ongoing rapport and a good working relationship is also essential. Other than the supplementary powers introduced in Scotland, which involve the power to remove an adult at risk for assessment or for longer periods and to ban third parties, (as we describe below), there are few further legal provisions to support social workers.

This chapter will first outline findings of our analysis of responses to the DH consultation, which will be followed by the findings from the analysis of the parliamentary debates. We then summarise some of our findings relevant to this subject emerging from Serious Case Reviews (renamed Safeguarding Adults Reviews under the CA). The chapter will finish by exploring some of the theoretical debates we drew out of the literature review.

Analysis of responses to the Department of Health Consultation

Responses to the consultation on a new adult safeguarding power (DH, 2012) are in the public domain. We elected to focus on analysing data collected in response to question three from the consultation on a new adult safeguarding power (DH, 2013) because it was most relevant to our research question. Question three asked:

How many times in the last 12 months, have you been aware of a situation where, had this power existed, it would have been appropriate to use it? What were the circumstances?

DH, 2013: 5

The detailed investigation and particular scrutiny of question three undertaken in Phase 1 of the research explored some of the experiences and reasons underpinning the findings of the previous more general analysis undertaken for the Social Care Policy Division of the DH by the Social Care Institute for Excellence. This had established that professionals were generally much more in favour of such a change in law than the members of the public who responded (DH, 2013).

The majority of respondents to the consultation generally reported that situations when a new power of entry would be required were seldom encountered, although a minority of respondents stated these situations occurred more frequently. Two main types of cases were identified by participants. First were cases where entry had been attempted with the objective of carrying out assessments, including mental capacity assessments, or to review care arrangements or medication. Second, there were more complex hinder situations where abuse was suspected and a safeguarding enquiry was being undertaken. A small number of cases were described where access was never achieved. Examples of situations where third parties appeared to be hindering access were
given across the different categories of adults at risk and types of abuse, including domestic violence. Practitioners responding to the consultation emphasised the need for good multi-agency working in hinder cases, particularly with GPs and the police, but also described more creative approaches involving housing officials and gas supply representatives, who have powers of entry for public nuisance or safety reasons. Court orders were very occasionally required, but consultation respondents gave a very small number of examples. There was only one mention of using the Police and Criminal Evidence Act 1984 in welfare cases involving danger to life or limb.

One of the arguments for a power of entry used by respondents to the consultation was that it could prevent cases progressing to a point that life or limb powers were needed and might generally speed up the process of safeguarding enquiries. In addition, some responses suggested that the awareness that social workers have this power might persuade some of the family members or other individuals obstructing access to allow a social worker to talk to the adult at risk without having to get a court order at all. The inverse of this view was also expressed: some consultation respondents felt that having a power of entry could make it harder to develop good relationships with adults at risk and their families. These respondents stressed the importance of perseverance and creativity in overcoming problems of access. Furthermore, some respondents felt that any new power could exacerbate risk of harm, particularly if professionals gained entry but were not able to change the situation. However, this possibility was also used as an argument for the need for the extra powers (of assessment, removal and banning) available in Scotland. Finally, many respondents were concerned about the possibility that the power might be abused, and stressed the need for careful management.

Parliamentary debates

As part of the contextual literature review undertaken in Phase 1 of this study during 2015, we located and analysed parliamentary debates from the process of passing the Care Bill, during 2013-14. Following approaches used in historical research, documentary analysis was carried out on transcripts of these parliamentary debates, which are available online from Hansard. The transcripts were supplemented by other materials referenced in speeches and set in the theoretical context of the representations of social problems.

Attempts to amend the Care Bill by introducing the ‘Adult safeguarding access order’, a new clause that was tabled in four different successive versions by Baroness Greengross and Paul Burstow MP, were unsuccessful.

Proponents of introducing a new power stressed the risk of leaving adults in need of care and support (but who have decisional capacity) to suffer abuse because professionals do not have the power to insist on access to them. Evidence of the scale of adult abuse was cited and the vulnerabilities of people living at home with family members, variously described as ‘voiceless’ or ‘imprisoned’, were highlighted in the arguments for a power of entry. The argument assumed that the current legal powers were insufficient to address these risks. The representations of the problem seem to have been framed by an accumulation of concern about elder abuse in particular and among organisations representing people with learning disabilities (for example, Mencap). Some social work bodies represented the problem as one where professionals would be better informed and empowered to intervene, if a new power existed.

Arguments against introducing a new power focused on concerns that giving professionals powers of access may infringe the rights of adults who have decisional capacity. A subtheme to this concern about rights was the view that there already exist sufficient legal routes to such access, of which professionals are sometimes unaware. Arguments against the new power therefore assumed that the legislation proposed would be over-reaching and that professionals’ lack of legal literacy was at fault.

Interestingly, proponents and opponents did not use case examples, which are so prominent in child protection debates, in arguments for or against the introduction of a new power. No Adult Serious Case Reviews, coroners’ reports, or reports of legal proceedings, for example, were cited as evidence specifically. The analysis highlighted that thinking about this problem in terms of powers of access was focused on professional powers in the situation and less on outcomes. This was contrasted with the need to explore how professionals can understand and address the reasons why some families may not wish to provide access to a vulnerable adult or how a mentally capacitous adult may not be willing or able to grant access to the authorities.
Managing difficult encounters – evidence from Adult Serious Case Reviews

More detail of practitioners’ engagement with relatives who may be obstructing access or assessment of an adult at risk is contained in a small number of Adult Serious Case Reviews (SCRs). (Under the CA these are newly termed Safeguarding Adults Reviews, see Manthorpe & Martineau, 2016.) We argued (Manthorpe et al 2017) that there are messages for safeguarding practice from these accounts.

A small number of SCRs illustrate these aspects. In the first the brother (JB) of Adult A was variously described in the SCR as capable, well-presented, but his ‘deceptive’ behaviour contributed to Adult A becoming invisible to many professionals and the local community. The SCR comments:

We now know that Adult A’s brother JB has been found criminally responsible for her death by gross negligence. In addition to neglecting her failing health and the condition in which she lived, he also effectively obstructed agencies, particularly North Tyneside Homes in what may have been positive interventions that changed events and alerted services to Adult A’s condition.

Wood, 2011: 22

Interestingly this SCR did not blame adult safeguarding services, but concluded that Adult A’s brother was deemed to have a duty of care for her; he was the person who could have helped her in her isolating life of squalor, cold and presumable pain. In an earlier and different set of circumstances, a mother appeared to have reassured professionals that there was no real cause for concern about her son (referred to in the SCR as X):

X ceased attending one of his day care placements and reduced attendance at a second. Staff had become concerned at his apparent weight loss; one contacting X’s mother. His mother reassured services that X would be taking up his place at the day centre again. In the event X did not. Several weeks later the same worker visited X’s home but again was unable to see X. In a further visit the worker spoke to X’s mother. Subsequent efforts were made to establish X’s condition and whereabouts. A few weeks later X’s body was discovered in the back garden of the family home.

He had been dead for some time. This followed the discovery of the body of X’s mother elsewhere.

Summarised extract from Tennant 2008

This SCR criticised professionals for not following up what was happening and appearing to be reassured by X’s mother, to the extent that they failed to see X and to make connections between different service contacts.

While few Adult SCRs note the presence of confrontation, a third SCR provides an account of a situation where the refusal of services – at some times – by a vulnerable adult was overshadowed by parental control of the situation:

Refusal of services and interventions was usually by the subject herself and there is widespread agreement that she had insight into her condition and also had capacity. However, on numerous other occasions it was her mother who refused the contact and this should have been challenged more assertively. Whilst the subject was in control of her condition, i.e. “she has good insight into her difficulties” … to a considerable extent it was her mother who was in control of the interventions … Now, the very extreme circumstances and particularly the threats and intimidation made by her mother (to professional staff and to the subject herself) would be deemed a safeguarding issue and would also be addressed under domestic abuse procedures”.

Tudor, 2011: 6-7

Here professionals were seen to be insufficiently assertive in the face of a seemingly assertive parent. In contrast, a fourth SCR (Wood, 2014) concerning the case of Adult D (which resulted in his son Adult E being convicted of wilful neglect under the Mental Capacity Act 2005) observed the potential complexities of families’ recourse to legal and other proceedings:

Whatever his motivation Adult E went to extraordinary lengths to prevent access to Adult D. In doing so Adult E mounted a classic campaign of resistance based on - delay, deny and defend. His resistance included making multiple formal complaints and eventually instigating complex and expensive litigation all of which slowed and distracted service response. The successful obstruction by Adult E did, however, present real
problems for it delayed the assessment of Adult D’s capacity and any potential implementation of Court of Protection proceedings under the Mental Capacity Act. In addition the disruptive presence of Adult E and an increasing number of friends/legal representation at Safeguarding Adults meetings together with the deluge of formal complaints and litigation served to slow and divert services from their prime purpose, placing them on the defensive and forcing them to give time and resource to address Adult E’s incessant demands.

Wood, 2014: 17

Newcastle Safeguarding Adults Board’s (2016) statement following the publication of this SCR (Wood, 2014) acknowledged that the level of obstruction as undertaken by Adult E was rare and that the case of Adult D was ‘extreme’.

This thematic analysis of SCRs provided examples of access problems from detailed case studies. It proved an interesting accompaniment to the other literature that tends to be more policy and theoretically orientated. It also highlights how prevention of access to provide services or for informal visits may be a sign of serious abuse.

**Beyond the UK**

We did not limit the literature review to the UK, but very little relevant material on this topic was identified. Much of what we did find was either concentrated on legislation providing for those without capacity and not concerned with third parties hindering access (e.g. Frimston et al., 2015; European Union, n.d.), or was based on legislation that was difficult to interpret and possibly out of date.

**Ireland**

O’Dwyer and O’Neill (2008) described two pilot studies conducted as part of the Working Group on Elder Abuse (2002) which had made recommendations with regard to police access in cases where abuse is suspected. The authors noted that the recommendations had been almost completely taken up by the Law Reform Commission in Ireland, but it was unclear whether there was the political will to make the changes. O’Donnell et al. (2015) assessed the case management approach to protecting older people from abuse and mistreatment, by way of interviews with 18 senior case workers, and suggested that Scottish legislation, the ASPA, may provide a useful model for an appropriate statutory response, providing procedural clarity for social work intervention.

**Canada**

The Canadian Association of Occupational Therapists (2013) has provided a state by state summary of the law applying to elder abuse in community and long-term settings. It notes the potential for emergency intervention orders in several states and outlines those who are permitted to make applications for them. An earlier practitioner guide (Canadian Centre for Elder Law, 2011) reported:

‘A small number of jurisdictions have broad adult protection laws that apply to adults who meet a definition of an “adult in need of protection”, regardless of the age of the vulnerable adult and where the adult lives. But even these adult protection laws vary in terms of the relative value they place on intervening to protect the vulnerable adult versus respecting the autonomy and independence of a person who might be in need of protection, and so among these limited jurisdictions the legal obligation to respond to abuse will vary’ (Canadian Centre for Elder Law, 2011: 16).
In Saskatchewan, the Victims of Domestic Violence Act provides for a Justice of the Peace or Judge of the Court of Queen’s Bench to make certain orders aimed at protecting victims from their abusers (PLEA, 2014). For example, an Emergency Intervention Order may be available in serious situations requiring an urgent response. Such Orders can provide immediate, exclusive occupation of a home; direct police to remove an abuser from the home; direct the police to supervise the removal of personal belongings from the home; or prohibit an abuser from contacting the victim. A Warrant of Entry may be issued where there is cause for concern about a person who may be a victim and unable to act on their own. The Warrant permits police to enter and search a place should access to a possible victim be denied. Such a Warrant allows police to examine or help a possible victim and remove them from the home if necessary.

Chesterman (2013) described the legal approach in Nova Scotia, where the Adult Protection Act 1989 defines an ‘adult in need of protection’. In the face of third party obstruction, the Minister may obtain an entry order, an assessment order, and orders to protect the adult concerned in their best interests, including where they are refusing assistance because of duress. Protective intervention orders are targeted at the third party or alleged abuser, and removal orders (which, again, include the duress provision) are also available under the Act.

United States (US)
The most recent analysis of elder abuse statutes across the US (Jirik & Sanders, 2014) did not collect data on statutory responses to obstructive behaviour on the part of third parties in potential abuse or neglect situations. An earlier survey of Adult Protection (or Protective) Service (APS) laws found that in non-emergency situations where access is denied, typically the APS may petition the court for assistance (Roby & Sullivan, 2001). More recently, Donovan and Regehr (2010) observed that while all US states have enacted legislation authorising the use of APS in cases of elder abuse, statutes vary widely in terms of definitions and reach. Stiegel and Klem (2007) produced a comparison chart of adult of APS laws providing for access to victims in order to conduct investigations (Lori Stiegel is in the process of updating this chart: personal communication).

In Washington State (US), Chesterman (2013) recorded that ‘vulnerable adults’ are defined under the state legal code. The APS has investigative powers, and has recourse to Vulnerable Adult Protection Orders, which are directed against the third party (and thus bear a similarity to High Court injunctions in the English context).

**Theoretical debates**
The literature review highlighted the different legal situation in the four countries of the UK, and a small number of international settings. Debates focused on the power of entry in general and in particular on the power introduced in Scotland by the Adult Support and Protection (Scotland) Act 2007 (ASPA) to obtain protection orders without the consent of the adult at risk:

Where the adult at risk has refused to consent, section 35 provides that the sheriff in considering making an order, or a person taking action under an order, may ignore the refusal where the sheriff, or that person, reasonably believes:

- that the affected adult at risk has been unduly pressurised to refuse consent; and
- that there are no steps which could reasonably be taken with the adult’s consent which would protect the adult from the harm which the order or action is intended to prevent (Scottish Government, 2014: 57).

Differing conceptions of privacy, vulnerability and autonomy were found in the literature review to be central to the arguments about whether to introduce a new legal power of entry and in individual social workers’ considerations about whether to use such legal powers in a particular situation.

Wyness (2014) described a move from a modernist view of a strong public and private boundary towards a postmodernist view, in which ‘private’ and ‘public’ are constructed as relative terms, which implies more porous boundaries. Commentators assuming a strong public-private boundary tend to place politics and society in the public domain and what happens within families in the private (Wyness, 2014). Consequently they see a power of entry as more draconian, breaching a formidable and valuable barrier. Changing family structures, policy and resulting professional practice have all contributed to a gradual breaking...
down of the public-private barrier, which perhaps
generates less concern about a power of entry.
However, family life is still more associated with
the private.

Different conceptions of vulnerability were
also identified as being at the heart of policy
and practice decisions about a power of entry.
Vulnerability can be seen as simply the result
of physical or cognitive impairment, or as a
combination of impairment and relationships and
social contexts. It is important to note that to
be vulnerable (under any conception) does not
necessarily mean that a person lacks decision
making or mental capacity. The important
question here is the extent to which inherent
characteristics, such as physical or mild cognitive
impairments alone, reduce the ability to resist
pressure. If vulnerability is an amalgam of
impairment, social contexts and wider social
structures, then a more complex assessment is
required before making decisions to intervene.
It may be that the extent and nature of social
supports and relationships are able to bolster the
individual’s ability to resist pressure. Neither
conception of vulnerability is correlated with a
pro or anti position on the power, but seems to
affect the kinds of arguments used in debates.

This concern about vulnerability echoes the
contrast between two conceptions of autonomy.
The first, liberal view, conceives of autonomy as an
inherent characteristic that defines human beings
as self-sufficient and independent of others (Series,
2015). The second, so-called relational autonomy,
emphasises the impact of social relationships
and wider social structures on personal identity.
On this view, such impacts can raise questions
about whether the person’s choices are made
autonomously in the liberal sense (Mackenzie,
2008). Mackenzie also argued that doubts are
generated about the requirement to respect
autonomy in situations where undue influence is
being brought to bear on the individual.

Using this less individualistic understanding of
autonomy could provide some justification for the
use of the more intrusive powers as introduced by
the ASPA without the consent of the individual.
Use of such powers would still require: precautions
over who can exercise these powers (only social
workers or other professionals); a court order; that
orders have strict time limits; and that decisions
made by people with capacity are respected, after
the protection orders have been implemented.
However, it does not allow for extremely paternalist
interventions that are risked by automatically
categorising decisions to stay within a very risky
situation by individuals seen as being vulnerable
because of impairment (for example), as being
non-autonomous and therefore not to be respected
(Mackenzie 2008).

Summary

Debates about a legal power of entry often focus on
practical problems of gaining access and whether
the extent of such problems warrants the potential
invasion of privacy represented by using a legal
power of entry. The review outlined various legal
approaches overcoming obstruction from third
parties, highlighting different balances between
protection and autonomy in the four countries
of the UK and internationally. In England, the
responses to the DH consultation suggested that
many professionals had experienced cases where a
power of entry would have been useful, although
such cases were rare. Most professionals were in
favour of a power of entry, believing that in some
situations this could enable swifter intervention to
reduce abuse. The professionals who were against
the idea of a new power felt that existing powers
were sufficient and that potentially a new power
could mar existing relationships.

The parliamentary debates also hinged on the
question of whether the problem of access was such
that it justified the invasion of privacy presented
by having a power of access. The sufficiency of
current legal provisions and the awareness of social
workers and managers of when and how to use
them were also key factors. Serious Case Reviews
(SCRs) provided more detail about the nature of
hindering within families – ranging from avoidance
to manipulation and active resistance. Academic
debates have more often centred on conceptions of
privacy, vulnerability and autonomy, which turn
on arguments about a conception of individuals
as separate and individually autonomous, against
a conception of the importance of social and
relational factors in constructing the individual,
which can promote or limit autonomy.

Having explored the findings of Phase 1 of the
research, the next chapter sets out the methods
used in Phases 2 and 3.
3 | Methods

Introduction

This chapter describes the methods used in the second and third phases of the study. A detailed description of the methods used for the literature and policy reviews of Phase 1 was given in the Interim Report in 2016, which is available on request from the Social Care Workforce Research Unit (scwru@kcl.ac.uk).

Phase 2 – Survey

Questionnaire

A national survey of Adult Safeguarding Managers was undertaken to obtain estimates of the numbers of hinder cases and to seek details of local policies and practices from local authority perspectives in England. The full questionnaire is given in Appendix 1 with the key questions being:

- What is the nature, and scale of such problems?
- What do adult safeguarding leads report as difficulties in engaging adults at risk that are related to the views, actions and behaviours of third parties?
- What do adult safeguarding leads report to be successful in overcoming such problems?
- Are practice and policy documents in place and do they assist with such problems?
- Is there a source of expertise locally within the local council and/or its partners and is this accessible?
- Are data collected and analysed about difficulties in engagement that appear to be the result of other parties’ actions?

Sample

The survey was created using the Survey Monkey online questionnaire software. It was distributed in two ways. We worked with national, regional and local safeguarding leaders and networks to encourage responses to this survey. Direct emails with personalised links were sent to 108 out of the 152 authorities and a general link was widely publicised through the network. We sent three reminders to the specific email addresses we had and repeatedly distributed the generic link through the networks. We also published a call for participants on the Community Care blog. However, only 27 safeguarding managers responded to the survey, which was somewhat lower than expected, although organisational surveys have tended to have low response rates: Baruch and Holtom (2008) found an average response rate of 35.7% for organisational surveys. The characteristics of this sample are given in Table 1. It was possible for participants to respond anonymously, and three chose to do so. Of the remaining 24, 10 worked in unitary authorities, eight worked in Metropolitan Boroughs, three worked in London Boroughs and three in County Councils.

<table>
<thead>
<tr>
<th>Type of Local Authority</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>County</td>
<td>3</td>
</tr>
<tr>
<td>London Borough</td>
<td>3</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>8</td>
</tr>
<tr>
<td>Unitary Authority</td>
<td>10</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
</tr>
</tbody>
</table>

Data analysis

Survey Monkey data were downloaded into SPSS (v22) for analysis. However, given the small sample, we decided only to use basic frequency analysis, to give a flavour of the distribution of opinions.
Phase 3 – in-depth research in three research sites

This study aimed to shine a light on practice, which we achieved by exploring and comparing practices in three different sites (local authorities). Two County Councils and one London Borough agreed to participate. We approached several Unitary Authorities, none of which were able to take part.

We initially planned to examine aggregated data on hinder cases, but none of the sites (and none of the survey sites) collected such data, so we relied on accounts by professionals for the detailed stories of cases. We report on the narratives the professionals related in Chapter 5.

Analysis of the interviews with practitioners and managers about the case took an exploratory, comparative approach. We categorised data by site according to the research questions, but at the same time there was scope for developing emerging questions, themes and issues. This case study work is reported separately (see Chapter 5).

Vignette interviews with older and disabled people

It proved difficult to obtain agreement to interview adults at risk who had experienced hindering: social workers were reluctant to approach them because of the sensitivity of the situations. Instead, we interviewed 11 disabled people, older people and people in need of care and support (including people with long-term mental health problems) (n=6) and carers (including of older people and people with substance misuse problems) (n=5) identified through their involvement in local advisory or other groups. Interviews were preferred over focus groups in order to get individual responses to the vignettes. In addition, we felt the vignettes could trigger distressing memories or evoke new concerns, which would have been more distressing in a focus group. We will refer to participants in these interviews as ‘older and disabled people and carers’ for the rest of the report. A fictional vignette of a typical case was developed, using the insights gained from the first phase and discussed with one member of the Advisory Group, as a check on its validity. The vignette interview guide is given in Appendix 4.

Interviews covered:

Vignette Questions (after the first and second parts of the vignette):
1. What approaches from professionals might overcome such problems of access?
2. When would more extreme measures to gain entry be appropriate?
3. Would a power of entry have helped and when would it best be used?
4. How might it have helped and in what way?
5. Why might it not have helped?

More general questions:
6. Overall views about a power of entry and any associated powers:
   a. Overall value
   b. Positives and negatives, in hinder situations
   c. Positive and negative impact on safeguarding practice in general
   d. How often and in what circumstances a power of entry might be used.

Interviews with professionals

Interviews were conducted with senior safeguarding managers, team managers and social workers involved with adult safeguarding. We contacted service managers in each of the three sites and asked for volunteers to be interviewed and for them to pass on the information to their team managers and social workers. Interviews covered:

1. The ‘model of adult safeguarding’ in the social care department
2. Awareness of hinder situations
3. A detailed account of a particular hinder situation they had worked on
4. Department policies/practice guidance
5. Views about a power of entry and any associated powers:
   a. Overall value
   b. Positives and negatives, in hinder situations
   c. Positive and negative impact on safeguarding practice in general
   d. How often a power of entry might be used and in what circumstances.
Characteristics of interview participants

Table 2 shows that just over half of all interview participants were White English (n=32); White-Other British (n=3); or Any Other White (n=2). There were small numbers of participants from Black and Minority Ethnic (BME) groups: Black African (n=3); Indian (n=3); Bangladeshi (n=1); Any Other Asian background (n=2). Two thirds of interview participants were women (n=35), and there was a good spread of participants of different ages.

All the professionals interviewed had a social work background; none had other professional qualifications. Just under half (17) worked with all adult service users; five worked with all adults of working age; and two with all older adults. Smaller numbers of participants worked with one specific group: six worked with adults with learning disabilities; two worked with people with mental health problems; and five worked with people with physical disabilities and older people (see Table 3).

### Table 2: Role of interview participants by ethnicity, gender and age-group

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Older and disabled person</th>
<th>Carer</th>
<th>Social Worker</th>
<th>Team manager</th>
<th>Service Manager</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White English</td>
<td>5</td>
<td>4</td>
<td>12</td>
<td>6</td>
<td>5</td>
<td>32</td>
</tr>
<tr>
<td>White Other-British</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Any other White</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Black African</td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Indian</td>
<td></td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Any other Asian background</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>No answer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>3</td>
<td>4</td>
<td>16</td>
<td>6</td>
<td>6</td>
<td>35</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>25-40</td>
<td>2</td>
<td></td>
<td>10</td>
<td>2</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>41-50</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>51-60</td>
<td></td>
<td>6</td>
<td>4</td>
<td>2</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>61 and over</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td></td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>No answer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>5</strong></td>
<td><strong>22</strong></td>
<td><strong>8</strong></td>
<td><strong>7</strong></td>
<td><strong>48</strong></td>
</tr>
</tbody>
</table>
Table 3: Role of professional participants by team/specialism

<table>
<thead>
<tr>
<th>Teams in which the participant worked</th>
<th>Service Manager</th>
<th>Social Worker</th>
<th>Team manager</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All adults</td>
<td>3</td>
<td>12</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>All adults of working age</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>All older adults</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Mental health</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Physical disabilities and older people</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7</td>
<td>22</td>
<td>8</td>
<td>37</td>
</tr>
</tbody>
</table>

The professionals had been working in social care for between two and 30 years, and had been in their current posts from about two weeks to 12 years. About one third of the professionals (n=12) were Best Interests Assessors (several more indicated they were about to do the training).

Data analysis

Thematic analysis was undertaken, as the most appropriate approach to analysing the interview data. This approach is fundamental to many kinds of qualitative research (Braun & Clarke, 2006). In addition, we used some matrix analysis techniques (Miles & Huberman, 1994) to compare the categories relating to processes and meanings and to identify different perspectives. All interviews in Phase 3 were recorded, with permission, and transcribed in full (or notes taken for a minority of older and disabled people and carer interviews). Anonymised transcripts were read in the Word files and coding undertaken using an Excel Spreadsheet.

Coding is a key element of the approach to analysis, in order to interpret and organise the data (Basit, 2003). We based the coding frame around the interview guide, but also read a small number of transcripts and field notes to develop more detailed codes and to identify more overarching themes. We attempted to balance the influence of prior theorising with a grounded approach, to avoid the tendency for researchers to find ‘only what they are looking for’ (Ryan & Bernard, 2003: 92).

Advisory group

We recruited a small advisory group of three safeguarding managers, whom we considered were the most informed participants to advise us on the main focus of the research, namely, what helps and hinders in a hinder situation. A single teleconference was held, in which the group advised about:

- The discussion from the Interim Report
- Survey of adult safeguarding managers. This discussion covered which staff to target in each local authority and how to maximise the return. In addition, advisory group members had been sent a copy of the draft questionnaire, and were asked for comments about this, which we incorporated into the final design
- The kinds of data that might be available from local authorities
- Which staff to interview for Phase 3 of the study and what topics we should cover
- Whether it was feasible to interview adults at risk or their families who had experienced a hinder situation, or to use vignettes in focus groups or interviews.

The teleconference provided useful feedback on all these topics and we amended our approach accordingly. For example, we decided to develop a vignette and aim to have interviews, rather than focus groups, with older and disabled people, recruited through local groups, as well as to try to recruit adults at risk or families who had experienced a hinder situation. Subsequently, we continued to consult with members of the advisory group by email about the questionnaire and vignette for interviews.

Ethics and research governance

We obtained a favourable opinion from the Wales 3 Research Ethics Committee (REC), after some minor amendments to some of the documentation, in respect of Phases 2 and 3 of the study. Ethics approval was not needed for Phase 1 because it did not involve primary research. Research
Governance approval was also obtained from the three research sites for Phase 3.

We stressed, in our applications to the REC local research governance committee, our commitment to maintain the anonymity of respondents to the survey and our approach to maintaining the anonymity of participants in interviews, and in particular the need for confidentiality about individual adults at risk. Given the extent of personal and sensitive information involved, we did not seek direct access to case records. Instead, we asked social workers to give an account of anonymised cases, using the records, but focusing on their own reactions and practice response to the situation. We stress that we are therefore focusing on reporting professionals’ perspectives and interpretations of experiences.

Phase 3 site descriptions

All three sites had similar rates of adult safeguarding enquiries and rate of supported adults per population. In order to contextualise the interview analysis, some background information about each site is presented:

- Region
- Type of authority
- Approach to adult safeguarding

Site 1
- London
- London Borough

Approach to adult safeguarding
Site 1 has a specialist safeguarding team, handling all the local authority’s work – except that the local authority has a section 75 arrangement (s 75 NHS Act 2006) whereby all mental health cases under the age of 65 are transferred to the local NHS Mental Health Trust; this includes all safeguarding work for this age group. There is no adult Multi-agency Safeguarding Hub (MASH). There is a Multi-Agency Risk Assessment Conference (MARAC) with which the safeguarding team has good links: the adult safeguarding co-ordinator is a member of the MARAC.

Site 2
- East of England
- County Council

Approach to adult safeguarding
Site 2 is a large, local authority with a high proportion of older people. It used to have a specialist safeguarding team, but this was disbanded. It now has a team who carry out organisational (formerly called institutional) abuse cases and Deprivation of Liberty Safeguards work. The remainder of safeguarding work is undertaken within locality teams. Teams are split between older people and working age adults (which includes learning disability, physical disability, domestic violence, alcohol and drug misuse and some work around immigration). All workers are expected to undertake safeguarding work as part of their caseload. A MASH is being piloted; in this social workers (including mental health representatives) and the police triage team provide advice and support. A MARAC was set
up recently. This local authority has its own legal team which can support workers. A section 75 arrangement is in place, so mental health service users aged 75 years and over are supported by the Older People’s teams.

Site 3
South of England
County Council

Approach to safeguarding
Site 3 recently moved to a more Dispersed Generic approach to safeguarding, in which most adult safeguarding enquiries are undertaken by operational social workers. This has changed from a Dispersed Specialist model, where specialist adult safeguarding coordinators worked in operational teams and undertook some safeguarding work. Currently, there are three ‘safeguarding and governance’ consultants who work strategically (on training and policies) and provide advice and consultancy on the most complex cases, sometimes chairing meetings, for example. A MASH screens concerns initially, and resolves if possible, but they can only give advice over the phone. If staff in the MASH are not able to resolve concerns, they pass them to the long-term social work teams. Safeguarding concerns about people for whom there are already allocated social workers are passed straight to the relevant social work teams. Decisions about whether concerns should be considered as safeguarding are made by senior practitioners or team managers, who usually chair any meetings required for the enquiry. Social workers coordinate section 42 enquiries, but often ask care providers to do the investigations, unless the provider is under suspicion. Social workers might coordinate and undertake an enquiry. Depending on the circumstances, this might involve visits and interviews with service users and carers, but could equally involve asking other professionals (e.g. health colleagues) to do this.

Safeguarding is also linked to quality work. A Quality and Outcomes Contract Monitoring process takes up some of the quality issues that emerge from safeguarding cases. Indeed, some cases initially characterised as safeguarding are addressed through quality work if this is considered to be the more important aspect. Similarly, unaddressed quality issues can lead to safeguarding concerns and the need for a safeguarding response.

Summary
This chapter has set out the methods used in Phases 2 and 3 of the research. The next five chapters present the findings of the research. As a reminder, the order of the subsequent findings chapters that was set out in Chapter One is repeated here:

- Chapter 4 examines how big a problem hindering represents, gives the findings about numbers of cases, views about different levels of seriousness of cases experienced and the characteristics of adults at risk and the third parties involved.
- Chapter Five describes the context of cases, using the extended accounts of individual hinder situations and proposes a tentative typology of cases and reasons for hindering.
- Chapter Six explores current practice responses to hinder situations by social workers and managers and identifies the benefits of and barriers to joint working in these cases.
- Chapter Seven describes the use of current legal routes to gaining access (as set out in Box 1 above), focusing on the frequency of use, decision-making and barriers to using these legal approaches.
- Chapter Eight presents participants’ views about the potential introduction of a power of entry where it is very difficult to gain access when undertaking safeguarding enquires. It also explores views about a possible need for the further powers available in Scotland (as set out above).

Anonymised quotes from participants are used in the Findings chapters. The individual participants are labelled as follows: Role (i.e. MGR – Manager; SW – Social Worker; Vignette interview), Number of interview, e.g. SW 01 (Social Worker, Interview no. 1).
4 | How big a problem is hindering?

Introduction

This chapter presents the evidence on the extent of hindering or problems accessing adults at risk and the characteristics of cases reported by survey respondents and the social workers and managers we interviewed.

Contextual factors influencing numbers of hinder situations

Some social work participants commented on social changes that they thought were pertinent to adult safeguarding and access to adults at risk more generally. The key themes of these related to social changes, such as more younger people having drug and alcohol problems that lead them to prey on or exploit others, the current affordable housing shortage so that ‘cuckooing’ is more common (where a third party (often unrelated to the adult at risk) moves in with a person with care and support needs and takes over the property, often financially and emotionally abusing the adult at risk), and greater opportunities to abuse people via their phones and social media.

New caps on social security benefits and reassessment of Deprivation of Liberty Safeguards cases was reported as having meant cases were coming to the notice of social workers when a family’s income was dependent on the benefits of an adult at risk with learning or physical disabilities and family members were thus unwilling to allow them to live a more independent life in separate accommodation. Cuts in local authority and other public funding were also declared to have implications for the scope and length of certain interventions particularly where there might be insufficient evidence of abuse, fluctuating or indeterminate capacity, criminal acts or public interest considerations. All these factors were mentioned by social workers as changing their work and adding to the numbers and types of cases they are encountering where it is difficult to access a person who seems to be an adult at risk.

Numbers of cases

None of the survey respondents or social workers and managers interviewed in the three research sites reported that data were collected specifically on cases where there had been problems accessing or interviewing an adult at risk, other than routine data collected about all safeguarding enquiries. In their comments to the survey question about recording and responses to interview questions, most respondents reported that any such information would be entered in free text in individual case records. Consequently, it is difficult to get precise numbers about numbers of cases where access was denied or private conversations impossible. Thus the figures given by participants are estimates based on their experiences rather than reports of known figures.

Table 4 shows that most (20/27) survey respondents were aware of cases of hindering and only two were not aware of any such cases:

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>20</td>
<td>74</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Don’t know</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>100</td>
</tr>
</tbody>
</table>

The survey asked respondents to estimate the number of hinder cases in their local authority since April 2015 up to the date of the survey, September 2016. Table 5 shows that numbers of cases reported by respondents varied from 0 to 18, although most respondents (11/14) reported five or fewer cases. Almost half (13/27) respondents did not answer or said they did not know the number of cases. Overall, 75 cases were identified by the 14 respondents who answered this question. However, two of these respondents mentioned 33 of these cases, which may mean they were including less
serious cases. Only one respondent reported a case where access was not achieved.

Table 5: Cases since April 2015 where staff encountered hinder situations

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Number of respondents</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>5</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>15</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total respondents</strong></td>
<td><strong>14</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td><strong>Total cases</strong></td>
<td><strong>75</strong></td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td>5</td>
<td>100</td>
</tr>
<tr>
<td>Missing</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

The social workers and managers interviewed in the research sites also reported being aware of widely different numbers of cases ranging from 0 to 70. However, only one respondent, a safeguarding manager, described situations where access was never achieved. In these cases, it was generally decided to withdraw because there was no legal basis to intervene:

...some of them we’ve had to walk away, because of the capacity issue, we can’t interfere with people’s lives and we walk away with great trepidation…15 of them we had to give up on. I’m waiting for something awful to happen. Because the police can’t go in, they haven’t got mental health issues.

MGR 24

Much more common was the view that while there were often problems with access, it was possible to talk to the adult at risk in private in the vast majority of cases. This team manager gave a typical description of the problem:

It’s a big problem, yes, a big problem. Access is very often a difficult one and you’ve got thinking in terms of scenarios that come to mind and you’ve got family members who are preventing, or not necessarily even preventing physically but psychologically, not allowing the person to give us access... [But] it very rarely gets to a point when we would have to take another route, for example the Mental Health Act or something like that.

MGR 27

One social worker referred to the fact that there is no power of access as an impediment to gaining access, and that this made hinder cases more difficult:

It’s not every day, but it does happen and it creates additional pressure on the social worker because of making safeguarding personal and we don’t have powers to access people and the length of time it takes to use other avenues to get access to somebody, so it makes it quite difficult.

SW 34

The survey also asked respondents to comment on the problems caused by hinder situations. Delays in assessing and responding to risk, which meant that adults may be abused for a longer period were the main negative outcome for adults at risk mentioned. In addition, hinder situations were felt by some survey respondents to require more work (and therefore cost) and could make multi-agency working more difficult, as illustrated by these two comments:

More detailed planning and coordination is required. This could lead to a delay in responding to the safeguarding concerns.

MGR Survey 18

Heightened professional anxiety across agencies with all seeking to identify one agency as being responsible rather than being prepared to work together and use the resources all have available at their disposal to support the work.

MGR Survey 09

A small number of managers also commented that social workers find these cases frustrating and that they can cause them anxiety, because of their fear about whether the adult at risk is being harmed:
High risk cases where access cannot be obtained leave social workers feeling powerless and leaves family/public feeling that there is little point in telling us about situations

MGR Survey 17

Costs of hinder cases

Despite a view that problems in gaining access were often an integral part of social work practice, many social workers and managers felt that this was a very costly element of the work. More protracted problems in gaining access, could mean that individual cases became very costly in terms of professional involvement, with multiple professionals, including doctors, where mental health problems were involved, and much communication and debate. This manager and social worker described typical situations, although both felt this was ‘part and parcel of our job’:

RESP: Oh it’s a time sucker. Anything like that. You just are…a million emails going back and forwards and phone calls and what should we do…A team manager, me, my manager, colleagues in safeguarding and governance. It went all the way to the top really.

INT: All spending time trying to…

RESP: All spending time on it.

MGR 31

Hours. Absolute hours on top of my own other caseload. Absolute hours…’A lot of my time ‘cause you’re always trying to think outside the box, and think how can I gain access to the person?

SW 26

Some interviewees also described how these cases impacted on their other work. Staff time was not the only source of increased cost identified. Several social workers and managers described how it had been necessary to commission extra services in some cases to facilitate contact with the adult at risk:

A person might not need the amount of domiciliary care that we have to buy or prescribe or the extra day at the day centre to keep the person out of the way of or to get the person in a situation so we can monitor or keep safe.

MGR 29

Social worker interviewees and survey respondents commented explicitly on the time rather than costs; managers may have been more conscious of the financial commitment. One manager said costs were not an issue in hindering cases and that management was more focused on the costs of Deprivation of Liberty Safeguards cases; in their view the costs of gaining access through different approaches (for example, going to court) was irrelevant when making decisions about how individual cases were pursued.

The older people and disabled informants, in particular, noted the costs to the public purse would be high and two participants commented that lawyers would be making money out of the current situations. One was explicit that new powers of entry should be brought in immediately as:

This would save resources being wasted, including legal fees currently being incurred. The current situation is wasting social workers’ and other professional’s time and tax payers’ money and new powers would save on legal fees.

Vignette 16
Characteristics of adults at risk and hinder cases

Only 13 survey respondents were able to answer questions about the characteristics of the adults at risk and the types of abuse involved, as shown in Table 6. These respondents reported that more cases related to older people (n=37) than people of working age (n=30). However, given the relative numbers of older people using care services in the community (359,275 aged over 65 compared with 237,505 aged between 18 and 64 in England: NHS Digital 2016), this is not an indication of a difference in the numbers of hinder cases in the different age groups.

Very few respondents were aware of who had obstructed the professionals. Sons (n=13 cases), daughters (n=15 cases) and other male relatives (n=15 cases) were most often identified. Similarly, very few participants identified the kinds of abuse or neglect potentially involved in hinder cases. Psychological/Emotional abuse (n= 20 cases) and Neglect (n=16 cases) were the most common types identified. However, in the interviews, financial abuse and psychological or emotional abuse, including coercive control, were most commonly mentioned as being involved in hinder cases, although physical and sexual abuse and neglect were also reported.

Domestic violence was involved in 11 hinder cases reported by survey participants, and several of those interviewed described situations where domestic violence created problems of access. For example, one social worker described a situation where a person with learning disabilities was being abused, and pointed out that it was harder to obtain injunctions in these kinds of circumstances:

*The thing is you can get an injunction for domestic violence but at the moment these people, we’ve got nobody doing that. You can’t do that. We have no powers to stop any perpetrator being near our people.*

MGR 20

Where the difficulties were in having private conversations with the adult at risk, rather than simply gaining entry to the home, several interview participants stressed how difficult it was to establish or disprove that the alleged perpetrator was coercing the adult at risk:

*It’s really difficult to prove, that’s the problem we’ve got. It’s how do you evidence that someone is in the background and it puts pressure on the victim not to speak? It’s really difficult.*

SW 34

<p>| Table 6: Characteristics of adults at risk involved in hinder cases (Survey respondents) |
|----------------------------------|---------------------------------|----------------|------------------|------------------|</p>
<table>
<thead>
<tr>
<th>No. cases</th>
<th>Older People</th>
<th>Disabled person</th>
<th>People with learning dis.</th>
<th>People with mental health problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2</td>
<td>8</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. cases</td>
<td>37</td>
<td>8</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>No. respondents</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
</tr>
</tbody>
</table>
Generally, there was much less experience of modern slavery, although three interviewees related instances involving this newly introduced aspect of adult safeguarding under the CA, one of which is outlined in the following chapter.

The 15 respondents who answered the question about how confident they were in the figures as to the prevalence of hindering cases were evenly split between those who were ‘Very’ (n=2) or ‘Fairly’ (n=5) confident and those who felt ‘Slightly’ (n=3) or ‘Not at all’ (n=4) confident (see Table 7).

<table>
<thead>
<tr>
<th>How confident</th>
<th>No.</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very confident</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Fairly confident</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Slightly confident</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Not at all confident</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100</td>
</tr>
<tr>
<td>Missing</td>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>

**Summary**

This chapter has identified that none of the survey respondents or practitioner interviewees reported that data were collected specifically in relation to obstruction by third parties. Estimates of numbers and frequency of hindering cases vary widely. In most hinder situations described, access was achieved, although it was often compromised by an inability to conduct a private interview. However, one social worker reported a case of complete obstruction, where access was only achieved by chance outside the house and another reported 15 unresolved cases. Several survey respondents and interviewees stressed the heavy demands placed on human resources from these cases, some of which ran for several years.

Chapter 5 describes some of the contexts to hinder situations and proposes a tentative typology.
5 | Contexts of hindering

Introduction

This chapter explores the contexts of cases identified in the interviews in two ways. First, it presents views of the reasons why family members, ‘friends’ or other third parties might obstruct social workers from accessing adults at risk. Second, it presents a tentative typology of cases, based on the analysis of interviews and provides detailed examples of each type.

Reasons for hindering

One social worker confidently outlined some of the reasons for hindering and the quality of relationships between the hinderer and the adult at risk, whether these be family or friends in their experience:

Invariably, the person causing hindrance is likely to be fairly isolated in the community, tends to be in a position of power, more controlling, coercion and kind of, created that position for themselves, made that person... dependent on them.

SW 04

Hinderers were most often reported to be family members, but some were classified as ‘friends’. Several reasons for hindering behaviour were suggested by social workers and managers, although each reason was mentioned only by one or two interviewees:

- Over-protective parents or other family members, typically when the adult at risk has learning disabilities
- The hinderer has his or her own mental health or addiction problems
- Concerns about the hinderer’s own tenancy or immigration status
- A desire to have the hinderer’s voice heard
- Cultural difficulties (for example, not accepting a male social worker to see a female adult at risk)
- Fear that the social worker will disrupt a relationship.

Most social workers and managers mentioned the distinction between preventing entry to a property and refusing to allow a private conversation, and acknowledged that both of these represented a problem of access to the adult at risk.

Types of cases

We asked social workers and managers to tell us about a recent case in which they had experienced problems accessing the adult at risk because of the actions of third parties. The 37 social workers and managers we interviewed described 36 cases of hindering in detail. In the analysis of the stories and other comments about typical contexts, we identified seven types of cases. However, there were some cases where the allocation of stories was not straightforward, because of the difficulty of distinguishing poor care from neglect or more active abuse:

1. Obstructive family – Poor care (11 cases)
2. Obstructive family – Abuse (9 cases)
3. Obstructive family – Risk management (2 cases)
4. Obstructive family – Hoarding (4 cases)
5. ‘Cuckooing’ (5 cases)
6. Domestic violence (3 cases)
7. Modern slavery (3 cases)

Family members included parents, partners, adult offspring or siblings.

1. Obstructive family – Poor care (11 cases)
The most common type of hinder case described by the social workers and managers involved situations where family members (Parents, n=3; Adult offspring, n=5; Partner; n=2; Friend, n=1)
prevented social workers from accessing the adult at risk because of concerns about difficulties over providing care for the adults at risk, rather than abuse. As one team manager noted, these were situations in which the hinderers were coming from an essentially ‘good place’, but may be reluctant to accept help:

...a lot of the time with hindering as well, I think the person who was doing the hindering is coming from a good place in the sense that they've always done it that way, they might be proud, stubborn.

For example, one social worker described a situation where concerns had been raised about an older woman whose son was her main carer. A care package had been set up after the woman was discharged from hospital, but the son was reluctant to accept it:

Yeah, he said he didn't need the carers [care workers], he was able to take care of the mother but you know, she was very frail. She needed at least two carers, you know, to assist with, you know, standing, you know, supporting her. And this is the son, you know, saying he's okay caring for the mum but then, you know, we were concerned that actually, though he's done a great job you know before, she ended up in hospital. I think that was the second time, so I think, you know, the risk was a little bit high.

These cases represented particular challenges for social workers in interpreting the reasons for the difficulties and establishing the condition of the adult at risk and the motivations of family members.

2. Obstructive family – Abuse (9 cases)

There were nine hinder cases where families were obstructing access and the professionals suspected abuse, as opposed to fears about the quality of care and the adult at risk’s wellbeing. In one such case, the adult at risk’s daughter, who lived with her mother, had prevented the mother from meeting the social worker on a pre-arranged visit. The daughter had previously assaulted her mother and a neighbour had heard shouting, which had raised the concern. Eventually, access was achieved through a combination of focusing on the daughter's mental health needs and working with the Housing Department:

We finally addressed the issue through other channels by using the mental health team and concentrating more on the daughter than the mother, and we, we managed to get housing in, because it was a council house, to see the mother, so we were able to use other agencies to address the issue through other means.

In another case, where financial and psychological abuse of a young woman with learning disabilities was suspected, the family was thought to be reluctant to allow social workers in because of negative feelings towards social services, possibly because of previous experiences:

Some of it is around the fact that they hate – and I am not using that word lightly, as the mother-in-law said to me, we hate social services, we hate social workers, they are a waste of space, they've never been any use to us other than trying to take our children away and if you think I'm letting you through the front door, think again.

These cases represented particular challenges for social workers in interpreting the reasons for the difficulties and establishing the condition of the adult at risk and the motivations of family members.
In this case repeated visits and negotiations with the family led to an agreement to allow the social worker to see the young woman. Other cases proved more difficult to resolve, and required more serious, legal approaches. For example, one social worker described a case in which physical and sexual abuse of a young woman with learning disabilities was suspected and access to her had not been granted. An application for a non-molestation order had been made to the High Court, but this was still ongoing after an appeal by one of her parents. As a result there had been a long period where the social worker had to ‘manage the risk’:

... it goes round and around as they appeal it. In the meantime we manage the risk. In the hinder cases, they’re the worries because, although the families won’t let you in, you’ve still got the responsibility for the person; it’s a bit like child protection.

SW 22

MGR 28 (joint interview)

3. Obstructive family - Risk management (2 cases)
In two cases, families had prevented social workers accessing an adult, but were managing risks at home and were obstructing because they did not want the social worker involved because of previous conflict, for example. For example, a social worker described a case involving a young man with learning disabilities who had served a custodial sentence for assault. However, his family and the care provider he had been placed with until he was aged 18 were of the opinion he had been the victim. The family expected him to get round the clock support, although the social worker expected this to be much less, possibly 4-10 hours a week, because she assessed he could meet his own needs in many regards. The family was reportedly unhappy with the ‘fluffy’ social worker’s view (SW 42). However, her assessment was supported by the Police Officer in the case. In this case the family was said to have made it very difficult to talk to the young man on his own, and even when the social worker had been able to do this, she felt he wasn’t giving his own views:

Then the opportunities that I have had, the opportunities to meet him on his own, which I’ve been transparent about, when I speak to him, the wording that he is using, I know is coming from that family member because there are particular words that that member uses.

SW 42

Identifying the young man’s views was complicated and required nuanced understanding:

So I’ve been allocated to him for three months and he’s only just started speaking to me and he will actually talk and say that the family member has said x, y and z. I can then unpick sometimes actually that’s not the family member has said that, that’s your way of telling me indirectly because you don’t want to say that’s from you.

SW 42

Eventually the social worker reported that the family had acknowledged that he was a risk to them and then refused to have him in their house, which disrupted plans to set up a supported living arrangement. However, this meant he was no longer living with his family, so, as the social worker acknowledged, access was no longer a problem.

4. Obstructive family - Hoarding (4 cases)
In four of the extended stories, a family member was preventing the social worker accessing an adult at risk because of the hinderer’s hoarding behaviour, which they wanted to hide. Several other social workers mentioned hoarding as a big problem and two suggested that the hoarding behaviour of one member of the household could sometimes be behind hindering. The extent to which this was self-neglect was not established.

In a joint interview, two managers described a case where a son was preventing access to his mother who was hoarding. There were low level fears about the condition and lifestyle of the older woman. However, social workers never made contact and nothing much changed in the life of the older person. The social workers were not able to establish any rapport, partly because of what was described as the ‘shared psychosis’ of the son and mother. However, this case raised questions for the service manager (MGR 28) about whether the social workers were in danger of ascribing
their own values to the lives of the older person. She felt that a power of entry might have led to an inappropriate judgement:

*I worry, to some degree, that other professions sometimes make a judgement about people’s lives and then a power would be used to remove that person because we all judge that one shouldn’t live in those conditions.*

MGR 28

5. ‘Cuckooing’ (5 cases)

Five social workers and managers described cases of ‘cuckooing’, where a third party (often unrelated to the adult at risk) moves in with a person with care and support needs and takes over the property, often financially and emotionally abusing the adult at risk. Several social workers (some of whom did not give an account of a particular case), reported that such cases were common:

*That’s very common, moved in on them, targeted them because they’re evidently vulnerable, [they] could be spotted in the community kind of thing. Might get followed home for instance, might start controlling their finances and their property.*

SW 04

Other social workers and managers also described hinder situations as involving ‘mate’ crime, which were similar in form. In these the ‘friends’ were hindering access, but the adult at risk, who typically would be assessed as having capacity, was reluctant to complain. In these cases, social workers and managers felt it was very difficult to prove that the ‘friends’ were coercing or otherwise abusing the adult at risk.

Gaining access to the adult at risk in these situations was often very difficult, and required a great deal of co-working with the police and health professionals. For example, one social worker described:

*I’ve had… I’ve got a safeguarding at the minute for a gentleman that was living in his own flat. He has drug dependency and he has a physical impairment… He had support from us via a care agency and also district nurses’ support, but there was a group of gentlemen that had taken over his flat, I think they called it cuckooing, and we couldn’t get access to him. And getting police support was also very difficult; it took… a week in total, to get access to this man that was being abused.*

SW 19

Another case was deemed particularly complex because of the uncertainty about what was happening and the mobility problems of the adult at risk. Here a group of men prevented the social worker from seeing the adult at risk. The police eventually helped gain access, which the social worker described as being essential, in order to understand the situation:

RESP: Yeah, the only way that we could get access was to take the police, but even that was difficult because the police have their own priorities and us phoning asking for support isn’t a priority to them...

INT: I suppose it’s not an imminent risk, either.

RESP: No, it’s not. And we didn’t actually know what the risk was. All we knew was that we had a concern so, until we actually got eyes on the gentleman, all we could do was make assumptions.
6. Domestic violence (3 cases)
In three of the extended cases described in the interviews, the central problem was presented as domestic violence involving someone with care and support needs. Partners were the suspected perpetrator in two cases and an adult son in the other. Many other social workers and managers discussed the overlaps between safeguarding and domestic violence and felt that hindering was likely in these cases. However, proving coercion or control was felt to be difficult, particularly where the adult at risk could be presented as not being a reliable witness by the alleged perpetrator, as illustrated by one social worker:

Then we’ve also had the husband who might have some suspicions that the partner is talking to us and raising the concerns. So they have been contacting us painting a bit of a different story, maybe questioning the person’s capacity which then puts doubts on their story.

SW 39

In one case a young woman with advanced neurological problems was living with a man, although the status of the relationship was unclear. The social worker was very concerned about the standard of care the man was providing and there were suspicions of physical and sexual abuse. It had proved very difficult to have a private conversation with the woman, because the man would either refuse access altogether or refuse to leave the room. The young woman was not complaining and appeared to want the man to be in the room when the social workers were there:

We have tried many, many times to get to see her and in fact, have managed to get to see her on, on a few occasions. So I think there’s been two types of hindering really. There’s been preventing us getting in the, the property at all, and that’s happened on a number of occasions. There’s also been allowing in but standing over us and the young lady concerned when we’ve been conducting capacity assessments or, um, or any other form of assessment.

MGR 05

The manager stressed that access was only required to check capacity and undertake basic health and wellbeing checks, given that it had been established that there was a presumption of capacity, but acknowledgment that her situation might fluctuate:

She is assessed as having capacity... We weren't asking for any great draconian measures. What we were asking for was just uninterrupted access to the individual so that you can... do a physical examination, check the health of the individual and do a capacity assessment.

MGR 05

7. Modern slavery (3 cases)
Three cases involved concerns about modern slavery, which made accessing the adults at risk particularly hard. For example, this manager described a case in which a young woman had been married to a disabled person, and had been treated as a slave. It had proved impossible for the social worker to gain access to the person, but she had been able to attend a specially arranged GP appointment, where it had been possible to establish what was happening and the police had removed the woman from the matrimonial home:

I’ve had one where a woman was brought in, married abroad to a disabled person, and she had full capacity and she was really being treated most appallingly, to do all the housework, the caring, she wasn’t allowed to do that, and by chance we came into contact with her. Yes. The police did try to have communications with her, but it was difficult because, on the face of it, nothing was going on. She wasn’t allowed to speak to anybody and her English was not very good, so we had to wait for her to go to the GP. So the GP was very good in proactively making an appointment to see her, and it’s not the best way to do it; that was the only opportunity we had to see her. And when we saw her, I interviewed her and straightaway they took action. (Int: Oh, really?) Yeah, they removed her; the police did. Yeah. (Int: The police removed her straightaway.) Straightaway, yeah.

MGR 09
Summary

Practitioner interviewees identified an array of scenarios. Sometimes parents or other family members were being arguably over-protective (often in cases involving an adult at risk with learning disabilities). Some third parties were thought to be fearful that the social worker would disrupt an established relationship. The obstructive third party might have his or her own mental health or addiction problems. Third parties might also be anxious that their opinion will not be heard; in some cases they were concerned about their own tenancy or immigration status. Cultural factors might be in play – for example, the third party objecting to a male social worker seeing a female adult at risk. As indicated by this variety in motivation, hindering was not always associated with abuse, according to interviewees.

We identified seven types of risk accompanying obstructive behaviour: poor care (11 cases); abuse (9); risk management (3); hoarding (3); ‘cuckooing’ (5); domestic violence (3); modern slavery (3).

Chapter 6 explores the approaches taken by social workers faced with hinder situations.
6 | Current approaches to gaining access in hinder situations

Introduction

Interviewees and survey respondents described how they tried to make contact with adults at risk and negotiate with third parties obstructing access and how, if this was unsuccessful, other informal or multi-agency approaches were considered.

Informal approaches to gaining access – negotiation

The survey asked about the kinds of help social workers sought in initially gaining access, and respondents most commonly reported negotiation with the third parties (n=11 cases) in which social workers’ communication and relationship-building skills were used to persuade family members or others to cease obstructing access to the adult at risk.

Interview respondents discussed the different approaches to such conversations ranging from assertive styles to ‘softer’ social work skills depending on the level and likelihood of risk of harm. For example, in cases where the third party was the parent of an adult with learning disabilities there was often a tendency to see this as an individual acting mistakenly, yet seemingly in their child’s best interests. Here participants stressed the importance of partnership working with carers, and so gentler approaches were often effective:

*I think we’ve been quite fortunate that people are I think willing to work with us. I think we’ve got a fairly good approach and fairly good relationships with people that we are very gentle in the way we approach things so that people are willing to talk to us so we can at least get that initial information.*

SW 15

I'm not shy of saying, well, if you don't let us in I'll just come back with a couple of policemen and I will come in and, believe me, I'll do it, and I will. They're pretty... I'm not just threatening, I'll go, I'll get the phone out and start ringing, that sort of thing. Then, oh, we'll try and negotiate first. Look, we don't want the police, I don't want them round here, for God's sake, just have a chat.

SW 16

One social worker pinpointed the importance of explaining to family carers exactly what adult safeguarding is and how it works, believing that misunderstandings about the nature of safeguarding were often at the root of hinderers’ behaviour or emotions. However, in other cases social workers described the need for more assertive conversations and the importance of insisting on having a private conversation with the adult at risk:

*I have just had to have that very honest conversation with the other relatives to say it is a requirement for me that I speak with your husband/wife/whoever on their own.*

MGR 35

Interestingly, two interviewees noted how they alert a person obstructing access to an adult at risk to the ‘fact’ there would be legal recourse if they were not allowed to enter the home, which could be viewed as demonstrating an under-current of, or actual, threat:

*I'm not shy of saying, well, if you don't let us in I'll just come back with a couple of policemen and I will come in and, believe me, I'll do it, and I will. They're pretty... I'm not just threatening, I'll go, I'll get the phone out and start ringing, that sort of thing. Then, oh, we'll try and negotiate first. Look, we don't want the police, I don't want them round here, for God's sake, just have a chat.*

SW 21

The extent to which current legislation could be viewed as a ‘threat’ and how seriously this is taken
Informal approaches to gaining access – creative approaches where negotiation is unsuccessful

Interviewees discussed informal tactics where a person refuses to negotiate with social workers after repeated efforts to access the adult at risk. For example, social workers stated they would take opportunities to conduct interviews in a range of locations to ensure the meeting was held away from the person refusing access, for example, meeting an adult at risk at a day care, when visiting local shops, parks or gardens, or picking up the adult at risk in their car and driving them to their office.

Interviewees described using social work skills of resourcefulness, persistence, taking opportunities as they arose, and being creative to pursue other routes. These included getting in touch with and involving members of the extended family; identifying who else is going into the home (e.g. care workers) and asking for their support; conducting therapeutic family counselling; and accessing further information about the family’s background to open up other options.

One social worker, for example, summarised such an approach:

*The only thing I think that the social worker can attempt to do is to negotiate with the daughter. It’s a skill that most social workers have to a really good degree, because they need that’s part of their role. ... obviously, it would be really helpful if anybody had any idea why the daughter is, is acting in this way, but that’s not something that, information that’s going to be available.*

SW 04

One of the older people we interviewed and who discussed the vignette suggested contacting the hairdresser who was visiting the home to do Celia’s hair and ask for her help in gaining access and also others who could advocate for social workers to find allies in getting in, ‘You know, to try and, and connect with somebody else who can get a, a way in’ (Vignette 03). Participants in two of the vignette interviews commented on the potential for contacting neighbours to help verify what was happening in a situation. For example, one older person suggested an approach to investigating the extent of the problem by visiting the neighbour at the appropriate moment:
The only thing I would say is maybe not get into the house but surely somebody would have gone in to speak to the neighbour to hear their concern. Then if maybe the neighbour had specific times when the shouting was going on and if it was in the daytime or somewhere they could do, they could go to the neighbour’s house and witness it themselves so that they would witness of what was going on to present to somebody else, because otherwise it’s one person’s word against the other and whatever.

Vignette 10

Survey respondents also reported using other third sector sources of support in hinder situations either in establishing rapport, ‘digging’ for more information and making individual or joint visits to gain entry. These organisations included the RSPCA, Age UK, Women’s Aid, Trading Standards, Victim Support, independent mental advocacy services (IMCAs) and solicitors managing the ‘trust fund’ of the adult.

Making more use of advocacy services was suggested by one carer as a way of engaging obstructive third parties. The CA states that local authorities must consider if an adult at risk needs independent advocacy to support them in a safeguarding enquiry if they find it hard to understand, remember, use and communicate information about their care and support and have no ‘appropriate individual’ to assist them with decision making (Local Government Association, 2015). However this remit could be widened to include provision of advocacy for third parties in obstructive cases:

If you feel the professionals have ganged up against you and are not hearing you, I think an advocate would be the way forward, regardless. Especially in an extreme situation like this when the carer has an issue with professionals, you need to get to the bottom of it. [...] In the long run you might save more by using an advocate, a good advocacy service could be cheaper than the legal process. There is such a lot or jargon involved so people don’t understand and it can be quite intimidating.

Vignette 18

Social workers also outlined the importance of allocating the right person for the job in gaining access to an adult at risk, underlining the acceptability of different approaches depending on the case as in the following illustration:

I’m an alpha male, I’ve got a loud voice, [...] I have to be quite careful with my voice because if I slightly raise my voice, I sound aggressive, and I know that. [...] I can dominate a room and so it’s maybe a little easier for me to persuade somebody to let me in than if it was some wee slip of a girl... you know...

Working with colleagues (social care workers/social workers/managers) was also mentioned by survey respondents (n=13) as a way of gaining access. Interviewees discussed co-working on cases and how some obstructive complex family cases involved many team members in different ways over long time periods. Also mentioned was how social workers worked together with members of other teams (who might have pre-existing relationships) such as mental health workers, drugs and alcohol or domestic violence teams.

Inside the home, a few social workers mentioned the strategy of co-working they adopted, when two professionals undertook a visit, one would distract the hinderer while the other attempted to talk to the adult at risk:

Normally what we try and do, [...] is sort of say to either one, ‘Come in the kitchen, let’s make a nice hot drink’ or something, and separate them without having to formally say, ‘Would you please leave the room so we can talk to you or whoever.

MGR 31

Social workers also outlined the importance of allocating the right person for the job in gaining access to an adult at risk, underlining the acceptability of different approaches depending on the case as in the following illustration:

I’m an alpha male, I’ve got a loud voice, [...] I have to be quite careful with my voice because if I slightly raise my voice, I sound aggressive, and I know that. [...] I can dominate a room and so it’s maybe a little easier for me to persuade somebody to let me in than if it was some wee slip of a girl... you know...

SW16
Effective allocation was said to require good team working to ensure everyone is aware of each other’s skillsets, experience and professional backgrounds. Participants in one site, for example, discussed developing and building on expertise and advanced training in general areas such as mental health, cognitive impairment, or end of life care, as well as specific skillsets such as counselling. The following observation illustrates this:

We’re lucky, we’ve all got different niches, so what will happen is we will look, and we’ll think that case would be best suited if that person’s got the most experience. And, as seniors, you get the most complex work in the team.

One manager considered that more experienced staff do not need any new powers because they were able to use their skills to get into people’s houses; whereas the less experienced staff struggle with gaining entry.

**Current informal multi-agency approaches to gaining access when access is hindered**

Informal multi-agency working with the police, health, fire and housing services were described and discussed at length in the interviews and commented on by survey respondents. Relationships with banks were also mentioned.

Survey respondents made many comments in response to being asked what was helpful to them, generally highlighting the importance of good multi-agency working:

Multi-agency working is essential so we can try and work together to find a way to safely contact the individual.

Survey respondents noted various multi-agency colleagues assisted them in initially gaining entry including health colleagues (district/community/psychiatric nurses and GPs (n=14)), police (n=5), and housing officer/tenancy support workers (n=4). The following case description provides an illustration of the multi-agency approaches reported as being commonly taken by social workers:

Mrs X needs to be medically examined by a GP, needs to be seen by the community matron, and get the environmental protection team involved due to state of the house and because of the garden being overgrown. Also speak to housing office as it is a council property. Also contacted fire (service) to see if they had ever done a risk assessment or visited the property. Environmental team said yes they were aware of the concern and they had had no response from contacts to Mr X. GP was refused entry. Police said they would raise an incident and booked a police officer to come out with the Social Worker. As a result of police visit, Mr X cut the lawn and the GP was now allowed in on the second visit. Mr X cooperated with district nurses. The case is ongoing.

**Health services**

Participants commented on wider organisational matters which impacted on multi-agency working in the different sites. In one site interviewees noted they had an agreement in place with the NHS Clinical Commissioning Groups (CCGs) and local GPs that a safeguarding lead would be in place in each surgery who could assist with accessing information.

In another site, interviewees stated that community health and social care teams had been disaggregated, but were still co-located, which was valuable in terms of accessing support in these cases. One social worker noted that co-location was useful in terms of building relationships and educating health staff about safeguarding, but there were still some concerns about the different approach to safeguarding taken by health staff and the need to coordinate thinking and actions (SW 39).

Positive comments were made about health professionals, such as GPs and community nurses, being able to gain access when social workers were unable to do so:

Often we find, in our experience, that people respond better to health practitioners as opposed to adult services.
GPs, in particular, were viewed as highly useful in cases where it was proving difficult to speak to an adult at risk, as the following comments illustrate:

On the whole I would say we’re still enough of a, of a society that sees doctors in a particular way, that they’re viewed very positively by most people….we tailgate in behind him or her.

MGR 05

So the GP was the mainstay. We had a suspicion that he [carer] was getting some kind of drugs in her name and that was the reason why he wanted to keep the relationship with the GP sweet.

SW 13

Such relationships were not without their difficulties at times or in some places as these reports acknowledge:

Often GPs are unable to do visits as constrained by appointment times and surgeries, but the care coordinators in the surgeries can undertake joint visits and access all GP medical records, so they could give us the health information that we need. Mental health services can be contacted....Yeah. I sent an email and telephone conversation, and with safeguarding if you can get the duty on the phone, they’re able to give you information over the phone, but they’re few and far between. So the care co-ordinator is a very good resource as a link and they have all access to GP records.

SW 18

It’s sort sporadic. Some you can phone and they say send me an email and I’ll send it, some will not. You have to go down (to the surgery), formally present who you are with ID, so I don’t think the GPs have a clear process; for it to be that different when we phone different GPs, I think they must themselves not have... so it literally is whether or not you’re going to get one that just accepts who you are.

SW 19

Across the sites, fewer comments were made about working with NHS hospitals and mental health hospitals. Nonetheless, one survey respondent commented that ‘It can be difficult when patients come into hospital when certain carers/family members refuse to leave a patient alone so a private conversation can be conducted.’ (MGR Survey 27) This may be thought of as a continuation of hindering away from the home.

Police

Across the three case-sites variable reports were given of informal police involvement. Welfare checks were described as informal visits carried out with police which were carried out ‘pretty much to make sure we’re [social workers] safe, and the...client’s safe’ (MGR 01).

Interviewees also frequently stated that the mere presence of the police was often enough to gain access:

But very often if you’re with the police, and they see someone in uniform, that seems to be enough to, to give me the authority to walk in.

SW 03

One case, was enough for the police to be present, to encourage the person to let the social worker in. [...] On the other occasion the husband was removed by the police under breach of the peace. Because he kicked off so badly and threatened to kill me and my colleague on the doorstep.

MGR 35

One social worker in site 1 explained that once a call had been made to the police, they prioritised the call and tended to visit in under an hour. This participant explained that out of six requests for welfare checks recently, the police had visited on their own in five of these cases and then updated social workers about the outcome; on the other occasion they had attended jointly. This was regarded highly positively.

In the other two sites more negative examples of joint practice were given and commonly cited comments and opinions included: the police being insistent on having information to confirm that gaining entry is part of a formal safeguarding process or the not being keen to be involved; the police tending not to be interested unless a clear crime has been identified; police being unwilling to prosecute (or refer to Crown Prosecution Service) where the victim had learning disabilities, dementia or lacked capacity.
Yeah, I think working with the police is difficult. [...] And then trying to engage with the allocated worker that would have raised that safeguard is very difficult because the shift work doesn’t match social care shift work. So it goes round... the communication is lost; you go round in circles for quite a while. And even for the here and now we call 999 if we want police support; even that takes time, because we’re not a priority.

The social worker related having tried for four days to get the police to go on a visit with them and ultimately feeling they had to just call 999 from outside the house and wait for the police to come. However, this social worker conveyed understanding of the problems for the police in responding:

And the police do... I think they make their best endeavours to support, but I think they’re stretched; they’re very stretched and they’ve just got to prioritise.

Another social worker described how police were helpful in checking when there was a cause for concern to see no-one had died and their power usefully included breaking into properties to check the person was alive. One social worker considered it would be more helpful if there was a set procedure rather than having to ‘renegotiate it every time’ (SW 16).

A small number of examples were given where social workers said they had tenaciously pursued cases in order to ensure police involvement. One example was of a case where the social worker described looking back through a hinderer’s notes, establishing possible benefit fraud, and using this as justification to ensure the police investigated whether the hinderer might also be financially abusing the adult at risk in their care.

One disabled person who participated in a vignette interview suggested phoning the police for advice, rather than asking for direct involvement. This was after the first part of the vignette (which is given in full in Appendix 4), at the point at which the social worker has tried on her own to gain access, but is not fully aware of the urgency of the problem:

In that situation I think I might phone the police and get their perspective and maybe use their knowledge a little bit and maybe put a quote or two of what they were saying from a legal perspective into a letter.

Vignette 43

Ambulance/Fire Services

Fire and ambulance services were referred to in respect of many of the cases related by interviewees. Both organisations have power of entry when there is a threat to life or limb and were viewed by social workers as useful options. Fire services, in particular, as trusted uniformed agents, were described as useful as they could carry out fire safety check visits (especially in the case of hoarders) where someone else was denying access, and could report back to social workers or joint visits could be undertaken. Examples of this included:

PARTICIPANT: Fire [...] they have workers that do pieces of work and they do fire safety checks and one of the ones, one of the tasks I would have undertaken was to do a joint visit with the fire service - so a means of access.

INTERVIEWER: (I): And what about ambulance?

PARTICIPANT: It's the same scenario, so if there is... if they're endangering themselves, then they can get access. [...] So for us, we need consent, and with the life and limb there isn't a consent needed.

INTERVIEWER: But what if it isn't really life and limb?

PARTICIPANT: I think it's arguable, because if somebody hasn't got capacity, then they would make a decision straight away, they wouldn't wait for an MCA (assessment), for example. It's in their professional judgement to make that decision.

One social worker described ambulance staff taking an adult at risk to a residential shelter for a night when he had been excluded from the Hospital Accident and Emergency (A&E) department following disputes between himself and the person who was obstructing contact. An opportunistic confidential interview took place there after months of unsuccessful multi-agency attempts to gain entry (SW 16).
**Housing services**

Current practice examples of working with housing services to gain access were given by interviewees. However, as a few interviewees stressed, these approaches were not available to people living in private accommodation – and greater numbers of this group were coming to the attention of local authorities because of the CA duty on local authorities to offer advice, information and assessments to people regardless of their financial status:

> Private property presents more of a problem, because the council has also, under the tenancy agreement, can assist if there is a concern. If it’s a council property, we can do something about it, but if it’s their own property, we have a struggle.

MGR 24

As another interviewee (SW 06) stated, in public housing home visits are permissible without a stated purpose. One social worker (SW 04) reported some housing organisations being very useful as they keep a register of vulnerable tenants and have a right of access for an annual gas safety check. Another social worker (SW 39) stated local social housing providers would consider taking eviction proceedings in some circumstances against a hinderer if the case was serious enough. The following case summary describes work with housing personnel to gain entry and gives an indication of the range of services that can become involved when someone is obstructing access to an adult at risk:

> Local authority (was) trying to gain access to the property for some time [denied due to a hinderer] now and to carry out essential electrical works and asbestos testing. Involvement of council officers, inspectors, electrical engineers, housing officers.

SW 18

**Finance – Banks, the Office of the Public Guardian and legal support**

Financial abuse was mentioned in the interviews as a common reason why an individual might be obstructing social workers’ entry to an adult at risk. Whereas in Scotland, powers are available to view financial and medical records, in England these are not available. In some cases cooperation with banks was seen as problematic as the quote below illustrates, but in these cases it seemed that the concerns were possibly about an adult lacking decision making capacity. They are included because, if access is obstructed, then there may be no way to establish if the adult at risk does or does not have capacity:

> Banks not so much; banks are difficult because of all the hurdles you have to jump, especially if the adult might have a joint account with the parent, but the adult might not have capacity, then you can’t look until the parent gives you permission, because they’re joint on the account, so banks, in my experience, hasn’t been too helpful. It’s going to the carers or the adults or the parents and rely on their information. Even if you go to the DWP, they don’t talk to you.

SW 19

A few comments were made in interviews about working with the Office of the Public Guardian in relation to financial abuse, but again this would be in relation to an adult at risk who might lack decision making capacity:

> I had a feeling that this may have gone the other way and maybe we would have had to go through the Court of Protection, because the daughter hasn’t got lasting power of attorney; we checked that with the Office of the Public Guardian (OPG), I think they’re called. If we email them and send them a form, they will tell us. So they need an official email for it to come back to. They will tell us. I think it’s called an OPG 100 form we fill out and I send it to them with my details who the referrer is and they verify that and give us the details. So that was quite a good system in place to check, because somebody may be lying and we haven’t got documents to see if they’ve got lasting power of attorney, especially for finance, because there could be financial abuse. The only records we would get is to see if somebody has got lasting power of attorney or not. But, in terms of financial records, they won’t give us that at all.

SW 18

---

1 Lasting powers of attorney were created by the MCA 2005. They enable individuals to appoint a person to take decisions on their behalf should they subsequently lack capacity to make decisions. The person granting the power may choose to appoint someone to make decisions about finances, and/or about health and welfare.
Finally, when asked about use of legal advice (in-house or external) in the survey as a source of support in gaining access when this was obstructed, several participants (n=25) noted they accessed this and three respondents stated they also gained legal advice from the police. A minority of respondents also discussed asking the Deprivation of Liberty Safeguards teams for assistance, acknowledging that they worked with people lacking mental capacity.

Information sharing

The findings on informal collaborative working have highlighted the importance of accessing information – and this was reported as a potential problem across the sites. The CA requires local authorities to work together with the police, NHS and other key organisations to safeguard adults at risk. Skills for Care (2015) states that ‘fears of sharing information must not stand in the way of protecting adults at risk of abuse or neglect’ (Skills for Care, 2015: 3). One manager reiterated that the CA and Caldicott principles mean a framework for information sharing is in place and information sharing should no longer be problematic for social workers in relation to the NHS:

I advise my guys you have, quote the Care Act at them, and our information sharing agreements and you’re all signed up to this, and what are your reasons for not sharing this information, and then obviously escalating it to the appropriate people, CCGs and NHS England, if we’re not actually getting that.

MGR 23

However, in practice, information sharing was reported as problematic by some interviewees:

There’s a lot of talk bandied about around how we should work collaboratively; well, the only way you’re going to work collaboratively is if you’re able to share information between different systems. So we’ve all got different systems, the police have their own system, different parts of health work on different systems, mental health work on a different system; unless we’re all able to actually just have a view, we’re not asking for in-depth information, but if you could get an overview, just get an overview or a risk indicator, anything would actually help, but it would have to be a two-way thing.

SW 21

Other informants noted how information sharing was highly dependent on personal contacts, as one manager (MGR 27) explained, they ‘kept in touch with officers formerly on the police safeguarding team that was disbanded’ demonstrating the importance of personal contacts in gaining access. A social worker also discussed how information sharing was also a matter of building up relationships:

PARTICIPANT: With mental health I’ve got good relationships with the community teams. I do know most of them, and I can ring up and go to the first response team and I can say I want this information, we’ve had a safeguard and I’ll get it. INTERVIEWER: But it’s because of relationships?

PARTICIPANT: Because of the relationship. One of my workers will ring up and they’re like, no, you’ve got to email, we want to know who you are, we want to do this.

SW 22

Interviewees described how accessing information was often based on assessments of risk. When a case already had multi-disciplinary input, then information was generally easily available, but in cases where the adult at risk was unknown or there were no pre-existing multi-agency data, a social worker described ‘walking into cases blindly’ and commented that this could be dangerous for their own personal safety. In one site, interviewees discussed how this was particularly relevant given the rise of gun crime in some locations locally:

So we do sometimes get a head start in risky situations. It’s a sharing of information and the person has to agree.

SW 22
... because quite often, [...] there were several occasions where we identified that there was a risk in this particular household and then you would see that the district nurses, okay, they're going to go in and you go, hold on... because we worked with an integrated team... you could actually say to the district nurses, because we were all sat together, hold on a second, you don't want to be going in there on your own, you need two because there's this risk [...] and they'd go, oh great, okay. So they knew, our health colleagues knew that there was a risk; that's what you call collaborative working.

**Summary**

Negotiation with third parties was the most common approach reported in the survey: this might range from ‘soft’ styles aiming to develop rapport to a more assertive approach, sometimes with explicit reference to legal routes. Good ‘matching’ as part of social worker allocation to the family in question was felt to be important. Creative approaches to arranging interviews and identifying potential allies in the community (such as Age UK, or the RSPCA, housing or utilities representatives) were also important ways of securing access.

In addition to the deployment of social worker skills, good multi-agency working was identified as essential in this aspect of safeguarding. Police, health, fire ambulance and housing services involvement was discussed at length in interviews and commented on by survey respondents. Relationships with banks were also mentioned. While practitioners in other agencies were often willing to help, there were often problems in relation to resource capacity. Participants suggested improved multi-agency information sharing would be helpful in hindering cases. They also suggested more explicit powers/responsibilities for multi-agency partners, so that their support could be relied upon in certain circumstances.

Chapter 7 now examines the use of current legal approaches in England.
7 | Impact of the Care Act and use of current legal routes to effect access

Introduction

This chapter explores the views expressed about the current legal powers and duties in respect of adult safeguarding. First, the chapter discusses survey respondents’ and interview participants’ views about the impact of the Care Act 2014 (CA) on safeguarding and hinder cases. The chapter goes on to explore reports of the use of, and views about, legal powers currently available to social workers in England that may be relevant:

- Police and Criminal Evidence Act 1984
- Mental Capacity Act 2005
- Inherent jurisdiction of the High Court
- Domestic Violence Protection Orders; and the offence of controlling or coercive behaviour
- Mental Health Act 1983

Impact of the Care Act 2014

The adult safeguarding provisions of the CA came into force on 1 April 2015. This study sought the views of adult safeguarding managers and social workers in the three sites on the impact of the section 42 enquiry duty and the duty to cooperate (ss 6 and 7 CA).

Effect on number of hinder cases

There was general agreement among those interviewees (with sufficient length of professional experience) that the duty to make enquiries (which we set out in Chapter One) had made no difference to the number of cases with access problems being investigated at each of the sites. One social worker, though, suggested that the number had risen because other agencies who were now being asked to carry out an enquiry under the section were more likely to face obstruction than if the local authority was undertaking it (SW 33).

General effect of the Care Act 2014

That said, a number of interviewees stressed that the number of safeguarding enquiries in general had gone up. Two suggested this was because of the change to the threshold over which someone could be considered an adult at risk. One manager said that adult safeguarding concerns had gone up by a third since April 2015 and that this was because the threshold was now ‘broader and lower...and so it feels as though we’re looking at a lot of different cases, different types of cases that we’ve not, historically, looked at.’ (MGR 05). A social worker commented:

So prior to the Care Act, we probably realistically, would largely only pick up people that had a diagnosed learning disability or autism. Since then, actually some people don’t have a diagnosis but actually need the same level of support, we would now pick those people up. The eligibility threshold in the Care Act obviously has changed and some people now are eligible that wouldn’t have been before. We would pick them up now.

SW 42

One social worker emphasized the new duties under the CA to consider the wellbeing of family carers (SW 18), a factor that may be relevant in hindering scenarios where the obstructive individual themselves had needs arising from their caring role.

More generally, interviewees often emphasized the continuity pre- and post-CA, that is in the move from No Secrets (DH, 2000) and the duty to make assessments under section 47 of the NHS and Community Care Act 1990 to the new formality brought to adult safeguarding by the 2014 Act. As one social worker observed:

So I don’t think the duty to enquire means that we do more enquiring, I think we know now that we’re acting under a duty.

SW 32
And one manager said of hindering cases:

I wouldn’t have treated them, the ones that I’ve got now, any differently [pre-CA]…They would’ve still come through a safeguarding route and stayed in safeguarding because of the level of concern.

MGR 01

Action before a section 42 enquiry is initiated

Several interviewees highlighted their practice of endeavouring to broker progress in cases before formally triggering a section 42 enquiry. One social worker commented, ‘I think we’re quite keen that we don’t use safeguarding procedures in that section 42 due to it’s a big stick to beat people with’ (SW 32). Likewise, one adult safeguarding manager reflected:

The reason being if you bring the safeguarding team in too soon it can feel very punitive to...the family...and then actually it has the counter, it’s counterproductive

MGR 01

To stave off the moment when a concern is ‘ratcheted up’ (MGR 01) to enquiry level, adult safeguarding staff may suggest that the social work team manager asks the GP to make a visit. Such an approach may itself form part of the triaging of cases (assessing whether a particular case merits a section 42 enquiry), and also conforms, according to this manager, to an ethic of the ‘less restrictive’ and ‘more proportionate’ (MGR 01) response to a situation – reflecting both the wellbeing principle in s 1 CA, and the statutory guidance to the CA, where one of the principles for the local decision making process in safeguarding is prescribed as a: ‘proportionate and least intrusive response appropriate to the risk presented’ (DH, 2017: para 14.92).

Advocacy

The duty to provide independent advocacy support in safeguarding enquiries where the adult has substantial difficulty in being actively involved in the enquiry (s 68 CA), and where they have no ‘appropriate individual’ to assist them, was raised rarely in the context of hinder scenarios by interview participants. One social worker, though, commented that advocates are sometimes very effective in building relationships, where the social worker perhaps does not have sufficient time (SW 33). Another indicated that this can extend to assisting in overcoming the obstruction, on occasion:

We tend to look at advocacy as our first option because it’s about what that person wants not necessarily the family and an advocate isn’t seen as a social worker. So they can tend to get in but there are times when an advocate can’t necessarily access the person either or the family is always around when that advocate goes to visit. It makes that quite difficult.

SW 34

Echoing this point about potential difficulty, another social worker pointed out the potential dilemmas of engaging an advocate in a fraught situation:

It’s quite a lot of, you know, responsibility to give an advocate, to try and manage that situation and gather somebody’s views while there’s someone who’s potentially aggressive and... But, so I don’t know what difference an advocate would have made, um, and, yeah, I don’t know.

SW 02

Indeed in relation to the same case, the safeguarding manager characterised the hinderer as himself putting himself forward as an advocate:

From his point of view he was just strongly advocating for his wife … She was very clear she wanted him as her advocate, she wanted him as her voice.

MGR 01

The social worker on the case reinforced this point (about it not being thought necessary, or for there not being scope for an advocate in the situation) in relation to another case: it was only at the point of successful separation of the adult and the obstructing carer that advocacy could be brought in (SW 02).

Duty to cooperate

There was variation in interviewee responses to the statutory duty placed on partner agencies to cooperate with the local authority in its
safeguarding enquiries (such as taking on the enquiry themselves: s 42(2) CA). Several practitioners pointed out that a multi-agency approach to adult safeguarding was hardly new, given its centrality to No Secrets (DH, 2000). Two adult safeguarding managers suggested the statutory duty to cooperate had made no difference – cooperation had already been good (MGR 27; MGR 30).

On the other hand, one social worker indicated that among some agencies there was a loss of clarity as to whose role it is to safeguard – that is, there seemed to be an expectation that social workers will take on all safeguarding work (SW 42). Another reported having to be ‘forceful’ in explaining the responsibilities of health partners and banks in this area (SW 26).

On the ground, social workers reported, in relation to the duty to cooperate and GPs: ‘You can quote the Care Act and then that will push. So yes, I think that helps.’ (SW 32); likewise, one social worker commented that alerting a GP to the fact that a ‘safeguarding investigation’ is in train has, post-CA, ‘more resonance’ (SW 06).

In this context, one manager saw the local authority’s power to cause others to make an enquiry as having encouraged the authority to train other agency staff in safeguarding responsibilities (MGR 37). Still another manager expressed the continuity and change inhering in the move from the No Secrets guidance to statute: ‘Because previously safeguarding wasn’t anyone’s business but ours... And now it’s everybody’s business. I mean it always was, but we didn’t have anything concrete and it wasn’t law in any sense was it?’ (MGR 31).

**Current legal provision**

In the course of its opposition to the proposed amendment to the Care Bill, which would have introduced the ‘Adult safeguarding access order’ (a power of entry for social workers), the Coalition Government announced that guidance would be commissioned (as described in Manthorpe et al, 2016) outlining current legal provision where access was proving difficult. Gaining access to an adult suspected to be at risk of neglect or abuse: a guide for social workers and their managers in England was published by the Social Care Institute for Excellence in 2014 (SCIE, 2014).

This section of the report gives an account of interviewees’ experiences and views of using these legal avenues. Predictably, a number emphasized that legal action was a last resort, for cost reasons and because of the likely deleterious effect on relationships within families and between social workers and the adults involved. In relation to applications in the inherent jurisdiction of the High Court, for example, one social worker commented:

> It would be the very last resort because it’s quite draconian and would totally break down the relationship with the family.

SW 34

A manager echoed this view, again in relation to potential High Court action:

> ... it sets up a whole different relationship, doesn’t it, between the council, the workers and the individuals, plus the cost means it is our last resort.

MGR 05

Police and Criminal Evidence Act 1984

Respondents to the online survey reported five hindering situations which had been resolved by the use of police powers (and where the local authority was involved) under the Police and Criminal Evidence Act 1984 (PACE). However, none was reported by interviewees across the three study sites. One example from before the CA, though, had involved a woman who lived alone who was locked into her own flat by her son (with a padlock on the outside of the front door) because she had started to ‘wander’. As a result, the social worker was unable to access the adult and the woman herself was unable to get out. The adult safeguarding manager commented: ‘With this lady we couldn’t see her... All we could hear was noise and distress’ (MGR SM 01). The local authority worked with the police who were able to use section 17(1)(e) PACE, the police power of entry and search, without warrant, in order to save life or limb.

One manager recounted a case where the police had arrested a hindering relative for breach of the peace, rather than under PACE, for threatening to kill a social worker; this had allowed the social worker to get in and talk to the adult at risk. Social workers in both sites 1 and 2 stressed the need for evidence before the police could take this action:
In terms of in hindering situations, they have to, I would imagine they have to actually think that, they have to know the person’s behind the door in the first place, which was, which we weren’t sure, and it turns out they weren’t actually there anyway. They, they have to be sure the person’s behind the door and have enough evidence to suggest that this person’s come to some kind of harm or is at risk of being harmed at that point, which is, you know is easier said than done.

In addition to the need for evidence, the SCIE (2014) guide emphasizes that the risk to life or limb should be serious; it is not enough to have a general welfare concern about the adult.

**Mental Capacity Act 2005**

The SCIE (2014) guide explains that in circumstances where there is difficulty in accessing someone who, in the terms of the Mental Capacity Act 2005 (MCA), lacks capacity, applications may be made to the Court of Protection (COP) for a personal welfare order under section 16(2) MCA to effect access. This facility extends to instances where there is doubt, but there is ‘reason to believe’ that the individual lacks capacity: here the COP may make interim orders preliminary to a full determination (s 48 MCA). One question that arises, for adult safeguarding in hindering cases, is whether the mental capacity of the adult can be determined at all, given a lack of access, and thus whether applications can be made to the COP for orders.

A second broad issue arises in hindering, though, when access is compromised over time. Assessments of capacity under the MCA are decision and time specific, and this is likely to necessitate multiple assessments over time if there is cause to believe that the situation has changed. Also to be taken into consideration is that an individual may be experiencing temporary incapacity or fluctuating capacity. Given this, one of the statutory principles of particular relevance is:

*A person is not to be treated as unable to make a decision unless all practicable steps have been taken without success.*

Section 1(3) MCA

This principle is reiterated in the statutory guidance to the CA (DH, 2017: para 14.55). In the Practice Learning Materials for adult social workers on the MCA, the same principle is described as calling for ‘supported decision making’ since ‘[s]upporting people to make their own decisions is a key element in social work practice’ (DH, 2015: 14). And when making a ‘best interests assessment’ under the MCA, consideration should be given as to whether, if the individual does not have capacity now, he or she may have capacity in relation to the decision at some time in the future (s 4(3) MCA).

**Making capacity assessments**

Several interviewees in all three sites referred to difficulties in making satisfactory mental capacity assessments in hindering situations. At one extreme was the case of the woman locked into her own flat by her son (mentioned above), which left adult safeguarding staff unable to assess her mental state – ‘we didn’t know what state she was in other than she was locked in’ (MGR 01). Having resorted to PACE to gain entry, she was found to lack the capacity to make the decision as to whether to stay where she was, and was removed to hospital, where she recovered her decision making capacity because of the support she received there.

More commonly referred to were the difficulties thrown up by compromised access. A manager described a woman whose sons were stealing her money for gambling and leaving her with no food. Regarding assessments the manager said:

*I guess what we would be saying: you’ve got to do it many times to be quite clear about this person’s capacity. You can’t just go and do it once and come away and say yes or no, you have to be quite clear, keep going in, keep asking the same questions in different environments, with the family there, without the family, that kind of issue and then you’ll know or be better informed.*

MGR 27

In a case that led to an application to the High Court under its inherent jurisdiction, all three members of the safeguarding team who were involved stressed the difficulty of making an assessment. Sometimes the husband would hinder ‘at the door’ (MGR 05) – meaning not allowing the social worker in at all. The adult safeguarding
manager (who was never allowed past the front door by the husband) said:

... he was obstructive so it was a bit hit and miss you know, you could never predict in any day how much care you would get through the door.

MGR 01

When social workers were able to see the adult at risk in this case, the husband ‘gate-kept, he would stand in the room, you couldn’t do a mental capacity assessment without him being present’ (MGR 01). On the same case, another manager said:

We weren’t asking for any great draconian measures. What we were asking for was just uninterrupted access to the individual so that you can…do a physical exam…check the health of the individual, um, and do a capacity assessment.

MGR 05

Assessments that had been completed had shown the adult to have capacity, but latterly the social worker with direct contact with the individuals concerned said: ‘we couldn’t carry out a reliable mental capacity assessment we felt at that point any more, we couldn’t get access’ (SW 02). Ultimately, the case was moved to the COP because a psychiatrist was able to do an assessment while the third party was at the High Court hearing, and the woman was found to lack capacity under the MCA.

The difficulties hinderers present to a social worker trying to take all practicable steps were highlighted in another case involving someone the interviewee referred to as an obstructive carer:

I made it clear to the carer and to her that I needed to carry out a mental capacity assessment. Um, and at every possible opportunity he said, no, no, no, no, no, no, no, you know. Oh not now, she’s too... And obviously, in line with the Mental Capacity Act you have to see somebody when they’re, you know, when there aren’t other... If it, if it can be delayed, you need to see somebody when they’re most likely to be able to give their, you know, most informed answers. That it wouldn’t be fair if she’s got a UTI [Urinary Tract Infection] or she’s under extreme stress because she’s being evicted, it wouldn’t be fair to carry out a capacity assessment based on, you know, on those circumstances...

SW 02

A social worker had experienced comparable difficulties, arguing that it would be useful to have powers to assess someone’s capacity, not least on the grounds that it was a legal procedure that might have to be defended in court, and there was great concern about the dangers of coercion if someone was in the room when an assessment was being done.

Other cases of obstruction

Beyond these difficulties surrounding capacity assessments, interviewees had come across obstructive behaviour in cases involving disputes (often long-running) with families about residence, and in relation to the use of Lasting Powers of Attorney.

Two cases were described, which had involved adult children with learning disabilities and one other an adult child with autism all of whom were living with their parent/s and considered to be at risk. For example, the parent of the person with autism would not allow social care access to their adult child, though this was considered to be essential in order to review the personal budget. The local authority was seeking a best interests decision from the COP, to enable the person to move to supported living away from the parent. Sometimes, according to one interviewee, parents were partly motivated to resist their offspring living elsewhere because having them in the home.
increased benefit income. Another case involved a young person with learning disabilities, whose personal budget was held by the parent, who was suspected of financial abuse: social workers had only been able to access the adult child, by chance, when the person was at the swimming pool. In each of these cases, the local authority was seeking an order from the COP as to residence, with a view to resolving the problem of obstructive behaviour, as well as other concerns about wellbeing.

Hindering arose in relation to relatives of an adult who had Lasting Power of Attorney status, or said they did. The first step was to check, with the Office of the Public Guardian, whether the claim was true:

We’ve had applications to the Court of Protection under MCA where we’ve not so much... we’ll we’ve applied to check the register, to see if someone’s got a registered Power of Attorney because sometimes they’ll say, yes, I’ve got Power of Attorney, and they haven’t. So we say can we see a copy? Oh yes, it’s under the mattress in my 12th house which I only go to once every 10 years. So we would do the checks then and we would apply and then we can use the clout that that gives us to say either you don’t have Power of Attorney, which breaks down that hindering because then they say, okay there’s nothing to share anyway. Or they do have a Power of Attorney and then we can go to the Court of Protection with a view to raising concerns with them about the way they’re handling the finances. So if they’re hindering us by trying to block our access, we can go that way and that’s quite useful. That’s been quite useful in the past.

In another case, it had to be pointed out to a carer by the social worker that being an attorney did not give them the right to bar social workers from making a capacity assessment. In another case, a person holding health and welfare attorney powers was obstructing healthcare workers:

Currently we have a case going that we’re supporting the Office of Public Guardian, around removing somebody as a Lasting Power of Attorney, because of their behaviour, and they are preventing the health service supporting the [person – who is] not being taken for blood tests, and speech and language support around the risk of swallowing. [Their] next of kin is preventing

that, because [they have] got a Last Power of Attorney for Health and Welfare, so [they] can make those decisions. We’re saying – not really. You know you should still be doing things in [the disabled adult’s] best interests, so that’s going to Court.

In these cases managers found that the legal status of best interests decisions helped in working with the carer to bring them on board; the MCA gave helpful backing to the discussions with families. Respondents to the online survey reported that applications to the COP had been made to resolve such situations in five cases.

Applications to the Court of Protection

In terms of the mechanics of COP applications, more generally, there was widespread comment as to how resource intensive these were for local authorities. At the level of everyday use, a manager in one of the sites suggested that managers and care workers are ‘really confident with the Mental Capacity Act now. I think people know when and when not to use it’ (MGR 37). However, going to court was another matter: in one site it was acknowledged that social workers were still learning to become ‘friendly’ with the MCA and the COP, in the word of one manager at site 1 (MGR 05); ‘learning and training [in adult social work] is still trying to catch up’ in the face of the discipline of court procedure, compared to child protection social workers for whom this was their ‘day-to-day bread and butter’ (MGR 01). The same manager, when asked about the experience of going
to the COP with a hindering case, recognized that
the demands made by legal process were severe,
while also acknowledging that these arose because
of the human rights questions that were at stake in
such circumstances:

It is really hard…I think because quite rightly so
the judges are really cautious because they are
intervening on the Human Rights Act. So it, it
can be really difficult to argue your case as to your
reasoning, and I think there's element of reluctance
by the judges...you're really, really having to state
your case as to why you want to do this, and why
it's justifiable, and there's still a bit of a reluctance
to rule against someone's human rights. It's my
sense...my feeling. But it's, it's difficult for social
workers...it's a difficult position to be in. It's
probably not a good position for a judge to be in
either to be frank.

MGR 01

Inherent jurisdiction of the High Court
The inherent jurisdiction of the High Court in the
adult safeguarding context refers to a protective
jurisdiction exercised by the High Court on behalf
of an adult where that adult is deemed unable
to protect themselves. It grew up prior to the
Mental Capacity Act 2005 (MCA) in relation to
health and welfare decisions concerning adults
lacking capacity – such decisions not being within
the jurisdiction of the old Court of Protection.
The MCA rendered the inherent jurisdiction
inapplicable to such decision making because the
Act brought health and welfare decisions within
the jurisdiction of the new Court of Protection set
up by the Act.

However, the Court of Appeal confirmed,
in re L (Vulnerable Adults with Capacity:
Court’s Jurisdiction) (No 2) [2012] EWCA Civ
253, that the inherent jurisdiction survived the
implementation of the MCA in respect of some
adults in certain situations. These are adults:

whose autonomy has been compromised by a
reason other than mental incapacity because
they are [...]...: (a) under constraint; or (b) subject
to coercion or undue influence; or (c) for some
other reason deprived of the capacity to make the
relevant decision or disabled from making a free
choice, or incapacitated or disabled from giving or
expressing a real and genuine consent.

McFarlane LJ in re L, para 54

At its High Court stage this case of re L had
elicited in interim orders, applied for by the local
authority, issued against the middle-aged son of an
elderly couple, prohibiting him from engaging in
abuse of his parents and from hindering access to
them by care workers.

No applications to the High Court in its
inherent jurisdiction were reported in the
online survey. In the three sites, they had been
considered in all three, though no successful such
applications were reported. There was one case
in one of the study sites, involving an application
to the High Court and which had been going on
for three years, of a young woman with learning
disabilities, living with her father, who was
reported by the interviewee to be psychologically
and sexually abusing his daughter and refusing
entry to social workers. (In another case, not
involving the inherent jurisdiction, a Forced
Marriage Protection Order had been granted by the High Court in a case that involved hindering – the social worker involved stressing the helpful speed of the application.)

One further case had reached a late stage in the High Court before being switched to the Court of Protection. The case concerned an elderly married couple; the wife, who was restricted to bed, needed personal care three or four times a day. Problems had begun when the husband witnessed his wife in pain as she was turned by care workers. He subsequently became obstructive over a long period; it could not be predicted when care workers and social workers, to whom he was frequently aggressive and erratic, would be able to access his wife. Making capacity assessments was rendered difficult. In addition, he was also stopping his wife’s relatives from visiting her, although she wanted to see them.

At the same time the wife was very reluctant to go into hospital (to which she had an aversion) – this despite the fact that this was recommended by her doctor, chiefly because of the pressure ulcers she had developed. In due course, because of this delay, her care was changed to palliative care. Again, though, the medical advice was that she needed to be in hospital. The adult safeguarding social worker, with direct contact in the case, commented:

**PARTICIPANT:** We asked her about hospital admission. He, the partner, did agree to leave the room for the conversation, but he was outside the door and he made his presence known by sort of speaking through the door occasionally, um, so he would...

**INTERVIEWER:** Right. So you didn’t think it was private, as a result?

**PARTICIPANT:** It was as private as... No, it wasn’t, it wasn’t very private, that’s the short answer, no. So even if... her answers probably wouldn’t be heard through the door but our questions would have been. And such as she was able to, you know, given her frailty, she was able to express no, she didn’t want to be in hospital, she wanted to be at home. She understood that she could well die if she doesn’t go, receive hospital treatment, and she was able to express that.

SW 02

The local authority applied to the High Court for an order allowing it make an assessment (that is, to remove the woman to a hospital for a brief time before returning her) on the grounds that the wife, who throughout had been assessed as having capacity, was objecting to going to hospital as a result of being under duress from her husband. (‘Duress’ rather than undue influence or coercion was the word used by the social worker and managers involved in the case.) The authority also sought orders that would enable police to assist should the husband object. Reported inherent jurisdiction cases have thus far not gone as far as making orders involving the removal of the adult about whom there is concern; rather the High Court has limited itself to making orders about what third parties should or should not do (Ruck Keene et al., 2015), as in re L. Notwithstanding this, the manager here commented about the application for removal: ‘we were literally days away from her death, and severe, very painful and unpleasant death. So I, I felt we would have pushed the High Court very hard’ (MGR 05). At the same time, the other manager on the case stressed that the aim was to get good care for the woman, not to separate the couple. While the man was behaving unacceptably towards care and social workers, he was seen as an inadequate carer of his wife, rather than as an abuser (though in an earlier phase of their relationship there had been a history of domestic violence).

During one of the court hearings the husband was attending, which enabled access to the wife back at home, a capacity assessment was made which found the woman to lack capacity on the decision and so a removal order was made by the COP under the MCA. The woman was removed to hospital (though in the event neither husband nor wife objected to the move and force was not called for) and she died shortly afterwards in a hospice, having had the chance to see her other family members. Asked about resources in this case, one of the adult safeguarding managers said:

**Oh massive, massive amounts of time. Because this was, we were in crisis more than once, and you think, there’s myself, there’s my manager, there’s my safeguarding social worker, there’s a care manager, there’s the team manager for the care managers, the service manager over in the community teams. There’s lawyers. There’s the GP. There’s the nurses, the palliative care team... massive amounts of resources... in the end**

MGR 01
Both managers stressed that they felt that court was a last resort, but that they could see no other way of resolving the situation (an echo of the facts in re L). And while, on the one hand the obstruction to access had led to deterioration in the woman’s physical health:

She became ‘palliative’ because of the non-compliance and the obstruction...So she wasn’t eight or nine pressure sores when we started this process, she wasn’t ill...She needn’t, according to the professionals, she needn’t have died of what she died of.

MGR 01

On the other hand, the result was described as positive, in that good care had been provided in the last few days before the woman died:

[A] massive outcome...that lady died being well care for. She had an opportunity to say goodbye to her [relatives] um, and she wasn’t in any pain’.

MGR 05

The social worker with direct involvement in the above case commented that the adult safeguarding team had probably had three or four cases since April 2015 when they had considered an application under the inherent jurisdiction, that is to say, in instances of suspected duress. The same social worker suggested that codification of the inherent jurisdiction in statute might be beneficial because of the clarity it could bring to a confusing area of law.

Domestic violence and abuse
The study sought the views of practitioners about legislation and local policy on domestic violence and abuse (DVA) in the light of the fact that DVA is now expressly recognised as one of the forms of abuse that fall within the local authority’s adult safeguarding remit (DH, 2017: para 14.20). Also part of the context was the fact that, building on the new cross-government definition of DVA (Home Office, 2013), a new criminal offence of controlling or coercive behaviour had been introduced part-way through the period under study, in December 2015 (s 76 Serious Crime Act 2015). This offence is notable for not necessarily requiring either violence or threat of violence for a successful prosecution. While neither this offence nor Domestic Violence Protection Orders (ss 24-33 Crime and Security Act 2010) enable access on their own, they may have a bearing on case management where DVA is occurring and access to the adult with care and support needs concerned is compromised.

Domestic Violence Protection Orders
Issuable even when the alleged victim does not agree, these orders always prohibit the suspected perpetrator from molesting the alleged victim and, where they cohabit, may require the suspected perpetrator to leave those premises. This is a measure initiated by the police by way of a Domestic Violence Protection Notice; the police then apply to the magistrates’ court for the Order. It does require there to be a reasonable belief that violence or a threat of violence has occurred. It was reported by one adult safeguarding manager, where the safeguarding co-ordinator sat on the local MARAC, that:

Reality, no problem in obtaining them. Enforcing them, big problems...Because what tends to happen is that it is the victim and the perpetrator that will breach those orders

MGR 01

This view was echoed by the other manager at the same local authority, and by a social worker. While, in the online survey, there were four reports of the orders being used to resolve a hindering situation, none of the study site interviewees had any experience of employing them in this context.

Controlling or coercive behaviour
Likewise, none of the interviewees had any experience of the new offence of controlling or coercive behaviour. However, it was seen by two interviewees as potentially relevant, one manager remarking, ‘you could argue I suppose that if the level of coercion is such that the victim is too scared to allow any access...and is constantly turning the safeguarding team or professionals away’ (MGR 01) it would be applicable, and a social worker observing that such behaviour is:

... definitely relevant to the hinder type of situations that I’ve come across that, that the behaviour of the carers have, has been consistently quite, well definitely controlling ’cause they’re not
allowing access and they're not allowing the...other individual to have their views heard

That said, the same social worker stressed that in both cases of hindering she had come across it would have been:

counterproductive...to have social services encourage a criminal prosecution when really you're trying to support this woman to make decisions about her future and to be in a place where her needs can be met.

This point was reinforced by one manager who highlighted the danger of a prosecution against the wishes of the adult with care and support needs. This might lead to the breakdown of a good relationship between social worker and adult, when it was recognised that it would have been in the interests of the adult for the supportive relationship of the social worker to continue after the prosecution had completed.

To this wariness of some practitioners toward criminal proceedings should be added the limitation (not raised by any interviewees) that DVA legislation is only applicable in regard to specified relationships, and does not extend, for example, to boarders, lodgers, tenants and employees. This same limitation would apply if the government chose to implement section 60 of the Family Law Act 1996, which would allow the local authority to apply for occupation orders and non-molestation orders on behalf of the adult concerned. In its report, Adult Social Care, the Law Commission had recommended that the government should review the status of this section, at least in relation to occupation orders (Law Commission, 2011: 140-141).

Mental Health Act 1983

The SCIE (2014) guide highlighted two provisions of the Mental Health Act 1983 (MHA) that might be applicable in hindering situations, namely sections 115 and 135(1), in relation to people who have, or are believed to have, a mental disorder under the Act. Section 135(1)(a) MHA, in particular, enables a warrant for entry to be issued by a magistrate on the oath of an Approved Mental Health Professional that there is reasonable cause to suspect the person 'has been, or is being, ill-treated, neglected or kept otherwise than under proper control'.

Across the three study sites none of the interviewees reported using the MHA for a safeguarding purpose in a hinder situation; in one case, it had been considered in relation to a woman with a mental disorder who had a controlling partner, but the difficulty was worked around. In one site, managers reported never using section 135(1) MHA, though here adult services had a section 75 (NHS Act 2006) arrangement whereby all mental health services, including all safeguarding work, is transferred to the local NHS Mental Health Trust, for adults under 65 years.

It seems likely that section 135(1)(a) MHA is rarely used for a safeguarding purpose, as opposed to facilitating a Mental Health Act assessment. In advance of its amendment by the Policing and Crime Act 2017, the DH and Home Office commissioned a review of the views of professionals, service users and carers on sections 135 and 136 MHA. This made no mention of section 135(1)'s potential use for a safeguarding purpose; rather it focused on its use for carrying out Mental Health Act assessments (Durcan, 2014).

Summary

The new status of safeguarding under the CA was deemed helpful, particularly in relation to encouraging other agencies in their duty to cooperate. Legal action, if possible, was a last resort because of cost implications and the risk of damage to relationships. Interviewees reported no involvement in the use of the Police and Criminal Evidence Act 1984 in hindering cases in the period under study, though five cases were reported by the survey respondents.

Social work interviewees reported problems of conducting mental capacity assessments unimpeded by third parties. Some stressed the importance of the private interview as a result. Recourse to the COP was an option used by a number of interviewees in relation to hinder situations involving a MCA attorney or when best interests decisions about residence were being considered. While the MCA was seen as providing useful statutory backing when dealing with problems of access to a person lacking capacity, COP applications were perceived by some social
workers to take up much time and resources.

While the inherent jurisdiction of the High Court had not been used by survey respondents, it had been considered as a means of resolving access problems in all three interview sites, and two applications had been made. High Court cases also require a ‘massive’ amount of resources, which needed to be accepted as part of safeguarding responsibilities.

Domestic Violence Protection Orders (applied for by the police), which may involve the eviction of the perpetrator, were reported to be relatively easy to obtain, but not necessarily easy to enforce where both victim and perpetrator wish to breach the order. Four reports of the orders being used to resolve a hindering situation were mentioned by survey respondents. No cases of the new offence of controlling or coercive behaviour were reported and there was a view that caution was needed as to its applicability in cases where criminal prosecution might be counterproductive.

No instances of the use of section 135(1) Mental Health Act 1983 were reported by interviewees for a safeguarding purpose. There was no evidence of practitioners having used it, or knowing about it having been used, for anything other than a Mental Health Act assessment. However, two of the sites had arrangements whereby safeguarding for adults (except older adults) with mental health problems was managed by the local NHS Mental Health Trust, so this was not part of these participants’ responsibility.

Having explored the current legal powers in this chapter, Chapter 8 explores views about any need for further legal powers for social workers in England.
Introduction

This chapter presents the opinions of the social workers, managers, older and disabled people and carers we interviewed or who responded to the survey, about the need for new legal powers for social workers who encounter hinder situations. The chapter presents the proportions of survey respondents and interview participants who were in favour or against a power of entry and the other powers available in Scotland. Reasons for supporting or opposing these potential new legal powers are then explored.

Views about a power of entry

Table 8 shows that just over half of survey respondents who answered the question were in favour of introducing three of the legal orders available in Scotland: for a power of entry for undertaking a private interview (14/22), assessment (15/22) or banning a perpetrator (14/22). However, slightly less than half (10/22) were in favour of orders enabling local authorities to remove an adult at risk.

We asked the social workers and managers who took part in the interviews whether they were in favour of the same group of powers, and they responded in broadly similar ways to the senior safeguarding managers responding to the survey, as shown in Table 9. Over two thirds were in favour of introducing legal orders for a power of entry for undertaking a private interview (26/37), assessment orders (26/37) or banning a perpetrator (20/37). Again, about half (18/37) were in favour of orders to remove an adult at risk. We also asked the interview participants what they thought about allowing social workers to apply for any of the court orders without consent, if they were able to provide evidence that an adult at risk who has capacity was being unduly influenced by someone. Over half (20) of the 37 participants were broadly in favour of this extra element. Just over a quarter (eight) were against, with nine undecided. Many qualified their support in some way, as summarised in Table 9.
Nine of the 11 older and disabled people and carers taking part in the vignette interviews were in favour of the introduction of a power of entry. The other two were undecided. Eight felt that the power could have been usefully employed (had it been available) after the first part of the vignette, with two feeling this was not appropriate and one undecided. All but one of these participants felt that a power of entry could have been used after hearing the second part of the story. The one who was unsure was in favour of the introduction of a power of entry in general.

**Reasons for supporting a power of entry**

The reasons for supporting a power of entry concerned the process of making safeguarding enquiries, mostly directly related to hindering situations. Four main reasons were given by survey respondents (in free text) and interview participants:

- To overcome hindering (20)
- Help where someone has capacity and there are strong concerns (3)
- Shorten process (7)
- Improves the legal basis for adult safeguarding (11)

The most common reason cited for supporting a legal power of entry was to overcome hindering situations, to enable social workers to get in and check the welfare of the adult at risk. Many of these participants holding this view also noted that the power would only be needed in the last resort. This team manager gave a typical comment, saying that a power of entry would only be used in the:

...absolute minority of cases where every strategy you use and every agency you’re working with, you’re not getting anywhere.

MGR 40

A further two also felt that there was a need for a power to remove the adult at risk as well as a need for a power of entry:

The safeguarding in itself doesn’t give us the power to remove somebody.

SW 26

This was also the benefit identified by three of the older and disabled people who took part in the vignette interviews. They stressed the need to find out more clearly what the situation was:

RESP: They have to get a higher authority to give them permission to go in.

INT: And what do you think they should do, you know, if they get in? What should happen?

RESP: Then they should interview Celia, have
a chat to her on her own. That Mary hasn't to be within earshot. They have to reassure this Celia that whatever she says won't be passed on to Mary.

Vignette 44

Help where someone has capacity and there are strong concerns (3)
A power of entry was felt to be useful by these three participants, especially where the adult at risk had capacity, but there were strong concerns about potential abuse. This social worker felt that if the adult at risk had capacity, there were fewer avenues to try to assess and offer support and that a power of entry might be particularly useful in these circumstances:

It’s just that even if we’re assessing someone as having capacity in those particularly risk situations what then it feels like we’re quite limited to what we can do.

SW 33

Shorten process (12)
Seven professional participants felt that the power of entry could shorten the process of gaining access to the adult at risk, which may shorten the time that he or she was being abused and may also free up time for other cases, as typified by this social worker:

I think there needs to be a clearer, more swifter process for gaining access to an adult that can't safeguard themselves, maybe for reasons of capacity or vulnerability, because from my experience, if you’ve got someone in front of them, it’s very hard to get through the front door.

Seven of the older and disabled people who took part in the vignette interviews felt that a power of entry would be a good way of speeding up the process, which was a key factor in protecting Celia (the fictional older person who was at risk in the vignette):

Going to the High Court for that - and, and waiting all that time is a waste of everybody’s time, effort and therefore that resource is going to be tied up doing that when they could be out visiting another Celia.

Vignette 45

Improves the legal basis for adult safeguarding (11)
For ten social workers and managers and one survey respondent, a power of entry would provide welcome legal backing to undertake their duties in undertaking safeguarding enquiries, which would help avoid the need for extraordinary measures. For example, this social worker commented that a power of entry would bring similar powers to adult safeguarding as exist in child protection, where she felt the professionals had quicker access:

Gives [child protection social workers] a lot quicker access to children when they need to have that access, and I think that vulnerable adults should have that same access, if needed. Also some access to the courts, because although the High Court, in my situation was very good, the Court of Protection, they say you can have speedy access, but it’s not speedy. And something that I think was similar to children’s would be good in adults.

SW 19

Three of these participants specifically mentioned the new duty of enquiry in adult safeguarding created by the Care Act 2014, but that there was not enough legal power to fulfil the duties, as noted by this social worker:

I think in terms of obviously safeguarding being on that statutory footing now we have statutory duties to undertake those enquiries. It doesn't seem like we have a reflection in terms of statutory power to proceed with those.

SW 33
Reservations about introducing new legal powers

Despite the majority positive view about a power of entry, almost all the social workers and managers interviewed in the three sites and many of the survey respondents expressed reservations about the introduction of a power of entry, whether they were in favour of it or not. Five main reservations were identified:

- Existing legal powers are sufficient (5)
- Could affect social work relationships (13)
- Doesn’t fit with social work practice and values (15)
- Good management needed (21)
- Impact on adults at risk and their families (15)

Existing legal powers are sufficient (7)
A small number of interview (n=4) and survey participants (n=3) were of the opinion that existing powers were sufficient to achieve access, so an extra legal power was not needed. These participants felt that more training for professionals in using the current law was required, illustrated by this survey respondent:

Are there not already existing routes that can achieve the above i.e.: police powers, civic and criminal actions, Public Health Act? Would it not be worth considering developing the knowledge of professionals about what is available and also ensuring that support is available to the person to assist them to take the action that they feel is appropriate to protect themselves?

Survey Manager 04

As we note below, another four interviewees and one survey respondent made a similar point about the other powers available in Scotland.

Could affect social work relationships (13)
One of the most common reservations was that the power of entry might negatively affect relationships between social workers and adults at risk and their families: 13 social workers and managers we interviewed commented to this effect. This was a common concern among participants who were, on balance, in favour of the introduction of a power of entry as well as those who were against. This service manager, who was in favour of a power of entry, expressed a typical concern:

As in all cases when we have to get into the realms of using compulsory powers in social work it’s always got a bit of an unfortunate edge to it because the minute that we start to ‘compulsorize’ on something it’s taking away whatever small degree of cooperation we might have been able to gain, but if it’s balanced against life and death and somebody’s safety or potential murder or real harm, I do think that it is a tool that could ultimately be used to procure somebody’s safety and wellbeing.

MGR 29

Doesn’t fit with social work practice and values (15)
Another large group of interviewees was concerned that a legal power of entry went against social work values in some way. For example, this social worker felt that a power of entry might increase the control element of social work:

The primary role of a social worker is to support and empower. So it’s not to become another arm of the police to investigate, or to be, you know we are of the state because that’s who we’re employed by.

MGR 11

One manager was also concerned that the power of entry would encourage social workers to impose their own values in decisions about enforcing a legal order and intervening in a situation, and would affect the ability of people to live their own lives:

As a social worker, we have to be comfortable with other people living their lives the way that they wish to live them.

MGR 40
An important social work and legal principle is to identify and implement the less restrictive option in any intervention, including safeguarding enquiries. A small number of social workers and managers (n=7) were concerned that the introduction of a power of entry might lead social workers not to pursue the less restrictive option. As one social worker put it:

*The only reservations I have is that somebody might use it when perhaps it wasn’t needed, they haven’t gone down the route, you know, of looking at least restrictive.*

The risk of a temptation not to use the less restrictive option was linked to a concern about the impact on social work practice and values, particularly in the context of increasing workloads and pressure. This manager summed up this feeling in a pithy comment:

*If you’ve got that sledgehammer option in the first place, there’s the temptation just to use.*

SW 26

The roles of the police and judges were also mentioned as important in the implementation of any new power, which implies the need for careful management of relationships with the police and also the preparation of good court applications for entry warrants.

This social worker identified the need for a well thought out and managed process for making a decision to apply for a possible entry warrant, although she stressed the importance of striking a good balance between robustness and not discouraging social workers to make an application for an order because of the length and complexity of the process:

*It needs to be a long enough process and an evidential enough process, because that’s a really, it’s a really personal thing to do is to gain entry to someone’s property when they don’t want you there... But the other part, for me is it needs to be robust enough that people aren’t just doing it as routine because they’ve knocked the door once and didn’t get an answer.*

SW 38

Good management needed (24)

Many interview participants (n=20) and survey respondents (n=4) stressed the importance of closely managing the use of a power of entry, to make sure it was only used as a last resort in high risk cases. It was important also that the introduction of any new legal power would not mean that social workers had or were seen to have too much power. The roles of the police and two participants in the vignette interviews also stressed the importance of good decision-making to ensure appropriate use of any power of entry:

*I am sure that there could be the safeguard of having to apply to somebody outside their jurisdiction. You know I’m not saying just apply to your manager and your manager ticks the box you can go. The manager would probably have to say, yes let’s put a case to a, before the court.*

Vignette 44
Impact on adults at risk and their families (15)

Another group of interview participants (n=12) and survey respondents (n=3) was concerned about potential impacts on the adults at risk and their families when a power of entry was being implemented. Perhaps an obvious, but nevertheless significant outcome of the use of any power of entry would be a direct, emotional impact on the people living in the house. This was described variously as being potentially ‘frightening’; ‘terrifying’; ‘would scare somebody to death’; ‘traumatic’; ‘horrible’; ‘stressful’.

In addition to this direct effect, some interview participants (n=4) and survey respondents (n=2) felt that a legal power of entry for social work would infringe on the human rights of adults at risk and their families, in particular in relation to article 5 (Right to liberty and security) and article 8 (Right to respect for private and family life) (European Convention on Human Rights). Three participants thought that a power of entry alone, without the addition of extra powers, could increase the risk of harm, simply because of the raising of emotions within the household and potentially alerting family members to the enquiry, without being able to change the situation quickly:

I am not in favour of JUST have a power to see and interview an adult. This would leave them in greater danger and increase staff anxieties.

MGR Survey 9

Powers available in Scotland

Overall comments

We asked in the interviews and in the survey for views about the extra powers introduced in Scotland in the Adult Support and Protection (Scotland) Act 2007 (ASPA). These powers enable social workers to seek legal authority to: undertake an assessment in private, away from the person’s home; remove an adult at risk; and ban a third party from where the adult at risk is living (all with the consent of the adult at risk). Some of the comments made about the Scottish powers echoed the general comments made about a power of entry, particularly about the need for careful management to ensure the extra powers were used appropriately and only as a last resort in high risk cases. There were three main themes, and three other comments:

• Useful complement to power of entry (11)
• High risk only (4)
• No need, existing powers enough (6)

Useful complement to power of entry (n=11)
The most common response was broadly positive, describing extra powers as a useful complement to a power of entry, which if implemented alone was felt by these participants potentially to create risks of harm. This manager, for example, described how considerations about making situations worse by attempting to gain access, without being able to change anything, were already part of the management of safeguarding enquiries under current English law. He felt that having a power of entry on its own, without being able to remove an adult at risk could make the situation worse:

...we’re always weighing up the risks. So if we go in and walk out of the situation, what are we doing? You’re right, if we get the power of entry but then we’re not able to move it on, are we just making it worse? Again, it’s really difficult. I think it’s when you’re in that situation, when you’ve weighed those risks up, if you’ve already had power of entry and you need to remove if we had it.

MGR 37

Use of the powers needs to be limited to high risk cases (n=4)

These four participants were concerned that the extra powers should only be used in very high risk cases as a last resort, similar to comments made about the power of entry. This manager was keen to stress that the powers would only be used as a last resort because of the motivation of social workers to work with families and not wield a ‘big stick’:

... even if you give a social worker a stick it would be the last, last, last resort. You think how many cases we’ve actually taken to the High Court, it’s very few compared to how many we’re getting through, because you will tolerate a lot and you’ll try and work with families.

MGR 29

Existing powers are sufficient (n=6)

As with a power of entry a small number (n=5 interviewees; n=1 survey respondent) felt that
existing powers were sufficient. Only one of the interviewees made the same point about a power of entry. One social worker generally felt that there was already too much power for these professionals and another that any extra powers would infringe human rights, but the main view expressed by this group was that the additional legal powers were unnecessary, as typified by this social worker:

This might be because of my misunderstanding of the law but... so it’s accompanied by new legal powers to make orders with the consent of the adult at risk to ban perpetrators. Well if the adult is consenting, you can explore restraining orders surely. There’s already a legal tool or a remedy for some of those things, I feel.

SW 32

Three other topics were mentioned by one participant each. These identified the new powers as:

- Counter to social work values
- Improving the legal basis for social work
- Putting adult safeguarding on a par with child protection.

Comments about power to undertake an assessment in private

There was less comment on this potential power, and the following points about this power were made by one survey respondent each. They give a sense of how mixed the views were about the extra powers.

Good especially if there is if undue influence

*It would be a good idea to allow assessments to take place in privacy, particularly if the family/friend or individual is being coerced or forced to not make safe decision.*

MGR Survey 3

Not enough to ensure safety

*I do like the idea of (d.) but orders removing people from properties does not always make people safe.*

MGR Survey 6

Useful and proportionate, but adults at risk may find it hard after forced entry

*I think powers to have a private interview and/or assessment would be helpful, and possibly slightly more proportionate (also allowing potential evidence in some cases to be gathered to contribute to a subsequent application, e.g. COP or Family Court). However, this power would have to address the central issue of the adult having the time and being willing and/or free to talk, including recovering from the stress of unwanted or unexpected visitors in the property, possible police presence in the property too.*

MGR Survey 8

Comments on power to remove adult at risk

Comments on this potential power were made by seven participants, three from interview participants and four survey respondents. A power to remove an adult at risk was valued as being better than leaving people at risk of abuse. For example, one social worker had wavered between accepting and rejecting the adoption of ‘Scottish powers’ in the interview and stressed that social workers need to work to understand and accept relationships in order to explore the boundaries of what is acceptable. However, she added: ‘Some situations just call for just going in, bashing the door down, whipping the person [away].’ (MGR 30). Another manager felt that removing an adult at risk would enable a better assessment of a person’s behaviour and wishes.

As with the other aspects of the discussion of powers, two survey participants were keen to stress that this power should only be used in high risk cases:

*Being able to remove a person to safety is a nice idea but I would hope that if such an order existed it would only be used in exceptional circumstances.*

Manager Survey 6

Again, similarly to other powers, the idea that the power to remove an adult at risk was unnecessary because existing powers are sufficient was expressed by two survey participants.

MGR Survey 6
Comments on power to ban a third party
The power to ban third parties generated more comment than the other extra powers available in the Scottish regime. Three kinds of comments were made:

- Complexities of implementation (14)
- Particularly useful in domestic violence and ‘cuckooing’ cases (3)
- The fit with social work values (2)

Complexities of implementation (14)
The most common complexity mentioned related to the often ambivalent relationships adults at risk have with the family members or friends who may have abused them or be abusing them. For example, one manager made the point that the family member who had financially abused an adult at risk might be the only source of companionship, which would make it hard for the adult at risk to accept their being removed from the home. Another manager felt that some adults at risk would be likely to accept a banned person back into the home, for similar reasons (i.e. companionship):

Yes, so we should have power to remove an alleged perpetrator or if it’s proven, because...this is how

kind of everything is double punished or they [the adult at risk] have to escape to save themselves. So it will be the only one kind of what I can think of.

MGR 25

Furthermore, one survey respondent felt that a banning order would empower the police to act if the banned person returned to the home, which would help in other safeguarding cases as well.

Fit with social work values (2)
Two participants felt that banning people from homes (in common with the other powers discussed) was not a good fit with social work values, or was simply too much power for a social worker to wield:

...if we’re going in banning people, does it grind against what the backdrop of what social work should be about?

SW 38

Comments on obtaining orders without consent
One of the most controversial elements of the Scottish legislation is the fact that all of the orders potentially can be made without the consent of an adult at risk who has capacity, where it can be shown that they have been unduly pressurised to refuse consent (s 35 ASPA; Stewart & Atkinson, 2012). We asked the interview participants for their views on this aspect of the Scottish law. Three themes emerged from the comments:

- Duress or coercion can impair decision-making (14)
- Against social work values (7)
- Management of powers (5)

Duress or coercion can impair decision-making (14)
Many participants agreed that the decision-making abilities of adults at risk could be impaired by duress. Most of these participants agreed, therefore, with the idea of obtaining the orders without the consent of the adult at risk, in these circumstances. However, two social workers stressed the difficulty of assessing whether an adult at risk is under duress. Being able to remove the adult at risk from the situation where they were believed to be under duress was felt likely to help them make decisions by many of these participants:
[A] person who is the subject of coercion or psychological emotion so, so, so involved, so probably removing person from psychological point of view from the environment situation, it could give them some kind of insight from this stance.

MGR 25

Against social work values (7)
These participants objected in principle to the idea of obtaining orders without consent of an adult at risk who has capacity, even if they were being coerced. These objections were placed in the context of moral and ethical concerns, social work values or human rights. This comment was typical, emphasising the importance of dignity, privacy and individual autonomy:

Because the person’s dignity, privacy is important...Once they’ve got all the information and they make their own decisions we have to respect that.

SW 07

As a consequence, many of these participants indicated they would place much emphasis on capacity assessments, and would support the right of individuals to make what some would see as unwise decisions:

I think part of that role is for us to go back assessing capacity, to determine whether the person has the ability to weigh up the information to decide to have an ongoing relationship with that person.

SW 39

Good management (5)
As with the comments made about the other powers, good management and decision-making were stressed by five participants, if orders were able to be obtained without the consent of the adult at risk. This was needed to ensure that the power was only used in the right circumstances, as described by this manager:

I’d quite like to have all of those powers in my back pocket. But I’d want to have a, you know, a protection Chapter that makes me have to evidence to a very high level to be able to use any of those.

MGR 35

Summary
Most survey respondents and interviewees were in favour of a power of entry for undertaking a private interview; most were also in favour of the introduction of assessment orders (temporary removal for assessment) and orders enabling the banning of a perpetrator. However, less than half were in favour of orders enabling authorities to remove an adult at risk.

Some interview participants in favour of a power of entry argued that such a power would strengthen the legal basis of safeguarding and provide legitimacy for action where someone has capacity, but there are strong concerns about their wellbeing. They also argued that such a power could shorten the process of negotiation.

Many participants (those in favour as well as those who were against a power of entry) expressed reservations. These participants felt that: cases could generally be resolved with good social work; there would be a risk of negative impact on adults at risk and their families; the power of entry did not fit with social work practice and values; it could negatively affect social work relationships; it might infringe human rights; and, that current legal provision suffices.

The Scottish protection orders were seen by some as a useful complement to the power of entry. Again, some argued that existing powers were enough. Banning orders were seen as particularly useful in domestic violence and ‘cuckooing’ cases. The ability to override an adult at risk’s refusal to consent in the Scottish legislation was seen as relevant, since the effect duress or coercion can have on decision making was widely acknowledged, though again there was concern that it ran counter to social work values.

Chapters 4-8 have presented the findings of Phases 2 and 3 of the report. Chapter 9 discusses these findings in the light of other research and sets out some policy options that are suggested by the research.
9 | Discussion, conclusion and policy options

Introduction

In this chapter, we discuss the findings of the interviews and survey, and relate some of these findings to the messages emerging from our analysis of the responses to the DH consultation and the parliamentary debates. We conclude the chapter by setting out some policy options and note areas of possible further research, some of which may be needed in order to develop the policy options.

How big a problem is hindering?

One of the clearest findings of the research is that there are no specific data collected on situations where access to an adult at risk has been obstructed by a third party, which we have termed ‘hinder’ cases. Survey respondents and interview participants gave widely different estimates of the numbers of cases in authorities, or that they personally had been aware of or worked on. This reflects the differences between estimates provided by the respondents to the DH consultation in 2012. One of the reasons for this may be one of definition. Many respondents made the point that overcoming a reluctance to engage is a core social work skill, and that there are many cases in which gaining access is not immediate. The question therefore arises as to when this becomes such a problem that extra support is needed or legal interventions should be considered. The research points to factors that would need to be considered in making this decision:

- Immediacy of the risk of harm (its likelihood and seriousness)
- Types of abuse suspected
- Whether any contact with the adult at risk has been made
- Social worker’s judgement on whether the adult at risk is under duress or undue influence
- Length of time without acceptable access

Developing an approach to measuring the numbers of cases would be one step towards understanding the extent of the problem. This might be achieved by asking social workers and their managers to consider collecting data about their use of more assertive, multi-agency approaches or legal routes to gaining access that could be included in a prospective survey study. A focus on accurate record-keeping would be essential in order to generate useful data in this area. This could potentially be incorporated as a measure in the Safeguarding Annual Returns (SARs) submitted annually to NHS Digital (NHS Digital, 2016). Furthermore, some participants noted the increased ‘reach’ of safeguarding following the Care Act 2014, which is likely to be a factor in the numbers of hinder cases. Some exploration of how practitioners are deciding who might be an ‘adult at risk’ under this broader scope would help understanding the factors underpinning the overall size of the problem of hindering.

Problems in gaining access in cases involving hindering were identified as being a significant yet unquantified cost to adult social care and other services. These cases entailed social workers, managers and other professionals spending a great deal of time undertaking multiple visits, and attending meetings. In addition extra services might be commissioned partly in order to provide opportunities to check on the welfare of the adult at risk. While the rights of the adult at risk to live free from harm are paramount, any data collection would need to be able to report on cost implications of different options and safeguarding models.

As professional participants noted in the survey and interviews, cases where there are conflicts and different perspectives are part of normal social work, which typically requires skills of negotiation and partnership building (Trevithick, 2011). Again this reflects views expressed in responses to the DH consultation. However, improved guidance on different approaches to gaining access and clearer routes for securing support from professionals from other agencies might help minimise the extra
cost, in addition to facilitating speedier access to adults at risk so that their wellbeing can be established where it turns out that there is no cause for concern. Earlier access in some of these cases may also limit abuse and improve the adult at risk’s wellbeing. Further, negotiation and rapport building involved in gaining access through social work routes may enhance the effectiveness of other forms of social work involvement or assistance by others in promoting these positive outcomes.

The research has pointed to possible different reasons for obstructing social workers’ access to adults at risk and has suggested a tentative typology, based on different possible contexts for hindering, the third party’s needs, and his or her motives. Any guidance for social workers and team managers should include making an assessment of such possible reasons for hindering and an analysis of context. While these may only become clear after the initial negotiations with the third party, incorporating such an assessment may be of use in developing approaches to building trust and overcoming the reasons for hindering, developing a good or at least reasonable relationship with the third party, and gaining reasonable access to the adult at risk.

Current approaches to gaining access to an adult at risk in hinder situations

Social workers and managers identified many cases in which access to an adult at risk was obstructed by third parties, but where they had managed to gain access through what many identified as ‘good social work’, as did respondents to the DH consultation. Two broad ‘styles’ of approach were identified. One was a softer approach, which focused on negotiation and developing partnerships with third parties, typically if they were felt to be acting, however erroneously, in the adult at risk’s best interests. These were perhaps the most common approaches mentioned and often involved repeat visits, discussion with the third party and with the adult at risk, if the problem was more one of having a private conversation than in getting into the property.

However, as Cooper (2015) notes, negotiation involves social workers using their undoubted power in the situation as agents of the state. Cooper also comments that power and negotiation can appear to be ‘hidden concepts’ in practice as they are often ‘tacit or unspoken about’ (Cooper, 2015: 141). The power social workers have derives from their statutory role, which for safeguarding is enshrined in the Care Act 2014. Increasing the legal powers social workers can draw upon, particularly introducing powers of entry, removal or banning, may therefore alter this process of negotiation. This possibility was noted by some of the social workers and managers we interviewed, in both negative and positive ways.

Negatively, they felt such powers might make the process of negotiation more difficult, as third parties and adults at risk might be more likely to react badly to social workers because of their increased legal power over their lives. More positively, some professionals thought that possession of these kinds of powers might help them feel more confident and also might encourage some third parties and adults at risk to engage more directly with them. Indeed, the more assertive styles of negotiation already described by some social workers made more or less explicit reference to the legal duties and powers, which sometimes
seemed to be used almost as a means of coercing
the person to allow entry. Again, balancing
conflicting goals of support and more assertive
implementation of policy and law is a typical social
work dilemma. As Weinberg (2016) puts it, ‘social
workers need to work “in the spaces between care
and control”, one of those intrinsic social work
paradoxes’ (Weinberg, 2016: 69).

Working with a wide range of professionals
and other workers was seen as a very important
and useful way of gaining access without resorting
to legal interventions. A wide range of agencies
was included in such mentions, such as police,
fire and ambulance services, housing officers and
other workers going into homes, such as trades
or delivery personnel. Most often other social
workers and managers would work together on
cases, but other professionals were also commonly
requested to support access. This is where multi-
agency working has to work ‘on the ground’, but
interview participants reported great variation
in the availability and sometimes willingness of
staff from other agencies to support them. This
was dependent on a wide variety of contextual
factors including how safeguarding was organised
within the local authority (Norrie et al., 2016b).
Increasing the clarity of guidance to confirm
when and how the duty of cooperation in adult
safeguarding introduced in the CA could be
called upon could provide greater consistency in
joint working in these circumstances. However, in
many instances it appeared that the variation was
not due to a lack of will to cooperate, but a lack of
capacity. All public services have faced financial
restraint often leading to prioritisation, and this
appears also to be a factor that made working with
hinder situations more difficult.

The kind of reasoning about the impact
of a power of entry and the range of responses
described by participants in the research echo that
found in the responses to the DH consultation and
also some of the parliamentary debates. For the
most part, overcoming obstructions to access was
seen as an essential part of social work practice,
and could generally be achieved except in extreme
cases. This would support the continued need
for professional involvement in such cases, given
the difficulty of making decisions about which
cases require a more assertive approach and the
skills needed in negotiation and rapport-building.
They would appear to meet the definitions of
complex cases suggested as requiring social work
involvement in the CA guidance (DH, 2017).

Furthermore, the need for expertise and experience
among professionals working in these complex
cases supports the need for regular refresher
training and perhaps multi-agency training, to help
spread good ideas, develop good relationships and
discuss the realities of clear pathways to accessing
support from other agencies in individual cases.

**Current legal provision**

One of the Coalition Government’s arguments
for not including a power of entry in the Care Act
2014, to accompany the enquiry duty, was that
existing legal provision sufficed. The resulting
absence of such a power now stands in contrast to
safeguarding arrangements in Wales and Scotland,
under the Social Services and Well-being (Wales)
Act 2014 and the Adult Support and Protection
(Scotland) Act 2007 (ASPA), where duty and
power coexist.

Among the three sites of this study, there had
been no cases reported by staff since April 2015
of the use of available powers of entry in instances
of completely obstructive behaviour by a third
party (as opposed to instances of compromised or
intermittent access). The online survey returned
small numbers in relation to the use made of each
of the legal routes, except the inherent jurisdiction
where there was none, though no details were
recorded about this use. In two sites there were no
reported instances where the local authority had
never gained entry; one manager, though, reported
that of 25 hindering cases, 15 had been abandoned
because no access was possible and, according to
the manager, there was no legal recourse (MGR
24). Without closer analysis it is difficult to assess
the gravity of this finding – how serious, for
example, was the risk in each of these 15 cases
considered to be, and how much effort was put into
gaining entry through non-legal social work means
as a result? The manager’s remark, ‘I’m waiting for
something awful to happen’ (MGR 24), suggests
worrying uncertainty here, at the very least.

A further question would be whether the
manager had sufficient knowledge of the possible
means of access in law. Four interviewees and
three survey respondents maintained that current
provision was adequate, referring particularly
to police powers and the usefulness of having a
good relationship with the police. However, as
the Interim Report of this study recounted, the
existence of a gap in legal provision was argued for
by the Law Commission when (going beyond its
brief of developing mental capacity legislation in the 1990s it recommended a power of entry and associated powers in respect of those it termed the ‘vulnerable but capable’ (Law Commission, 1993: 23; 1995). Similar measures have been proposed since then by a number of senior academics on human rights grounds, with the Equality and Human Rights Commission also supporting the inclusion of a power of entry in the Care Bill (Martineau et al 2016: 13-14; 51).

**Use of current legal provision in study sites**

The three sites had no experience of the use of police powers under the Police and Criminal Evidence Act 1984 (PACE) since April 2015, although one case of considerable seriousness prior to the CA was discussed, as was the requirement for evidence before there can be a forced entry under the ‘life or limb’ provision (s 17(1)(e) PACE).

Under the Mental Capacity Act 2005 (MCA), one subset of cases involved adult children with a learning disability living with their parent/s whose denial of professional access went hand in hand with other possible risks of harm for their offspring, ranging from poor care and neglect to psychological, emotional and financial abuse. These had become protracted residence disputes, where one can surmise that seeking an entry warrant under the MCA would have been neither necessary nor proportionate (SCIE, 2014).

The other striking finding in relation to mental capacity and hindering was the difficulty social workers reported facing when their client might have been in the position of having or needing multiple capacity assessments, for example an older person who was in declining health where specific decisions needed to be made. These may be adults who do not yet come within the ambit of the MCA, meaning that personal welfare orders under the MCA are not available, yet who require regular care and whose decision making capacity is in doubt.

The High Court inherent jurisdiction case described in some depth in this report (Chapter 7) culminated in it being switched to the Court of Protection at a late stage, but it was nevertheless illustrative of this means of resolving situations involving coercion or undue influence. Following the Court of Appeal case of re L, the DH was reported as being concerned as to how many cases the jurisdiction might apply to (Samuel, 2012). A 2016 Freedom of Information request by the charity Action on Elder Abuse to local authority legal teams returned a result of only six such cases in a 12 month period – though the response rate was not given (Action on Elder Abuse, 2016).

However, this low figure may arise in part because of concerns about resources, and possibly, as was suggested by Ruck Keene and colleagues (2015), fear on the part of some social workers of confronting powerful families (as some Serious Case Reviews illustrated, see pages 14-15). A significant proportion of this study’s interviewees saw a place for the inherent jurisdiction. In one site, where there had been recent experience of the workings of the jurisdiction, eight out of the ten interviewees (including both of the managers) were in favour of a measure equivalent to section 35 ASPA being introduced in England. In broad terms, this Scottish provision codifies the inherent jurisdiction, as it serves to protect individuals where undue pressure is assessed as affecting their decision making capacity (and potentially leading them to object to protective action being taken on their behalf by the local authority or others). Across the three sites, two thirds of interviewees were broadly in favour of introducing such a measure.

The Law Commission made no recommendations, over 20 years ago, with respect to this aspect of adult safeguarding in its proposals for the ‘public law protection for vulnerable people at risk’ – proposals that did not find their way into law (Law Commission, 1995). But with the development of the inherent jurisdiction and the recent introduction of the crime of controlling or coercive behaviour, coercion and concepts related to it can be said to have gained greater prominence in the practice of adult safeguarding and perhaps, also, greater public acknowledgement. The debates about the nature of privacy, vulnerability and autonomy we explored in the literature are particularly relevant to policy and practice decisions about the response to suspected coercion. We return to this topic later in this chapter.

**Scotland and Wales**

Scotland provides a useful point of comparison since, contrary to England, the Scottish Parliament introduced a statute substantially dedicated to adult protection. As described in this study’s Interim Report, the ASPA authorises council officers (with a court warrant) to enter any place as part of its adult protection investigations and, with the consent of the adult at risk, to apply for certain protection orders on their behalf. Such actions must
be taken in accord with a set of express principles, including a ‘General principle on intervention in an adult’s affairs’ (s 1 ASPA).

The national Scottish data are incomplete (and warrants for entry are not part of the dataset), but our survey, conducted early 2017, of the biennial reports of Scottish local authority adult protection committees indicated that the period 2012-14 saw around 100 banning orders and two assessment orders being granted. We are not aware of any use of section 35 ASPA. These low numbers, discussed further below, and the high proportion of banning orders, which prohibit someone from a property or area for up to six months, are consistent with the earlier biennial reports (Martineau et al, 2016: 27-36).

The Adult Protection and Support Order, introduced by section 127, Social Services and Well-being (Wales) Act 2014 is a power of entry for private interview, without associated orders (Williams, 2015). However, only coming into force in April 2015, it is too early to assess its impact.

**Power of entry**

This study did not hear from a fully representative sample of authorities and social workers, although responses were received from nearly one fifth of local authorities. However, as we reported above, about two thirds of both survey respondents, who were responding on behalf of their authority, and the social workers and managers we interviewed in the three research sites were in favour of some kind of power of entry, including two of the three additional powers available in Scotland. This is a similar percentage of local authority professionals responding to the consultation undertaken by the DH in the development of the Care Bill (Norrie et al, 2016a), but lower than the findings of The College of Social Work survey, in which 84% of the 300 practitioners responding supported the introduction of a power of entry (The College of Social Work, 2012). Interestingly, all eleven of the older and disabled people and carers we interviewed were in favour of some kind of power of entry in these kinds of situation. This is in contrast to the findings of the consultation where members of the public who responded were firmly against increasing social workers’ powers (Norrie et al, 2016a).

Almost all participants stressed the need for any power of entry to be used as a ‘last resort’ in high risk cases. They were concerned about the potential for such a power to be abused, or for social workers to feel pressured to use it before trying the longer and more painstaking approaches of working to build trust and develop relationships. In addition, concerns were raised about the potential for the existence of a power of entry to interfere with social work relationships and the danger that it would run counter to social work values. These widely held reservations, which were mentioned by participants in favour of a power of entry as well as those against, suggest the need for strong, clear management and robust processes of decision-making when invoking any power.

Protection orders under the ASPA were being used at a rate of about one a week across the whole of Scotland. This suggests that social workers are not using these legal powers often, which may address some of the concerns about abuse of the powers, although they are continuing to be used. Further work exploring the kinds of cases where orders have been made, would help clarify their role and would also contribute to understanding the scope of the problem of hindering. The subtle impact on the context for social workers’ negotiations with adults at risk and their families is not known. Further research would be necessary to explore this and would potentially be very valuable in informing any decision about introducing more legal powers for social workers in England or determining that the need is not justified.

Any legal changes introducing such a power would need to be accompanied by clear guidance about the circumstances of its use and the approach to decision-making. The typology of cases and understanding of the reasons for hindering that this study has tentatively developed may be of value in producing such guidance. However, the involvement of practitioners, managers, adults at risk, their families and other carers, lawyers and the judiciary would be crucial in developing relevant and valuable guidance on this topic.

As we note (Stevens et al, forthcoming), different understandings of autonomy, privacy and vulnerability affect decisions about whether the use of a legal power of entry is appropriate in different circumstances. These concepts were identified as being important in the literature exploring controversial powers in the ASPA that enabled social workers to apply for any of the protection orders without the consent of or even against the expressed wishes of an adult at risk who has mental capacity, if there is evidence that they have been unduly pressurised to refuse consent.
Such situations are often complex and, as some research participants noted, it is difficult to identify that third parties are exerting such pressure. In these circumstances, a power of entry might be needed on multiple occasions, which would create added complexities in relation to consent. Furthermore, it supports the case for the need to introduce other powers as well as the power of entry. Such concerns were also raised by a small number of participants, who couched these comments in terms of human rights. Again, these concerns were raised when discussing a power of entry and the more controversial aspect of the Scottish ASPA. It is interesting that only a small minority of older and disabled participants raised this kind of objection to these powers. However, such objections were much more strongly represented in the DH consultation (Norrie et al, 2016a) and the parliamentary debates on the Care Bill (Manthorpe et al, 2016), although these respondents and parliamentarians were objecting to a proposed power of entry in England, rather than the powers introduced by the ASPA. Overall, this study supports the perception that most social work professionals working with adults are in favour of some increase in the powers of entry in England.

### Conclusion and policy options

While complex hinder situations appear rare but not unknown, practitioners report that they are usually resolved by good social work and multi-agency working. Social workers appear creative in their approaches, involving extended family and other workers who may be able to gain access to the adult at risk, to establish their basic welfare. However, in a small number of cases, gaining any access proves very difficult. Such cases can take up a great deal of time and resources, and also may mean that adults at risk suffer abuse for long periods, which is also distressing, frustrating and stressful for the professionals involved. In these cases, many social workers appear to support the introduction of a power of entry, and some of the other powers available in Scotland. However, they also raised concerns about a potential negative impact on the development of social work relationships – which indicates the complexity of and ambivalence about such powers.

Many of the experiences and views expressed and the arguments used by research participants to support these views strongly echo the responses to the DH consultation in 2012 and the parliamentary debates on the Care Bill in 2013-14 (later the Care Act 2014). This suggests that there are ongoing concerns about hinder cases and that the question of the need for further legal powers is still salient to professionals and older and disabled people. Consequently, further research and policy attention on this topic may be warranted. The research points to a number of policy options (which include some suggestions for further research), which are set out below.

### Policy options

1. **Wait for data from use of the legal powers in Wales and further data from Scotland before making firm policy decisions about further legal powers.**

2. **Undertake a public consultation through, for example, the Law Commission to consider legislation already proposed e.g. amendments to Care Act 2014.** The consultation could seek views on:
   a. Applying the approach adopted in Scotland to England (or that of Wales)
   b. How to improve the current legal routes to gaining access including speeding up legal processes.
3. Consider data collection and research to consider scale of problem, which would require:
   a. Commissioning further development work to define when to count a problem and developing guidance on recording in ‘hinder situations’.
   b. Commissioning sample surveys to test out the measure and to produce estimates of prevalence.
   c. Consideration of including a measure in annual statistical returns.

4. Consider commissioning further research, in due course, exploring legal and practice responses, such as:
   a. A UK wide study in order to understand the implications for hindering situations of the different policy frameworks within the four countries of the UK. This might incorporate a review of policy in other jurisdictions, for example in the US and Canada, where powers of intervention are often written into non-federal law.
   b. Research exploring the appropriate criteria and safeguards required for a statutory power of entry.
   c. Research exploring views about legal powers and perceptions of current practice of police officers, fire service officers and the judiciary.

5. Offer further guidance or policy and procedures. Five areas in which guidance could be valuable were suggested by the research participants:
   a. Practice approaches to gaining access, to complement the SCIE guide (SCIE, 2014), which sets out the legal routes (and updates it). In addition, SCIE’s ‘Safeguarding Questions’ (supporting the Care Act 2014) document could be expanded or other guidance, such as a ‘community of knowledge’ page with case studies, on ‘what’s worked for us’ and tips.
   b. A decision tool for social workers to use in deciding when to escalate concern about a hinder situation and when a legal route to gaining access should be considered.
   c. The Care Act 2014 section 6 duty to cooperate could be extended to give more structured powers (or responsibilities) to enable attendance and/or cooperation from professionals/ agencies. This might include clearer criteria for involvement of the police and advising hospital staff and GPs on their role in supporting social workers to have private conversations with adults at risk in hospitals or in the community.
   d. Guidance to the police and joint training with social workers on the remit and requirements for welfare checks.
   e. Guidelines for co-ordination with banks in suspected financial abuse cases.
   f. More training and skills development in the Mental Capacity Act 2005 for professionals working in agencies other than adult social care departments.

6. Advocacy was identified as a possible means of breaking down barriers to accessing an adult at risk. Consequently, it could be valuable to consider widening the remit of when advocacy is appropriate in safeguarding cases to include provision in cases of apparent obstruction, although advocates may also not be able to access the adult at risk.

7. Consider the professional and organisational response to hindering in adult safeguarding in the context of intended human rights reform (now timetabled post-Brexit).
References

Action on Elder Abuse (2016) Elder abuse is a crime – now let’s make it one, London: Action on Elder Abuse.


Canadian Association of Occupational Therapists (2013) Strategies for Interprofessional Health Care Providers to address Elder abuse/Mistreatment: Key Legal Information, Ottawa: Canadian Association of Occupational Therapists.

Canadian Centre for Elder Law (2011) A Practical Guide to Elder Abuse and Neglect Law in Canada, Vancouver: Canadian Centre for Elder Law.


Newcastle Safeguarding Adults Board (2016) Serious Case Review concerning the death of Edward Hedley, Newcastle: Newcastle Safeguarding Adults Board.


*In re L (Vulnerable Adults with Capacity: Court’s Jurisdiction) (No 2) [2012] EWCA Civ 253*


Appendices – Research tools

Appendix 1. Appendix 1: Online survey to adult safeguarding managers
Appendix 2. Appendix 2: Interview guide for managers
Appendix 3. Appendix 3: Interview guide for social workers
Appendix 4. Appendix 4: Vignette interview guide
Appendix 1: Online survey of adult safeguarding managers

Hinder situations

Social workers or other professionals are sometimes prevented from speaking to an adult at risk about a concern, by a third party such as a family member. We have termed this a ‘hinder situation’: it includes cases where access has been denied completely by the third party or where the third party is being otherwise obstructive e.g. by refusing to leave the room where a professional wishes to conduct a private interview with the adult at risk. This also includes cases involving the use of powers under the Mental Health Act 1983 or the Mental Capacity Act 2005. We are only asking about people living at home (not in care homes or hospitals). We are only interested in cases since April 2015, when the Care Act 2014 came into force.

We will be asking about:-
1) frequency of the hinder scenario
2) local sources of support/advice and assistance
3) presence of local policy and practice documents
4) what data is collected by LAs or SABs about difficulties in access

Questions 1-16 ask for information about different aspects of ‘hinder situations’. Please give the number of cases for each question. Approximations will do, if it is not possible to give exact figures.

1. Have there been any cases since April 2015 in which staff have been involved in ‘hinder situations’ where access has been denied completely by the third party or where the third party is being otherwise obstructive? For example, where the third party refuses to leave the room where the social worker (or other professional) wishes to conduct a private interview with the adult at risk.

This also includes situations involving the use of powers under the Mental Health Act 1983 or the Mental Capacity Act 2005.
Frequency of hinder situations

2. In how many individual cases since April 2015 have staff been involved in ‘hinder situations’?

These are situations where access has been denied completely by the third party or where the third party is being otherwise obstructive e.g. by refusing to leave the room where the social worker (or other professional) wishes to conduct a private interview with the adult at risk. This also includes situations involving the use of powers under the Mental Health Act 1983 or the Mental Capacity Act 2005.

Please give a number to answer to this question (Approximations will do)
Please put ‘0’ for none or ‘999’ for don’t know

Characteristics of Adults at Risk

3. In how many of these situations was the adult at risk a(n)

Please enter a number for each option (Approximations will do)
Please put ‘0’ for none or ‘999’ for don’t know

a. Older person?

b. Disabled person (physically disabled - not older person)?

c. Adult with learning disabilities (not older person)?

d. Person with mental health problems (not older person)?
4. In how many of these cases was the third party who seemed to be preventing access:

Please enter a number for each option (Approximations will do)
Please put '0' for none or '999' for don't know

a. Father of the adult at risk?

b. Mother of the adult at risk?

c. Son of the adult at risk?

d. Daughter of the adult at risk?

e. Other male relative of the adult at risk?

f. Other female relative of the adult at risk?

g. Male friend/neighbour of the adult at risk?

h. Female friend/neighbour of the adult at risk?

i. Other third party (please specify in Q5)

5. Please specify other third party from Q4 e.g. Live in care worker
6. In how many of these cases were the following kinds of abuse alleged?

Please enter a number for each option (Approximations will do)
Please put '0' for none or '999' for don't know

a. Financial abuse

b. Physical abuse

c. Psychological /emotional

d. Neglect

e. Sexual

f. Domestic violence

g. Modern slavery
Whether access to the adult at risk was achieved

7. Up to the present time (ie from April 2015-now), was access to the adult at risk achieved in ANY of these cases?

☐ Yes
☐ No

Gaining access to the adult at risk

8. Up to the present time (ie from April 2015- now), in how many of these cases was access to the adult at risk achieved?

Please enter a number to answer (Approximations will do)
Please put ‘0’ for none or ‘999’ for don’t know

9. In how many of these cases did the social workers (or others) undertaking the safeguarding enquiry gain access to the adult at risk:

Please enter a number for each option (Approximations will do)
Please put ‘0’ for none or ‘999’ for don’t know

a. Through negotiation with the third party?

b. With the assistance of another social worker?

c. With the assistance of a Team or senior manager?
10. In how many of these cases were the social workers/others undertaking the safeguarding enquiry able to gain access with the assistance of these other professionals?

Please enter a number for each option (Approximations will do)
Please put '0' for none or '999' for don't know

a. Social care worker (support worker or home care worker)?

b. District/Community Nurse?

c. Community Mental Health/Psychiatric Nurse?

d. Community Learning Disability Nurse?

e. G.P.?

f. Police officer?

g. Housing officer/tenancy support staff?

h. Environmental Health Officer/staff?

i. Other worker or professional? Please specify in Q11

11. Please specify other worker or professional from Q10
12. In how many of these cases was the social workers/others undertaking the safeguarding enquiry able to gain access with the assistance of:

Please enter a number for each option (Approximations will do)
Please put '0' for none or '999' for don't know

- a. Family members?
- b. Friends?
- c. Neighbours?
- d. Other members of the public?

13. In how many of these cases (if any) was legal advice sought from:

Please enter a number for each option (Approximations will do)
Please put '0' for none or '999' for don't know

- a. Social Care legal services (in house or external)?
- b. Local Authority legal services?
- c. NHS legal services?

Other source of legal help? (please specify in Q14)

14. Please specify 'other' sources of legal advice mentioned in Q13
15. In how many cases (if any) was use made of the following legal routes to resolving 'hinder situations' since April 2015:

Please enter a number for each option (Approximations will do) Please put '0' for none or '999' for don't know

a. Application to the Court of Protection under Mental Capacity Act 2005?

b. Use of police powers (under PACE 1984) where LA also involved?

c. Applications to the High Court under inherent jurisdiction?

d. Applications in respect of powers under the Mental Health Act 1983?

e. Supporting the police to apply for a Domestic Violence Protection Notice/Order?

f. Other legal avenues? (Please specify in Q16)

16. Please specify the 'Other legal avenues' mentioned in Q15
Confidence in answers so far

17. How would you describe your confidence in the accuracy of the figures given in answer to the questions so far

☐ Very confident
☐ Fairly confident
☐ Slightly confident
☐ Not at all confident
☐ Don’t Know

Sources of support for hinder situations

18. What (if any) other sources of support for hinder situations are you aware of in your local authority and safeguarding partners?


19. What (if any) extra support would be most helpful?


## Difficulties caused by 'hinder situations' and what helps

20. In your opinion what difficulties, if any, do hinder situations cause?

21. What, if anything, have you found to be helpful in hinder situations?
22. Which (if any) of the following powers, all of which would require an application to a court for a warrant, would you be in favour of government creating?

Please select 'Yes', 'No' or 'Don't Know' from the drop-down list, for each power

<table>
<thead>
<tr>
<th>Power</th>
<th>Yes / No / Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. A statutory power of entry for private interview</td>
<td></td>
</tr>
<tr>
<td>b. Assessment order – powers to conduct an assessment in privacy</td>
<td></td>
</tr>
<tr>
<td>c. Removing the adult at risk to a place of safety</td>
<td></td>
</tr>
<tr>
<td>d. Banning perpetrators from living in the property</td>
<td></td>
</tr>
<tr>
<td>e. Other power (please specify in the comments box)</td>
<td></td>
</tr>
</tbody>
</table>

Please comment on your answers
Local policy and guidance documents and data collection

23. In your authority, what (if any) practice guidance or policy documents offer information and guidance for practitioners about how to respond in situations where access to adults at risk is prevented by a third party.

For each document identified, please say how (if at all) the document supports practice.

24. Is routine data collected on:

Please select 'Yes', 'No' or 'Don't Know' from the drop-down list for each type of data

<table>
<thead>
<tr>
<th></th>
<th>Yes / No / Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of hinder situations?</td>
<td></td>
</tr>
<tr>
<td>The characteristics of the adult at risk?</td>
<td></td>
</tr>
<tr>
<td>The professionals involved?</td>
<td></td>
</tr>
<tr>
<td>Whether access is gained?</td>
<td></td>
</tr>
<tr>
<td>Outcome of the safeguarding enquiry in hinder situations?</td>
<td></td>
</tr>
</tbody>
</table>

Please comment on the data collected
25. Has your Safeguarding Adults Board considered this subject?

Please select 'Yes', 'No' or 'Don't Know' from the drop down list.

If yes, please comment

26. Has any local Serious Case Review/Safeguarding Adults Review or internal review (or similar) touched upon this subject?

Please select 'Yes', 'No' or 'Don't Know' from the drop down list.

If yes, please comment
About you and your authority

Please provide the following information, in order to assess how far the sample of respondents to the survey reflects the population of adult safeguarding managers. This information will not be made public in any published reports or summaries of the research.

27. What is your job title?

28. What is your local authority?

29. Please enter your email address if you would like us to email you a summary of the research findings

Thank You

Thank you very much for completing this questionnaire.

If you have any questions about the questionnaire, or the 'Helping or hindering in adult safeguarding' study, please contact:

Martin Stevens - martin.stevens@kcl.ac.uk - 020 7847 1860

Social Care Workforce Research Unit - King's College London - Strand - London - WC2 R 2LS
Appendix 2: Interview guide for managers

Helping or hindering in adult safeguarding: an investigation of practice

(Wales Research Ethics Committee 3: 16/WA/0122)

Questions for Adult Safeguarding Managers

We would like to discuss with you the ‘hinder’ scenario. We are defining this as when a social worker or other professional is prevented from speaking to an adult at risk by a third party, such as a family member in community settings only (not including care homes). In hindering, access may be denied completely by the third party, or it may be made difficult because, for example, the third party is refusing to leave the room where an interview or assessment is taking place. We are focusing on your experience since the Care Act came into force, i.e. since April 2015.

1. Can you tell me (briefly) your job title and what your role is in adult safeguarding?

2. Does this LA have a specialised adult safeguarding team:
   i) who deal with all the safeguarding work or ii) who deal with high risk work;
   OR do you have iii) specialist safeguarding leads/practitioners within locality teams;
   OR iv) do all staff carry out adult safeguarding?

3. Does this LA have a Multi-Agency Safeguarding Hub (MASH) for dealing with adult safeguarding enquiries?

4. Can you estimate how often (since April 2015, i.e. when the Care Act came into force) your LA has come across hindering situations in adult safeguarding where a third party has made it difficult to access an adult at risk in the community?
   i) In how many of these cases was access to the adult at risk denied completely by the third party?
   ii) And of those where access was denied completely, in how many has access to the adult at risk never been achieved?
   iii) Thinking about ALL the hindering cases since April 2015, have you noticed any patterns in these cases?

5. Has the Care Act had implications for the numbers of these ‘hinder’ cases?
   Probe if needed:
   i) Duty to enquire
   ii) Duty to cooperate with other agencies
6. Do you, the LA or the Safeguarding Adults Board (SAB) keep records of hinder situations?

7. Please describe the informal multi-agency working practices that support (or obstruct) social workers facing hinder situations e.g. using relationships with fire services, housing officers, welfare officers, community support workers, gas providers, third sector organisations or relatives/friends?

8. Does this LA have formal multi-agency procedures in place to deal with the ‘hinder’ scenario? e.g. involving community nurses - mental health/psychiatric services, GPs, Police?

9. In hinder situations within your LA, have you had experience of any of the following being used? In each case, please could you: (A) give an estimate of the number of times they have been used, if at all (since April 2015) and (B) comment on their usefulness:
   i) MHA 1983 esp. s 135(1); [Relates to a person believed to be suffering from a mental disorder. A magistrate may issue a warrant that gives a police officer, accompanied by an approved mental health professional and a doctor, power of entry and, if thought fit, power to remove the person from their home to a place of safety for 72 hours, where there is reasonable cause to believe they are being ill-treated or neglected.]
   ii) Police powers, e.g. PACE ['life or limb']
   iii) Applications to the High Court – [Inherent Jurisdiction]
   iv) Applications to the Court of Protection under MCA
   v) Domestic violence and abuse legislation, e.g. Domestic Violence Protection Notices and Orders.
   vi) Other legal avenues

10. Would you like to comment on the service cost implications of different ways of dealing with ‘hinder’ scenario cases?

11. According to the Care Act statutory guidance on adult safeguarding, modern slavery may be regarded as a form of abuse. Have you had any experience of modern slavery in the context of finding it difficult to access an adult?

**Recent or typical case**

12. Can you describe a recent or typical ‘hinder’ case (since April 2015), where the adult at risk was understood to have capacity? (interviewer to allow participant to tell the story and ask Qs 12 (i)-(v) if needed)
   i) What sort of abuse was alleged? What category of adult at risk was involved?
   ii) In this case, how did social workers undertaking the safeguarding inquiry try to gain access to the adult at risk (e.g. negotiation with the third party or use of multi-agency partners)?
   iii) Was legal advice sought in this situation? If so, from whom? Please describe how this helped (or did not help) in this situation. In general, what role do legal advisers play in these kinds of situation?
iv) Was there any consideration of application for a legal order (Court of Protection, inherent jurisdiction of the High Court or under s 135(1) of the Mental Health Act 1983, or under domestic violence legislation, or other)? Please describe how decisions were made about whether to apply for these orders.

v) Do you have any comments about the amount of time/human resources that was spent on this case?

**Power of entry**

After much debate, the Care Act 2014, did not include a power of entry for social workers or any related powers such as removal, assessment and banning. By power of entry we mean a statutory provision enabling the local authority to apply for a court warrant to visit the adult concerned accompanied by a police officer who may, if necessary, use reasonable force to facilitate the purpose of the visit, i.e. interviewing the adult in private.

13. Are you in favour of the introduction of a new power of entry of this kind?

14. In your opinion, what (if any) benefits would any new powers of entry bring? Please explain

15. Do you have reservations about the introduction of a new power? Please can you tell me about them?

16. In Scotland, a power of entry of this kind was introduced in 2008. It is accompanied by further court powers to make orders, where the adult at risk consents, to:
   i) conduct assessments in private (including medical examination)
   ii) ban perpetrators (for up to six months)
   iii) remove the adult at risk
   iv) view medical, financial and other records

Which (if any) of these additional powers are necessary in England as well?

17. Would you foresee there being any risks of introducing a power of entry without also introducing extra powers such as those in Scotland?

18. There may be occasions when the adult at risk does not consent to any action being taken on their behalf. If it can be shown that this refusal is the result of their coming under undue influence from the third party, then should it be possible (with court authorisation) to override their objections?

19. Any other matters you think relevant to this issue?
Appendix 3: Interview guide for social workers

Helping or hindering in adult safeguarding: an investigation of practice

(Wales Research Ethics Committee 3: 16/WA/0122)

Adult Safeguarding practitioners

1. Can you tell me (briefly) your job title and what your role is in adult safeguarding?

2. Can I confirm your role in adult safeguarding within the structure of this LA.? Are you:
   i. Working in a specialist team which undertakes all adult safeguarding work?
   ii. Working in a specialist team which undertakes high risk work?
   iii. A specialist safeguarding lead/practitioner within a locality team?
   iv. Based in a locality team where all staff carry out adult safeguarding?

3. Is safeguarding work allocated to you via a MASH – if not how?

4. Can you estimate how often (since April 2015, i.e. when the Care Act came into force) you have come across the hindering situation in adult safeguarding where a third party has made it difficult to access an adult at risk with mental capacity living in the community?

5. Do you think the Care Act (2014) has changed the numbers of these ‘hinder’ cases?
   Probe if needed
   i. Duty to enquire
   ii. Duty to cooperate with other agencies

6. Do you keep any records of ‘hinder’ situations?

7. Have you noticed any patterns of cases involved in ‘hinder’ scenarios since April 2015?

8. Please describe any informal multi-agency working practices that support (or obstruct) you in working with hinder situations e.g. using existing relationships with fire services, housing officers, welfare officers, community support workers, gas providers, third sector organisations or relatives/friends?
9. Do you have formal multi-agency procedures in place to deal with the ‘hinder’ scenario? e.g. involving community nurses - mental health/psychiatric services, GPs, Police? Are these helpful – probe about circumstances

10. Have you ever used or would you feel confident using the following in a ‘hinder’ scenario?
   i) MHA 1983 esp. s 135(1); [Relates to a person believed to be suffering from a mental disorder. A magistrate may issue a warrant that gives a police officer, accompanied by an approved mental health professional and a doctor, power of entry and, if thought fit, power to remove the person from their home to a place of safety for 72 hours, where there is reasonable cause to believe they are being ill-treated or neglected.]
   ii) Working with police powers using eg PACE ['life or limb']
   iii) Applications to the High Court – [Inherent Jurisdiction]
   iv) Applications to the Court of Protection under MCA
   v) Domestic violence and abuse legislation, e.g. working with the police to seek Domestic Violence Protection Notices and Orders
   vi) Any other legal avenues

11. According to the Care Act statutory guidance on adult safeguarding, modern slavery may be regarded as a form of abuse. Have you had any experience of modern slavery in the context of finding it difficult to access an adult?

**Recent or typical case**

12. Can you describe a recent or typical ‘hinder’ scenario, where the adult at risk was understood to have capacity under the Mental Capacity Act? (interviewer to allow participant to tell the story and ask Qs (i) – (v) if needed)
   i) What sort of abuse was alleged? What category of adult at risk was involved?
   ii) In this case, how did you try to gain access to the adult at risk? (e.g. negotiation with the third party or use of multi-agency partners)?
   iii) Was legal advice sought in this situation? If so, from whom? Please describe how this helped (or did not help) in this situation. In general, what role do legal advisers play in these kinds of situation
   iv) Was there any consideration of application for a legal order (Court of Protection, inherent jurisdiction of the High Court or under s 135(1) of the Mental Health Act 1983, or under domestic violence legislation, or other)? Please describe how decisions were made about whether to apply for these orders
   v) Do you have any comments about the amount of time/human resources that was spent on this case?

**Power of entry**

After much debate, the Care Act 2014, did not include a power of entry or any related powers such as removal, assessment and banning. By power of entry we mean a statutory provision enabling
the local authority to apply for a court warrant to visit the adult concerned accompanied by a police officer who may, if necessary, use reasonable force to facilitate the purpose of the visit, i.e. interviewing the adult in private.

13. Are you in favour of the introduction of a new power of entry of this kind?

14. In your opinion, what (if any) benefits would any new powers of entry bring for social workers? Please explain

15. If you have reservations about the introduction of any new power, please can you tell me about them?

16. In Scotland, a power of entry has been introduced and is accompanied by new legal powers to make orders, with the consent of the adult at risk, to:-
   i) conduct assessments in private (including medical examination)
   ii) ban perpetrators (for up to 6 months)
   iii) remove the adult at risk
   iv) view medical, financial and other records

   If a new power of entry was introduced in England, which (if any) of these accompanying orders would be necessary? Why do you think that?

17. Would you foresee there being any risks of introducing a power of entry without also introducing extra powers such as those in Scotland?

18. There may be occasions when the adult at risk does not consent to any action being taken on their behalf. If it can be shown that this refusal is the result of their coming under undue influence from the third party, then should it be possible (with court authorisation) to override their objections?

19. Do you have any comments you would like to add?
Appendix 4: Vignette interview guide

Helping or hindering in adult safeguarding: an investigation of practice

The Hinder Study: Vignette Interview guide

Introduction

As the information we sent you said, this research project is being funded by the Department of Health. Today we are going to ask you questions about situations where social workers or other professionals are being prevented from seeing an adult at risk, when there has been a concern raised about possible abuse or neglect. We would like to ask what these professionals do, or should do in these situations. We want to know your opinions about the idea of a legal power of entry for professionals in these situations. We will read you a fictional—or make believe case where people seem to be prevented from seeing an older person, and ask for your views at various points in the story.

Remember, that we will not reveal your name in any reports of the research. You don’t need to answer all the questions and you can stop at any time. Are you still happy for the interview to be recorded?

Fictional case: Part 1

Background

Celia is a woman aged 82. She has severe arthritis which makes it difficult for her to dress herself. She receives half an hour per day help from a home help or home care company which she pays for herself. Celia also has various health conditions, which require regular monitoring. A widow for ten years, Celia lives on her own in a house, which she owns. Two months ago, her daughter Mary moved in with her. Celia has no other relatives living close by or in regular contact.

Since Mary moved in with her mother the home care workers are finding it is increasingly difficult to provide Celia’s care. They have told their manager that when they try to help Celia get dressed, Celia’s daughter Mary keeps saying to them that she can dress her mother herself and she refuses to leave the room. Eventually, Celia tells the home care workers that she doesn’t need them anymore
and cancels the service. The care workers tell their manager that they feel that Celia may have been under pressure from her daughter to say this.

Celia’s neighbour has recently contacted the local council and reported that she hears shouting on a regular basis from the house. She also said that she has not seen Celia around the local area for some time, which is unusual. She is concerned about her welfare.

After the neighbour’s report, a social worker goes to the house to make enquiries. The social worker makes three attempts to make contact with Celia, after arranging days and times, on the phone. She does not get to see Celia. Each time, Mary answers the door and gives excuses why it is not convenient to let the social worker talk to Celia, such as: ‘Mum is asleep’; ‘Mum’s not feeling well’; or ‘Mum’s having her hair done by the visiting hairdresser’.

Have you got any questions about the situation?

Questions so far

1. Could the social worker have done anything else to gain entry to the house and talk to Celia?
2. What do you think the social worker should do now?
3. How much would you be worried about Celia at this stage?
4. If professionals had a legal power of entry, would this be a good time to use this to have a private conversation with Celia – away from Mary?
   a. If yes – why
   b. If not, why not

Fictional case: Part 2

Involving other professionals and other organisations or authorities

The social worker discusses the problem with her manager. They decide to hold a planning meeting, and invite Celia’s GP and the home care company manager. The home care manager tells the social worker about the home care workers’ concerns about the decision to stop the service. The GP says that Celia has not been in for the regular blood tests needed to monitor her dose of Warfarin. They decide to ask the District Nurse to visit, to check up on why Celia has not been to the GP for her regular appointments. The District Nurse also has a responsibility to look for signs of abuse or neglect, so this is thought to be a good approach.

The District Nurse also tries to visit three times, but like the social worker she does not get to see Celia. Mary says to the nurse ‘why don’t you people leave us alone?’

Questions on so far

5. Could the social worker and the District Nurse have done anything else to gain entry to the house and talk to Celia?
6. What do you think should happen now?
7. Would you be worried about Celia at this stage – what about?
8. If professionals had a legal power of entry, would this be a good time to use this to have a private conversation with Celia?
   a. If yes – why
   b. If not, why not

_Fictional case - Part 3_

_Police involvement and legal advice_

The social worker’s team manager now telephones the police about the case. The Police agree that a police officer can accompany the social worker on the next visit, but stress that the officer cannot enter the house without permission. This time, there is no answer when they ring the doorbell, despite having made specific arrangements on the phone. Each time they phoned, Mary answered and refused to pass the call to Celia.

_Court proceedings_

Another meeting is held with all the professionals involved in the case and the Council lawyer. It is decided to apply to the High Court for a temporary removal order. This would allow the social worker to take Celia to a place of safety. This would make it possible to ask her whether she has been pressured into giving up the care worker’s help with dressing, whether she is being abused or neglected and what she wants to happen. In addition, this will allow a medical examination to be made, if Celia agrees, to check on her general health. The High Court grants the order, but this takes a further three months and a great deal of work and expense for the social worker and council.

_Outcome_

As a result of the order, Celia is taken to a place of safety (a nearby care home), and the social worker is able to talk with her. Celia appears to know what she wants and has no signs of being confused. She said that she is very happy that Mary is living with her. However, she says that Mary is not good at helping her get dressed and often shouts at her, which is upsetting. She also thinks that Mary may be taking money from her, which again is upsetting. What she really wants is for Mary to stay, but for the home care workers to come back in to help her get dressed and some help in managing her money. She feels that Mary needs to have help with her own problems. Celia has a blood test and the GP has to reduce her dose of Warfarin.

Despite the problems, Celia wants to return home and does not want Mary to move out. She would welcome help with making a better arrangement with her daughter. The social worker accompanied Celia home and the home care service is started again. The District Nurse agrees to make regular visits, and Celia’s bank and solicitor visit Celia to sort out her financial affairs. In discussion with Celia and her daughter, an agreement is reached about all this. However there is no legal way to enforce the plan.
Final questions on the vignette

9. What do you think about the way the professionals worked on this case?
10. What do you think should happen next?
11. What difference would it make if a professional was able to get a legal order to so that they could get entry to the house earlier? Positive/negative

General questions

12. In general what are your views about whether professionals need to have more legal powers to enter a property when making enquiries about suspected abuse or neglect?
   a. What benefits might this bring?
   b. What dangers could this bring?

13. Could any other approaches be taken in order to avoid the need for a legal power of entry?

14. Any other comments?

Thank you for taking part