# IASW Supplementary Submission to the Department of Health on Adult Safeguarding July 2025

**Mandatory Reporting:**
IASW wholeheartedly supports the calls of the Law Reform Commission (LRC) for the introduction of mandatory reporting as set out in Chapter 9 of their report.

**Rationale:**

1. The IASW acknowledge continued disagreement across the sector in relation to the introduction of mandatory reporting. In our view, those who oppose mandatory reporting often place disproportionate weight on the value of education, training, and guidance as a means to encourage voluntary reporting. This approach is not evidence informed. Following the 'Brandon' case, intensive safeguarding training and education was provided in HSE area CHO 1. This and the availability of an adult safeguarding team did not prevent further failures to report concerns in HSE-run services, leading HIQA to publicly express a lack of confidence in the HSE's ability to run safe services in that area**.**
2. In addition, our social work members continue to encounter delays in timely reporting (putting adults at risk of further harm) or failure to report concerns, including in settings where adult safeguarding education and training have been provided. Social workers report that adult abuse/neglect continues to be minimised, overlooked or reframed as poor care, despite safeguarding education.
3. Mandatory reporting should not be universal and should only apply in certain circumstances. Aligning with the principles of the Assisted Decision-Making Act, the adult at risk must remain at the heart of all activity. They must be fully consulted and informed about all decisions relevant to any safeguarding concerns, and their wishes and preferences should be clarified. Consent should always be sought, though in some exceptional cases, reports may be made without consent, the reasons for which must be clearly documented. Mandatory reporting against the person's wishes (when required) does not mean they have to consent to proposed safeguarding actions; however, it does potentially protect others from further harm. Drawing on the IASW Position Paper on Adult Safeguarding, we believe mandatory reporting should apply when people are unable to seek interventions to protect themselves from abuse and neglect, for any reason, which may include illness, frailty, capacity, or disability.
4. Mandatory Reporting *should* apply in a context where issues of *capacity*, *risk to others* or *coercive control* are present and specifically if any of the following (a to d below) apply:
    a) *The adult at risk lacks the capacity to give consent or if there is a significant query over their capacity to consent or capacity to withhold consent,*
    b) *The adult at risk doesn't have the capacity to make this decision/weigh up the level of risk and/or protect themselves from the level of risk identified,*
    c) *There is a significant level of risk to others or where there is evidence that the abuse is allegedly perpetrated by a person in a paid/unpaid position of care who*

*has access to other adults who may be vulnerable to abuse (e.g., residential care staff/ resident perpetrating abuse in care setting/bus driver in disability service, home care worker),*

d) *Where there is evidence that the level of coercive control/undue influence experienced by the relevant adult prevents them from making a decision in accordance with their own will and preference.*

5. Mandatory reporting should only be implemented with due regard to the consent and capacity of the adult at risk except in circumstances and settings where failure to report may result in harm to another at risk adult or child (e.g. report of abuse by staff member in a residential facility and resident does not wish to make formal report).
6. Any list of mandated persons should include the list already outlined by the LRC and should also include those involved in delivering chaplaincy services, given their key role in health and end-of-life care where many adult safeguarding issues come to light.
7. Health care workers and health and social care professionals (HSCPs) currently have a two-tier model of reporting – (1) mandatory reporting in terms of children, and (2) voluntary/discretionary reporting in adult protection. This itself creates confusion. Health care workers and HSCPs work in an increasingly regulated and exceptionally busy environment. In the midst of this, they value clear, explicit, legal guidance on responding to safeguarding concerns, as is provided through a mandatory reporting model.
8. Mandatory reporting is also an antidote to a poor safeguarding culture. Staff members in services with poor safeguarding culture feel empowered by the law, to challenge culture and make a report. In our experience, voluntary/discretionary reporting underpinned only by policy, does not have the same impact.
9. Currently, unlike child protection, adult safeguarding training is not mandatory for health care workers across our health and social care settings. While mandatory training is not a panacea, our members report that it is much easier to encourage reporting in our workplaces in child protection, as staff take heed of their legal obligations to do so, once educated, or informed.

**On an Independent Safeguarding Authority**:
IASW support the establishment of a body which has direct and operational oversight/responsibility for safeguarding practice in the HSE and across wider society. Specific to the HSE, the IASW wish to see expert safeguarding knowledge embedded in and easily accessible to frontline services. In our experience, this is the most successful model (along with mandatory reporting) to develop staff competence in responding to safeguarding concerns.

Best practice dictates independent oversight of safeguarding concerns; there is consensus across the Sector that the safeguarding authority should be fully independent of the body it is investigating. The IASW call for independent oversight of operational safeguarding practice – an oversight body with powers to intervene and direct safeguarding activity if required (i.e. Ombudsman type role).

**On the Role of HIQA:**
As a systems regulator, HIQA plays a vital role in evaluating and supporting safe and quality systems. There needs to be a clear distinction between quality control systems regulation provided by HIQA and the equally important, distinctly different expertise of safeguarding social work services. Those latter safeguarding teams needs considerably expanded powers as recommended by the LRC.

Given reports of variability in social work practice across regions and areas, and particularly in the absence of clarity regarding the independence or otherwise of any new safeguarding body, the IASW fully supports HIQA inspections of systems of adult safeguarding social work activity as a form of quality control and as a source of learning however, specialised training must be provided to support HIQA to undertake this role. HIQA's role will also need to be appropriately mandated and resourced in order to be effective.

**On National Independent Review Panel (NIRP):**
IASW supports the strengthening of the NIRP role and processes. Work should be undertaken to support HSE to see NIRP as an instrument of learning rather than a forum of criticism (i.e., rooted in safe culture framework). The HSE, DOH and relevant Ministers should proactively support the release of NIRP reports and learnings in a timely, sensitive, and non-sensational way. We can learn a lot from Northern Ireland in this regard.

IASW continue to advocate for high-quality, standardised, competent safeguarding reviews carried out by skilled, accountable, registered professionals via a public service review model. The days of commissioning private, expensive reviews (which are not published) in Section 38/39 organisations must end.

**On Independent Advocacy:**
IASW continue to receive concerns from members about unqualified and unregulated advocates working beyond their skillset in safeguarding. This is a quality and safety issue. IASW strongly urge the regulation and training of advocates and in the absence of this, we query the expansion of such services.

**Interagency Working:**
The IASW agrees with LRC that new legislation is required whereby a statutory requirement/duty should be placed upon all relevant services for interagency working and information sharing when it is necessary within the context of protecting adults at risk. We also agree with the LRC recommendation that interim regulations, guidance documents and codes of practice should be developed to enable this critical and special category of information sharing whilst we await legislation to be drafted and passed.

The McIlroy report also clearly outlines the strong evidence base for interagency collaboration being a key pillar for adult safeguarding practice; therefore, this legislation is imperative.

In addition, legislation must also provide for a 'duty to provide assistance' or to direct the provision of supports and services as part of the Safety Plan; there must be a commitment for specific funding channels to adequately resource safeguarding plans as often agencies can be placed in situations where they have identified and reported safeguarding concerns but they cannot act to address these concerns due to resource issues such as staffing, lack of residential placements, etc.

**Evaluation and Audit**

We recommend routine audit and setting of KPIs. Service user experiences of safeguarding processes should also be evaluated, and Peer Evaluation/Reviews should also be routinely carried out.