Criminal Justice Inspection
Northern Ireland
a better justice system for all

AN INSPECTION OF

ADULT SAFEGUARDING ARRANGEMENTS IN NORTHERN IRELAND'S CRIMINAL JUSTICE SYSTEM

NOVEMBER 2026

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November 2026

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LIST OF ABBREVIATIONS

ASC	Adult Safeguarding Champion
Bill	Adult Protection Bill currently at Northern Ireland Assembly Committee Stage
COPNI	Commissioner for Older People for Northern Ireland
CRU	Central Referral Unit
DoH	Department of Health for Northern Ireland
DoJ	Department of Justice for Northern Ireland
ECHR	European Convention on Human Rights
EU	European Union
HiP	Healthcare in Prison
HSCT(s)	Health and Social Care Trust
IAPB	Interim Adult Protection Board
LASPs	Local Area Safeguarding Partnerships
NICTS	Northern Ireland Courts and Tribunals Service
NIHRC	Northern Ireland Human Rights Commission
NIPS	Northern Ireland Prison Service
Partnership Policy	Adult Safeguarding: Prevention and Protection in Partnership policy
PBNI	Probation Board for Northern Ireland
PECCS	Prisoner Escorting Court Custody Service
PPB	Public Protection Branch (in the PSNI)
PPS	Public Prosecution Service for Northern Ireland
PPU(s)	Public Protection Unit(s)

PSNI	Police Service of Northern Ireland
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust
SPPG	Strategic Planning and Performance Group (in DoH - established in March 2022 replacing the former Health and Social Care Board for Northern Ireland).
THRIVE	Threat, Harm, Risk, Investigation, Vulnerability and Engagement
UK	United Kingdom
VWCU	Victim and Witness Care Unit (within the PPS)
YJA	Youth Justice Agency

CHIEF INSPECTOR'S FOREWORD

We know of cases and organisations where people have suffered physical and emotional abuse and when neglect went unreported for too long. Financial exploitation has also become more evident and prevalent, both within and outside families. Too often, efforts at prevention were either insufficient or absent and the reporting of alleged crimes has increasingly involved police investigations and prosecutions through the courts.

In the last year alone, CJI reports on Probation Approved Premises, the Review of the Domestic Abuse and Civil Proceedings Act (Year Three Review), use of Special Measures in the Criminal Courts and Police Custody have all involved aspects of adult safeguarding. Successive prison inspections have also recommended changes to what has been a differential approach to safeguarding, and this is repeated in this report.

The Ministers of Justice and Health set the policy framework in 2014, founded on a partnership model around preventing harm and providing additional supports and entitlements in the Victims Charter and improved access to the justice services such as the Victim and Witness Care Unit and Registered Intermediaries schemes.

Working to prevent and respond to harm, abuse, exploitation, and the neglect of adults aged 18, and over should be recognised as a core element of public protection in line with delivering Safer Communities as a priority of the Northern Ireland's Executive Programme for Government.

But adult safeguarding arrangements do not have a legal basis in Northern Ireland, unlike Great Britain, and more work is required to progress the new Adult Protection Bill. It is hoped that this report will be helpful to those considering the Bill in its last stages.

Current partnership arrangements relied on committed and dedicated staff, with examples of proactive interventions to support those in greatest need evident from our review of adult safeguarding referrals.

We have made four strategic and two operational recommendations to support improvement.

My thanks to all those who engaged with Inspectors during this Inspection including the criminal justice organisations as well as others involved in supporting or advocating for people at risk of harm or in need of protection.

This Inspection was led by Dr Roisin Devlin and supported by David MacAnulty; I am grateful for their work.



James Corrigan
Acting Chief Inspector of Criminal Justice in Northern Ireland

November 2026

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EXECUTIVE SUMMARY

Adult safeguarding within the criminal justice system directly engaged the State's fundamental responsibility to protect people from harm, particularly those whose personal characteristics or life circumstances increased their risk of abuse, exploitation or neglect. This inspection found clear commitment across criminal justice organisations in Northern Ireland to the principles of adult safeguarding and to working in partnership to protect adults at risk.

However, in the absence of a comprehensive statutory framework, the inspection also identified significant structural, policy and operational weaknesses which undermined the consistency, effectiveness and oversight of safeguarding arrangements, most notably in custodial settings. Without sustained and co-ordinated action, these weaknesses risk leaving some of those most in need without the timely protection, support and access to justice to which they are entitled.

The inspection examined adult safeguarding arrangements across the Police Service of Northern Ireland, the Public Prosecution Service for Northern Ireland, the Northern Ireland Courts and Tribunals Service, the Probation Board for Northern Ireland, the Northern Ireland Prison Service and the Youth Justice Agency, with reference to the regional policy *Adult Safeguarding: Prevention and Protection in Partnership* and the emerging Adult Protection Bill. Fieldwork was completed between January and April 2026 and included engagement with a broad range of statutory, voluntary and oversight bodies.

Strategy and Governance

Adult safeguarding policy and governance arrangements were in a period of transition and uncertainty. While the regional Partnership Policy remained the overarching framework, it was dated and had not kept pace with evolving practice or the complexities faced by criminal justice organisations. The inspected organisations' strategic approach focused on the Adult Protection Bill which was at Northern Ireland Assembly Committee Stage when this Report was being drafted. This had left existing policy arrangements in a state of limbo. This had contributed to inconsistency in understanding thresholds for intervention, roles and responsibilities and referral pathways across organisations.

The absence of a statutory adult protection framework at the time of the inspection created particular challenges. Although the Adult Protection Bill was broadly welcomed, stakeholders raised concerns about resourcing, implementation planning, statutory guidance and outstanding issues such as mandatory reporting duties and human rights protections.

There was widespread recognition that without clear guidance and sufficient funding, the Bill's implementation risked being delayed or fragmented with some parts of legislation not commenced until later unknown timeframes.

Safeguarding arrangements in prisons were a critical and longstanding concern. Despite the Northern Ireland Prison Service being named in the regional safeguarding policy, it remained unable to refer adult protection concerns arising within prisons directly to Health and Social Care Trust Adult Gateway Teams. As a result, adult safeguarding matters in custodial settings were not assessed by suitably qualified social work professionals. This gap placed adults in prison at risk of differential treatment and fell short of regional policy expectations, despite previous inspections raising similar concerns and accepted recommendations that the issue was addressed at pace.

Across organisations, leadership commitment to adult safeguarding was evident, but governance and performance monitoring were variable. Adult safeguarding was not routinely or consistently reported at senior management level in all organisations, limiting opportunities for strategic oversight and learning from patterns and trends. Data collection and analysis were underdeveloped, particularly in relation to outcomes for adults at risk or in need of protection.

Delivery

Adult safeguarding awareness and training varied. While specialist teams, such as the Police Service of Northern Ireland's Public Protection Branch and Probation Officers, demonstrated strong knowledge and reflective practice, adult safeguarding was not consistently recognised or understood as a distinct concept by frontline Officers and staff in all organisations. There had been a focus on vulnerability or trauma-informed practice more broadly, rather than on adult safeguarding thresholds and referral responsibilities.

There was also inconsistency in how safeguarding concerns were identified, recorded and escalated. Inspectors found examples of good practice where timely referrals resulted in protective measures being put in place. However, there were also cases where potential criminal matters were not referred to police or where decision rationale was inadequately recorded. Quality assurance of safeguarding decisions was limited.

Access to justice for adults harmed by abuse was not well understood. Adult safeguarding cases often involved older victims or individuals with complex needs, and lengthy decision-making and Court timeframes had a disproportionate impact. Crime outcomes, prosecution decisions and Court outcomes were not systematically monitored for adult safeguarding cases, restricting the system's ability to understand what works, identify barriers and improve responses for victims.

Key recommendations

The inspection makes four Strategic Recommendations and two Operational Recommendation aimed at strengthening adult safeguarding across the criminal justice system. Key priorities include:

- **updating the regional safeguarding policy framework** with a view to improving clarity of thresholds, roles and responsibilities while preparing for forthcoming Adult Protection legislation;
- **resolving the adult safeguarding referral gap in prisons as a matter of urgency**, enabling adult protection concerns in custodial settings to be assessed and managed in line with regional policy;
- **strengthening governance and accountability**, including routine senior-level oversight, improved data collection and analysis, and the effective use of Adult Safeguarding Champion roles and annual position reporting that was proportionate to organisations' functions;
- **improving capability**, through service-wide training needs assessments and tailored adult safeguarding training plans that reflect the specific functions and risks faced by each organisation;
- **enhancing quality assurance and learning** to ensure that decisions are well-reasoned, recorded and subject to scrutiny; and
- **improving understanding of access to justice for adults in need of protection**, including research into crime outcomes and system barriers, to inform future policy and practice.

Taken together, these findings underline that adult safeguarding within the criminal justice system should be treated not as a peripheral issue but as a core component of public protection and access to justice. A sustained, collaborative and well-resourced approach will be essential to ensure that adults at risk of harm are identified early, listened to respectfully, protected effectively and supported in a way that recognises their vulnerabilities, dignity, rights and individual circumstances.

RECOMMENDATIONS

STRATEGIC RECOMMENDATIONS

STRATEGIC RECOMMENDATION 1

Within nine months of report publication, the Department of Justice in partnership with the Department of Health should agree a timebound plan to review and update the Partnership Policy and Operational Procedures.

Paragraph 2.7

STRATEGIC RECOMMENDATION 2

Within three months of report publication, the Northern Ireland Prison Service in partnership with the Department of Health and the Strategic Planning and Performance Group, should agree a timebound plan to enable adult protection concerns in prisons to be investigated and responded to effectively.

Paragraph 2.9

STRATEGIC RECOMMENDATION 3

Within six months of publication, the Northern Ireland Courts and Tribunals Service, the Northern Ireland Prison Service, the Probation Board for Northern Ireland, the Public Prosecution Service for Northern Ireland, the Police Service of Northern Ireland and the Youth Justice Agency should:

- review applicability of the Adult Safeguarding Partnership Policy and Operational Procedures, including the Adult Safeguarding Champion role, and ensure implementation as appropriate and proportionate to their functions; and
- ensure adult safeguarding features either as a standalone policy or within existing organisational guidance, ensuring as a minimum, that those in contact have guidance on how to recognise and respond to adult safeguarding concerns.

Paragraph 2.27

STRATEGIC RECOMMENDATION 4

Within six months of report publication, the Department of Justice, with the Police Service of Northern Ireland and the Public Prosecution Service for Northern Ireland, should develop a costed research proposal to examine the challenges and opportunities for access to justice for adults in need of protection who have been victims of crime. This should include the scale, equality characteristics, timeliness, access to special measures, reasons for cases not progressing and outcomes. An Action Plan should plan for completion of the research and actions to remedy gaps.

Paragraph 4.9

OPERATIONAL RECOMMENDATIONS

OPERATIONAL RECOMMENDATION 1

Within six months of report publication the Northern Ireland Courts and Tribunals Service, the Northern Ireland Prison Service, the Probation Board for Northern Ireland, the Public Prosecution Service for Northern Ireland, the Police Service of Northern Ireland and the Youth Justice Agency should:

- review governance arrangements for adult safeguarding and monitor performance to inform decision-making;
- undertake a training needs assessment and develop a training plan, including implementation timelines and a mechanism to review the training effectiveness; and
- implement a quality assurance process for adult safeguarding activity including recording of adult safeguarding reports to other adult safeguarding partners, decision-making and review of long-term safeguarding measures.

Paragraph 3.19

OPERATIONAL RECOMMENDATION 2

Within six months of report publication, the Police Service of Northern Ireland should implement a process to quality assure its Central Referral Unit decisions in adult cases and scope options to implement regular joint quality assurance and learning with Health and Social Care Trust colleagues.

Paragraph 3.23

CHAPTER 1: INTRODUCTION

WHAT IS ADULT SAFEGUARDING

1.1 Adult safeguarding is everyone's business. The *'Adult Safeguarding: Prevention and Protection in Partnership' policy* ('the Partnership Policy') stressed this.[1] Safeguarding was about preventing harm from abuse occurring in the first place, as well as the arrangements to protect adults at risk where harm had occurred or was suspected.

1.2 A 2024 study focused on adult safeguarding in Northern Ireland noted that, *'[a]buse of adults with care and support needs is an increasing problem given the demographics of an ageing society and the trend towards care in the community.'*[2] The importance of effective adult safeguarding arrangements had also been emphasised through seminal laws[3] and investigation reports and reviews [4] that highlighted the State's duty to prevent and tackle certain harms including those caused by domestic and sexual abuse, exploitation, human trafficking and abuse in care where older people or those with a learning disability lived.

INTERNATIONAL AND REGIONAL CONTEXT

1.3 The *United Nations Convention on the Rights of Persons with Disabilities*[5] was of fundamental relevance in the context of safeguarding adults from harm. It set out State Parties' obligations to protect people with disabilities from violence, exploitation and abuse, as well as rights to autonomy, legal capacity and non-discrimination. It was an important blueprint for the development of domestic laws and policies, as well as the assessment of how these applied in practice.

1 Formerly *DHSSPS and DoJ, Adult Safeguarding: Prevention and Protection in Partnership, July 2015*, available at **https://www.health-ni.gov.uk/publications/adult-safeguarding-prevention-and-protection-partnership-key-documents**.

2 *Montgomery, L., Doyle, L., Bunting, L., and Gleghorne, N., Adult Safeguarding Inequalities in Northern Ireland: An Exploratory Study, British Journal of Social Work (2024) 54, 2841-2861*, available at **https://niscc.info/app/uploads/2025/05/Adult-Safeguarding-Inequalities-in-Northern-Ireland-An-Exploratory-Study.pdf**.

3 For example, the Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021; and the Human trafficking and Exploitation (Criminal Justice and Support for Victims) Act (Northern Ireland) 2015.

4 See in particular *Commissioner for Older People for Northern Ireland, Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home, June 2018* available at **https://copni.org/publications-research/reports**; and *A Review of leadership and Governance at Muckamore Abbey Hospital, The Muckamore Abbey Hospital Review Team 31 July 2020* available at **https://www.health-ni.gov.uk/publications/review-leadership-governance-muckamore-abbey-hospital**. Subsequently there was an Independent Inquiry to examine the issue of abuse of patients at Muckamore Abbey hospital which had concluded oral evidence and closing statement sessions in March 2025. At the time of fieldwork, the Inquiry was in the process of preparing its report which was subsequently published on 18 June 2026 (see the Muckamore Abbey Hospital Inquiry website available at **https://www.mahinquiry.org.uk/**).

5 *United Nations, Convention on the Rights of Persons with Disabilities and Optional Protocol, enacted May 2008* available at **https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf**

1.4 Across Europe, while adult safeguarding law varied significantly by country, relevant cross-cutting standards included the *European Union (EU) Victims' Rights Directive (Directive 2012/29/EU)*[6], which required individual assessment of victims' protection needs and access to support, and Council of Europe instruments such as the *Istanbul Convention*[7] on violence against women and domestic violence, that set expectations for prevention, protection and effective investigation of domestic abuse.

1.5 In addition, the European Convention on Human Rights (ECHR) provided an overarching rights-based framework that was particularly relevant to adults at risk of harm and in need of protection. Provisions of particular relevance included *Article 3*, freedom from inhuman and degrading treatment and torture, and *Article 8* (both of the ECHR) in respect of the right to private and family life. In safeguarding contexts, this reinforced the need for proportionate, person-centred interventions, accessible communication and effective investigation where there were credible allegations of abuse or neglect, particularly if involving people with disabilities and/or those living in a nursing home, care or detention environment.

ADULT SAFEGUARDING ARRANGEMENTS IN NORTHERN IRELAND

Present arrangements

1.6 The Partnership Policy was the key regional document for adult safeguarding arrangements in Northern Ireland. It established that the Health and Social Care Trusts (HSCTs) were principally responsible for the act of protecting against harm and, where a crime was suspect or alleged, the Police Service of Northern Ireland (PSNI). The responsibility for preventing harm was wider and included statutory providers of services and '*...the voluntary and community sector, financial institutions, the legal profession, faith-based organisations, independent health and social care providers, carers and all citizens*.'

1.7 The Partnership Policy represented a shift in thinking away from 'vulnerability' noting that, '*The language of adult safeguarding previously focused on protection and used the term 'vulnerable adult.' This was widely misinterpreted, often used out of context and, for some, the term implied weakness on the part of the adult, which many found unacceptable. This policy moves away from the concept of 'vulnerability' and towards establishing the concept of 'risk of harm' in adulthood*.'

6 *European Union Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, October 2012,* available at *European Union (EU) Victims' Rights Directive (Directive 2012/29/EU)*

7 *Council of Europe (CoE), Action against violence against women and domestic violence (Istanbul Convention) adopted by the CoE Committee of Ministers on 7 April 2011, entered into force in August 2014* available at ***https://www.coe.int/en/web/istanbul-convention/about-the-convention***

1.8 The definition for an 'adult at risk of harm' and 'an adult in need of protection' were set out as follows (emphasis in original):

> *An **'Adult at risk of harm'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:*
>
> *a) **personal characteristics; AND/OR***
> *b) **life circumstances.***
>
> ***Personal characteristics** may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain. **Life circumstances** may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.*
>
> *An **'Adult in need of protection'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:*
>
> *a) **personal characteristics; AND/OR***
> *b) **life circumstances; AND***
> *c) who is **unable to protect** their own well-being, property, assets, rights or other interests; **AND***
> *d) where the **action or inaction of another person or persons** is causing, or is likely to cause, him/her to be harmed.*
>
> *In order to meet the definition of an 'adult in need of protection' either (a) or (b) must be present, in addition to both elements (c), and (d).*

1.9 Preventative safeguarding included the range of actions and measures to help reduce the likelihood of harm, whereas protective safeguarding was required when there was harm from abuse, exploitation or neglect. The Partnership Policy indicated that the decision as to whether an adult needed protection required '*the careful exercise of professional judgement on a case-by-case basis*.'

1.10 Where adults were at risk of harm and in need of protection, support and protective measures were required including access to justice for victims of crime and their families.

Legislative proposals

1.11 Unlike elsewhere in the United Kingdom (UK), adult protection arrangements in Northern Ireland did not have a statutory footing.[8] An Adult Protection Bill (the Bill), was at Committee Stage during Report drafting and was an important development. The Bill was delayed partly due to extended Committee proceedings and awaiting the Muckamore Abbey Hospital Inquiry Report that was subsequently published in June 2026.

1.12 At the time of the inspection, the Northern Ireland Assembly Committee for Health (the Health Committee) had scrutinised the Bill and published a report.[9] The Committee agreed a number of amendments to the Bill and reserved '*…the right to bring forward further amendments and recommendations after it receives legal advice and following the publication of the Muckamore Abbey Hospital Inquiry Report*.' Following a request from the Committee Chair, the Minister of Health advised that Consideration Stage of the Bill would be postponed until September 2026[10] to allow time to reflect on the Inquiry Report recommendations.

1.13 The Bill was broadly welcomed, however, clauses within it had been subject to varying submissions. The Bill had not explicitly referenced human rights obligations and the Northern Ireland Human Rights Commission (NIHRC) recommended this was addressed.[11] There were various submissions relating to proposed use of closed-circuit television with the Committee agreeing not to take a position until publication of the Muckamore Abbey Hospital Inquiry Report. The Clause 4 'duty to report' remained unresolved because, at the time of writing, the Department of Health (DoH), the Northern Ireland Prison Service (NIPS) had not reached agreement on NIPS Governors being explicitly listed as having a mandatory reporting duty.

1.14 Those giving evidence emphasised the need for statutory guidance to assist organisations on the practical outworkings of the legislation. There were also calls to ensure the Bill was adequately resourced, funded and implemented. The DoH indicated that the business case for implementation had been approved on the condition that it would not be enacted until such a time as funds were available. The Committee acknowledged the Department's difficult financial position but stated that the '*…Department should, at the earliest stage, bring forward a detailed implementation plan outlining the timeframes for the phasing of the Act and the associated costs*.' Stakeholders expressed concern about the proposed phased approach to implementation.

8 See *the Adult Support and Protection Act 2007* in Scotland; *the Care Act 2014 in England*; and *the Social Services and Well-being (Wales) Act 2014*. See also Professor Williams, J., *Adult Safeguarding Legislation in Northern Ireland, March 2020* available at ***https://copni.org/publications-research/reports***.

9 *Northern Ireland Assembly Committee for Health, Report on the Adult Protection Bill, 26 March 2026*, available at ***https://www.niassembly.gov.uk/globalassets/committee-blocks/health/2022---2027/ap-bill-submissions/doh-memo-and-papers/committee-for-health-report---adult-protection-bill.pdf***.

10 At time of this report's submission for permission to publish, the Consideration Stage of the Bill had not yet commenced in the Northern Ireland Assembly although preparatory steps had begun. See ***Northern Ireland Assembly website*** for further information.

11 *NIHRC, Submission to Committee for health on the Adult Protection Bill, September 2025*, available at ***https://nihrc.org/assets/uploads/publications/NIHRC-Submission-to-Committee-for-Health-on-Adult-Protection-Bill.pdf*** [referencing *Z v United Kingdom (2001) ECHR 333, at para 73*].

1.15 In full support of the Bill's aims, the PSNI[12] and the Probation Board for Northern Ireland (PBNI)[13] were among those urging for the Bill's financial implications to be assessed. As the PSNI outlined:

'The legislation is welcomed and supported within policing however it should be noted the impact that this will have on a number of key strands across the organisation including funding and resources. Any additional operational demands on the Police Service essentially mean not being able to undertake other roles and therefore it is important that when operationalising this legislation, consideration is given under the following thematic areas:

- *policy change and operational guidance demands;*
- *training;*
- *technology changes;*
- *operational support; and*
- *communications and media awareness.*

COMPARATIVE CONTEXT

1.16 In other UK jurisdictions, safeguarding duties were set in statute: in England, *Section 42 of the Care Act 2014* required local authorities to make (or cause to be made) safeguarding enquiries where specific criteria were met; in Wales, the *Social Services and Well-being (Wales) Act 2014* imposed a similar duty to enquire where an 'adult at risk' met the statutory test (*Section 126*); and in Scotland, the *Adult Support and Protection (Scotland) Act 2007* placed duties on local councils/authorities to make inquiries and provided a suite of protection orders.

1.17 In the Republic of Ireland, adult safeguarding was historically guided by national policy (including the Health Service Executive's *Safeguarding Vulnerable Persons at Risk of Abuse (2014)*), and more recently by the Government's *National Policy Framework for Adult Safeguarding in the Health and Social Care Sector (published in 2025*), which signalled an intention to strengthen safeguarding through clearer accountability and legislative underpinning.

12 *PSNI, Adult Protection Bill, PSNI Views, September 2025* available at ***https://www.niassembly.gov.uk/globalassets/committee-blocks/health/2022---2027/ap-bill-submissions/psni.pdf***.

13 *PBNI, Response to Call for Evidence at the Committee Stage of the Adult Protection Bill, 26 September 2025*, available at ***https://www.niassembly.gov.uk/globalassets/committee-blocks/health/2022---2027/ap-bill-submissions/probation-board-ni-pbni.pdf***.

THE ROLE OF CRIMINAL JUSTICE ORGANISATIONS

1.18 The criminal justice system's central role was to keep people safe from harm and protect the public. This did not mean that all adults in contact with the criminal justice system were at risk of harm or in need of protection within the meaning of the adult safeguarding Partnership Policy.

1.19 While criminal justice organisations' interface with adult safeguarding varied, all organisations needed to assess and understand the applicability of the Partnership Policy's provisions to their functions. In addition, because safeguarding was everyone's business, Police Officers, criminal justice practitioners, staff in contact with the public, and those delivering services to service users or the public on behalf of the organisation, required support and training to recognise the signs of abuse and respond effectively.

1.20 The PSNI undertook investigations when a criminal offence was alleged or had been committed. This was alone or jointly with HSCT colleagues pursuant to the *Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults*. The NIPS was in a peculiar position among the criminal justice organisations because, due to a longstanding strategic gap, it was unable to refer adult protection issues *arising within* prisons to the HSCTs. In practice, the NIPS was undertaking its own adult safeguarding investigations, which was a concern that had been raised through successive prison inspections published by CJI since 2023.[14]

1.21 Criminal justice organisations, particularly the PSNI, the Public Prosecution Service for Northern Ireland (PPS), the Northern Ireland Courts and Tribunals Service (NICTS), and the Department of Justice (DoJ) as the legislative, strategic and policy lead for criminal justice, also had a responsibility for ensuring access to justice where an adult at risk of harm had been a victim crime. The *Victim Charter*[15] had not explicitly referenced adults at risk of harm. However, all victims were entitled to timely assessment of needs so that any support and special measures could be identified. It stated that:

'In the context of the individual assessment by the police or Victim and Witness Care Unit, particular attention will be paid to you if you have suffered considerable harm due to the severity of the crime, the crime involves a bias or discriminatory motive that could, in particular, be related to your personal characteristics or where you may be particularly vulnerable due to a relationship with or dependence on the alleged offender. This would include consideration of a family member bereaved as a result of the crime, a victim with a disability or if you are a victim of sexual abuse or violence; domestic abuse or violence; gender-based violence; human trafficking; exploitation; hate crime; an intent or attempt to endanger your life; organised crime; or terrorism.'

14 CJI Inspection Reports on Northern Ireland prisons available at **https://www.cjini.org/report-category/prisons/**.
15 *DoJ, Victim Charter A Charter for victims of crime, September 2015* available at **https://www.justice-ni.gov.uk/sites/default/files/publications/justice/Victim%20Charter.pdf**.

PREVIOUS CJI INSPECTIONS

1.22 In February 2012, CJI and the Regulation and Quality Improvement Authority (RQIA) published a *Joint Review of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults*. Recommendations were made in the review for the PSNI to:

- develop and circulate a new service procedure to deal with Adult Safeguarding to include vulnerable adults and a role profile of the Officers engaged in this work;
- implement the recommendations of the 2010 internal review of Public Protection Units (PPUs), in particular the separation of roles and the practice should cease;
- review systems and processes designed to identify and record referrals to ensure a corporate approach and should monitor activity on a service-wide basis to establish trends;
- develop Information Technology solutions to ensure the free flow of information between the PSNI and the HSCTs; and
- develop a training package to ensure that all operational Officers are aware of the need to involve specialist assistance when dealing with vulnerable adults.

1.23 Inspectors completed an inspection of the criminal justice system approach to adult safeguarding in 2015.[16] This reported changes in motion, including a review of policies and procedures related to adult safeguarding, restructuring of the PSNI's PPUs and work to improve victims and witnesses' experiences of the criminal justice system. At that time, it was decided to be unhelpful to make recommendations during a period of flux.

1.24 Adult safeguarding arrangements were specifically examined during CJI inspections of places of detention. The effectiveness of adult safeguarding processes and procedures were highlighted in the most recent published inspection of Maghaberry Prison[17] and subsequent Independent Review of Progress,[18] the inspections of Hydebank Wood Secure College[19] and Women's Prison[20] and of Magilligan Prison.[21] These are discussed further in this Report.

16 *CJI, Adult Safeguarding: The approach of the criminal justice system to investigating and prosecuting crimes against vulnerable adults, September 2015*, available at **https://cjini.org/wp-content/uploads/2025/05/Adult-Safeguarding-web-FINAL-02-09-15.pdf**.

17 *CJINI, Report of an Unannounced Inspection of Maghaberry prison 20 September – 6 October 2022, June 2023*, available at **https://www.cjini.org/reports/report-on-an-unannounced-inspection-of-maghaberry-prison-2/**.

18 *CJI, Report of an Independent Review of Progress (IRP) at Maghaberry Prison 31 October – 2 November 2023, February 2024* available at **https://www.cjini.org/reports/report-of-an-independent-review-of-progress-irp-at-maghaberry-prison/**.

19 *CJI, Report of an Unannounced Inspection of Hydebank Wood Secure College 21 May – 6 June 2024, November 2024*, available at **https://www.cjini.org/reports/report-on-an-unannounced-inspection-of-hydebank-wood-secure-college/**.

20 *CJI, Report of an Unannounced Inspection of Hydebank Wood Women's Prison 21 May – 6 June 2024, November 2024* available at **https://www.cjini.org/reports/report-on-an-unannounced-inspection-of-hydebank-wood-womens-prison/**.

21 *CJI, Report of an Unannounced Inspection of Magilligan Prison 9-16 September 2025, March 2026, available at* **https://www.cjini.org/reports/report-of-an-unannounced-inspection-of-magilligan-prison-9-26-september-2025/**.

THIS INSPECTION

1.25 The fieldwork for this inspection was completed between January and April 2026. To inform the inspection, Inspectors met with stakeholder organisations who supported adults at risk and/or interacted with adult safeguarding issues either in a criminal justice context or more broadly. CJI Inspectors also spoke with statutory oversight and/or complaints bodies including the Commissioner for Older People for Northern Ireland (COPNI) and the NIHRC. The Office of the Police Ombudsman for Northern Ireland and the Office of the Prisoner Ombudsman for Northern Ireland were among the organisations CJI spoke to. CJI also met with representatives of the Office of Care and Protection, an office within the Family Division of the High Court, who dealt with the appointment of Controllers on behalf of the Court and supervises those individuals who have been appointed to manage the financial and property affairs of adults who lack capacity to do so themselves. The Master (Care and Protection) the judicial officer of the Court, also investigates circumstances where the property or finances belonging to an incapable adult appear to be at risk.

1.26 To help understand the wider strategic context for adult safeguarding, CJI met with the Strategic Performance and Partnership Group (SPPG), the DoH and a HSCT Adult Safeguarding lead. CJI also liaised with the RQIA colleagues at different points while undertaking the inspection.

1.27 This inspection focused on the criminal justice organisations named in the Partnership Policy - the PBNI, the PPS, the PSNI, the NICTS and the NIPS. Although not listed within the policy, the Youth Justice Agency (YJA) was included in this inspection given the potential for adult safeguarding concerns to arise in its work. Inspectors also met with DoJ officials.

CHAPTER 2: STRATEGY AND GOVERNANCE

REGIONAL STRUCTURES AND STRATEGY

Regional structures

2.1 In September 2021, the then Minister for Health, Robin Swann MLA, confirmed plans to stand down the Northern Ireland Adult Safeguarding Partnership and established an Interim Adult Protection Board. This was in anticipation of an Adult Protection Bill (the Bill) and the intention to establish an Independent Adult Protection Board (the Board) once the Bill was enacted. The Board was established in 2021 as an interim arrangement with the objective to *'...protect and safeguard adults at risk of harm or in need of protection in Northern Ireland by co-ordinating the work and ensuring the effectiveness of each person or body represented on the Board.'* [22]

2.2 The Interim Adult Protection Board was facilitated by the SPPG and had four subgroups: Training and Development; Serious Case Review; Data and Performance; Policies and Procedures. It consisted of statutory, community, voluntary and independent sector representatives. Criminal justice organisations regularly represented included the PSNI and the PBNI.

2.3 Local Area Safeguarding Partnerships (LASPs) had existed since the previous Northern Ireland Adult Safeguarding Partnership with membership from a wide range of local statutory, voluntary and community organisations. These were intended as a local mechanism to support awareness raising and development of adult safeguarding work. Many who CJI met hoped that public awareness of the LASPs and about adult safeguarding more broadly would increase as the Bill progressed.

2.4 More recently, a DoH-led 'Transformation Board' had been established with a specific role to focus on changes required to facilitate implementation of the Bill. Its membership included the DoH, the DoJ, the PSNI, the PBNI and the PPS. The NIPS had recently been invited to join.

Strategic framework

2.5 The 2015 DoH/DoJ *'Adult Safeguarding: Prevention and Protection in Partnership'* (the Partnership Policy) was the regional policy and the overarching strategic document for all organisations working with or providing services to adults.

22 Interim Adult Protection Board website available at ***https://online.hscni.net/partnerships/interim-apb/***

It was described as setting out clear and proportionate safeguarding expectations across the range of organisations and aimed, among other goals, to '*promote zero-tolerance of harm to all adults from abuse, exploitation or neglect*.' The policy named organisations that it had specific relevance to although the list was not exhaustive. Criminal justice organisations named included the PSNI, the PPS, the PBNI, the NIPS and the NICTS.[23]

2.6 The Partnership Policy was supplemented by Operational Procedures.[24] These established broad principles of good practice for responding to adults at risk or in need of protection, as well as practical guidance. Organisations needed to review the applicability of these documents and implement as appropriate to their functions.

2.7 The Regional Policy and Operation Procedures were dated. While organisations anticipated that guidance for the Adult Protection Bill would supersede existing policy, many emphasised the need for clarity and direction in the meantime. Leaders conceded that while the 2015 Partnership Policy required updating, the focus had shifted to consider what guidance would be required to support the Adult Protection Bill. In the interim, there was a sense of policy 'in limbo' and uncertainty around thresholds and the remit and roles of different organisations. Inspectors were concerned that the Adult Protection legislation was not imminent and organisations were concerned that full implementation may take years rather than months.

STRATEGIC RECOMMENDATION 1

Within nine months of report publication, the Department of Justice in partnership with the Department of Health, should agree a timebound plan to review and update the Partnership Policy and Operational Procedures.

2.8 One example of the issues caused by the absence of clear, up-to-date policy was a risk of ineffective oversight and governance, particularly in the prison environment where application in practice had been problematic. Although the Partnership Policy listed the NIPS as a relevant organisation, it was unable to refer adult protection concerns to HSCT Adult Gateway Teams. This risk was identified as a priority concern in a 2023 Inspection Report on Maghaberry Prison,

'The safeguarding policy was up-to-date and aligned to the regional Adult Safeguarding Prevention and Protection in Partnership policy. [...]

23 Policing and Community Safety Partnerships were also named but were not part of this inspection.
24 South Eastern Health and Social Care Trust (SEHSCT), Northern Ireland Adult Safeguarding Partnership, Adult Safeguarding Operational Procedures: Adults at Risk of Harm and Adults in need of Protection available at ***https://setrust.hscni.net/wp-content/uploads/2019/09/Adult_Safeguarding_Operational_Procedures_Adults_at_risk_and_Adults_in_Need_of_Protection_2016_2.pdf***

We found several examples of serious safeguarding incidents that had been investigated by leaders but had not been managed in accordance with the NIPS policy. Although we found examples where referrals had been made to the Police Service of Northern Ireland, there was limited liaison by the NIPS to the SEHSCT Adult Safeguarding team for advice on referral and management.'

2.9 During this inspection, the position was unchanged for Maghaberry and the other prisons. A programme of work to remedy the gap was being facilitated by the SPPG with the DoH, the DoJ, the NIPS, HSCTs and stakeholders, but a solution had not been agreed and progress had been intermittent. Accepting that resourcing and structural issues remained, arriving at a solution was taking too long. The NIPS policy, the Partnership Policy and Operational Procedures required referral of adult protection matters to an Adult Gateway Team for assessment by a suitably qualified Social Work professional, which in practice the NIPS was unable to do.

STRATEGIC RECOMMENDATION 2

Within three months of report publication, the Northern Ireland Prison Service in partnership with the Department of Health and the Strategic Planning and Performance Group, should agree a timebound plan to enable adult protection concerns in prisons to be investigated and responded to effectively.

CRIMINAL JUSTICE ORGANISATION'S GOVERNANCE

2.10 Within the PSNI, the Head of PPB led on Adult Safeguarding policy. In practice, all Central Referral Unit (CRU) referrals were reported to the PPB Daily Management Meeting, and a bi-monthly report card reflected the caseload and investigations allocated to the Adult Safeguarding Team. Adult safeguarding and performance oversight was also managed through a performance scorecard and monthly performance meetings within PPB. This involved routine monitoring of demand, timeliness, supervisory reviews and outcomes.

2.11 The PPB monthly Tactical and Tasking Co-ordination Group reviewed emerging risks and mitigations for adult safeguarding. It also focused on operationalising requirements arising from the Adult Protection Bill. The Service Tactical and Tasking Co-ordination Group and Service Performance Board was responsible for strategic oversight although this was limited by what data was available. Inspectors assessed that qualitative analysis of the PSNI performance around adult safeguarding was a gap. The establishment of the CRU was positive, however, the PSNI still needed to review systems and processes to ensure an approach that monitored safeguarding activity on a service-wide basis. The PSNI was developing this and including the use of data dashboards to improve analysis of repeat suspects and victims.

2.12 Adult safeguarding was not routinely included within the NICTS or PPS internal governance structures, but it was an area each were open to review. The YJA had a Safeguarding Champion and designated Safeguarding Officers across all its service areas and teams including in Woodlands Juvenile Justice Centre. It intended to include adult safeguarding as a standing agenda item at strategic meetings where child safeguarding was already reviewed.

2.13 The PBNI demonstrated a maturing culture in its approach with a clear strategic lead at Assistant Director level and associated leads within the PBNI Area Teams. Adult Safeguarding was not routinely reported at Senior Management meetings and there was scope to address this as well as enhance analysis of adult safeguarding referrals for patterns and trends.

2.14 Adult safeguarding was a standing agenda item on the NIPS Safer Custody Steering Group, chaired by the Director of Prisons. Adult safeguarding referrals were reported by number, establishment and nature of referral. Incidents self-reported included bullying, control and restraint, assault, sexual assault, medication issues and domestic abuse. As with other organisations, there was scope to develop an analysis of patterns and trends, which was in turn dependent on the developing approach and understanding of adult safeguarding in prisons. Inspectors found a clear commitment to this among NIPS staff and leaders. Operational Recommendation 1 at paragraph 3.19 addresses the need for a review of governance arrangements and performance monitoring.

ORGANISATIONAL POLICY AND LEADERSHIP

Adult Safeguarding Policy

2.15 Most criminal justice organisations inspected had an adult safeguarding policy or featured this within a broader safeguarding policy applicable to adults and children. The Operational Procedures stated that. '*All providers of targeted services are required to have an Adult Safeguarding Champion and an adult safeguarding policy which demonstrates a zero tolerance of harm to adults*.' Targeted organisations included those with staff or volunteers subject to any level of vetting under the *Safeguarding Vulnerable Groups (Northern Ireland) Order 2007*. It was not, however, limited to these organisations.

2.16 Across organisations, there was varying familiarity with policy and procedures among those Officers and staff with Adult Safeguarding responsibilities. The PSNI *Adult Safeguarding Service Procedure*[25] was a PSNI-wide document supplemented by College of Policing Professional Practice and the DoH/DoJ regional policy and procedures. It highlighted the PSNI objectives in responding to adult safeguarding to:

25 *PSNI, Adult Safeguarding Service Instruction, 12 June 2023*, available at ***https://www.psni.police.uk/about-us/our-policies-and-procedures/corporate-policy/service-instructions***.

- assess and manage the risks to the Adult at Risk of Harm or Adult in Need of Protection and to manage those risks through appropriate interventions;
- investigate all reported crimes committed against Adults at Risk of Harm or Adults in Need of Protection in a consistent, robust and proactive manner, in line with investigative standards; and
- work in partnership with other agencies and organisations to collaboratively address adult safeguarding.

2.17 Outside of the PPB, CJI met Police Officers who were unfamiliar with policies relating to adult safeguarding. Officers tended not to use the language of adult safeguarding and instead talked about how the identification of vulnerability and risk assessment through THRIVE[26] helped in responding to adults at risk.

2.18 The 'Joint Protocol' was the core policy for the PPB. It had been revised through the Policies and Procedures subgroup of the Interim Adult Protection Board. This had been a welcome collaborative exercise among partner organisations. It was intended to improve practice and understanding of existing adult safeguarding referral routes in advance of the Bill being finalised and enacted. The Joint Protocol was premised on the fundamental right of every person to live a life free from harm and abuse. The aim was, *'...to ensure that the welfare and protection needs of the adult at risk and in need of protection are met in a manner which upholds their rights, in particular their right to equal access to the criminal justice system.'* It was a living document that required ongoing learning and review.

2.19 The PPS and the NICTS did not have a specific policy, but there was good scope for each to consider appropriate inclusion within existing guidance. The NICTS identified safeguarding as a core aspect of its duty in administering the Court estate. Safeguarding was included within Court custody expectations and was considered as part of CJI inspections.[27] The NICTS had a Service Level Agreement with the Prisoner Escort and Court Custody Service (PECCS) and was formalising agreements with voluntary and community organisations who required facilities within Courts to consult with victims and witnesses.

2.20 The PBNI policy had clear reporting structures and was described as helpful by staff. At the time of inspection, it was being reviewed using a trauma-informed lens in recognition of the harm experienced by service users and others, and the potential trauma for staff undertaking adult safeguarding work. A recently updated NIPS policy had been supplemented by posters and leaflets across the prison establishments, with nominated leads for each establishment. While this had been recent and familiarity was not embedded, the leaflets, posters and appointment of leads was welcomed by staff, prisoners and partner organisations. There was an opportunity to improve the accessibility of leaflets and posters in consultation with prisoners.

26 Calls to the police are assessed through a process called THRIVE which allows for consideration of six key factors - Threat, Harm, Risk, Investigation, Vulnerability and Engagement.

27 For the most recent inspection see *CJI, Court Custody: The detention of persons in the custody of the court in Northern Ireland, 23 March 2022*, available at **https://www.cjini.org/reports/court-custody-the-detention-of-persons-in-the-custody-of-the-court-in-northern-ireland/**.

Adult Safeguarding Champion

2.21 The Operational Procedures set out the role of the Adult Safeguarding Champion noting that an organisation was not required to have this if it did not have staff or volunteers required to be vetted, *'[h]owever, having an [Adult Safeguarding Champion] is identified as good practice for every group or organisation*.' In any event, '*Members of the public, voluntary and community groups NOT required to have an Adult Safeguarding Champion (ASC) should report all adult at risk or in need of protection safeguarding concerns directly to the HSC Trust Adult Protection Gateway Service*.'

2.22 Criminal justice organisations needed to assess if an ASC role was required and, if not, establish procedures that enabled safeguarding concerns to be reported appropriately.

2.23 Most criminal justice organisations included within this inspection had an ASC and benefitted from the support that this role provided. These organisations also had a more specific focus on adult safeguarding, including reviewing policy and procedures as applicable to their functions, and were clearer about how the minimum expectations for the role were met. The Operational Procedures stated that:

'The ASC should ensure that, at a minimum, the organisation safeguards adults at risk by:

- *recognising that adult harm is wrong and should not be tolerated;*
- *being aware of the signs of harm from abuse, exploitation and neglect;*
- *reducing opportunities for harm, abuse, exploitation and neglect to occur; [and]*
- *knowing how and when to report adult safeguarding concerns to HSC Trusts and/or the PSNI.'*

2.24 There was broad acknowledgement that the task of raising awareness about the signs of abuse, reducing opportunities for harm, and ensuring knowledge about how and when to report concerns, was continuous.

2.25 There was, however, less consistency in demonstrating the 'key responsibilities' of the ASC or an awareness of this and how it applied to the organisation's functions. This was particularly in relation to the responsibility *'...to compile and analyse records of reported concerns to determine whether a number of low-level concerns are accumulating to become more significant. These records must be available on request for inspection or by way of service level agreements or contract review meetings*.'

2.26 Except for the NIPS, criminal justice organisations were not compiling an annual position report. The annual position report was explained as follows:

'To meet the governance requirements set out in the Policy, the ASC will compile an annual Adult Safeguarding Position Report using the following core data:

- *number of referrals made to HSC Trusts involving both an adult at risk and an adult in need of protection;*
- *number of adult safeguarding discussions where the decision taken was to not refer to HSC Trust;*
- *any untoward event that triggered an adult protection investigation;*
- *adult safeguarding training opportunities provided and uptake across staff groups; and*
- *any action that your organisation plans to take to ensure it is compliant with Adult Safeguarding: Prevention and Protection in Partnership and to implement the organisation's own adult safeguarding policy.'*

2.27 There was scope for each of the criminal justice organisations to assess the applicability of this and relevance to their role.

STRATEGIC RECOMMENDATION 3

Within six months of publication, the Northern Ireland Courts and Tribunals Service, the Northern Ireland Prison Service, the Probation Board for Northern Ireland, the Public Prosecution Service for Northern Ireland, the Police Service of Northern Ireland and the Youth Justice Agency should:

- review applicability of the Adult Safeguarding Partnership Policy and Operational Procedures, including the Adult Safeguarding Champion role, and ensure implementation as appropriate and proportionate to their functions; and
- ensure adult safeguarding features either as a standalone policy or within existing organisational guidance, ensuring as a minimum, that those in contact have guidance on how to recognise and respond to adult safeguarding concerns.

CHAPTER 3: DELIVERY

AWARENESS AND IDENTIFICATION

Awareness raising and training

3.1 There was a range of adult safeguarding awareness among the personnel in criminal justice organisations CJI met with. Within some organisations that regularly encountered adult safeguarding such as the PBNI, knowledge was reflective and informed. The YJA had good awareness albeit its work more routinely involved safeguarding children, and PPB Detectives within the PSNI were familiar with adult safeguarding and the procedures that applied. Within other organisations, or service-wide in the PSNI, adult safeguarding was not a specific concept, and common sense was used to identify instances where concerns had existed about adults at risk of harm.

3.2 The PSNI Crime Training provided Joint Protocol training and specialist training required for Pre-Interview Assessment and Achieving Best Evidence interviews. Eleven Adult Safeguarding Officers and all those within the CRU undertaking joint protocol assessments were 'Joint Protocol' trained. This was completed together with HSCT colleagues. Adult safeguarding was covered as part of the training modules for Student Officers and Attested Officers. Contact Management staff were trained in 'THRIVE' and the training manual included various modules related to safeguarding.

3.3 Nevertheless, outside of the PPB, adult safeguarding was not a term used regularly or recognised consistently by Police Officers CJI met. Vulnerability was an established focus and Officers within District Teams and Support Hubs reflected on responding to adults in mental health crisis or domestic abuse with many localised examples of good practice. However, adult safeguarding was not identified as warranting a specific response. Senior leaders in the PPB aimed to build service-wide guidance for the PSNI, including a proposed guide for frontline use, potentially with a mobile phone application. Time pressures and uncertainty pending the final stages of the Bill had impacted the scope to progress this.

3.4 PPS Prosecutors and Victim and Witness Care Unit (VWCU) staff talked about a common-sense approach when concerns had arisen. There was clarity about referring risks of immediate harm to the PSNI. While the Code for Prosecutors and other PPS policies had a focus on vulnerability, there was an opportunity for the PPS to review and consider how adult safeguarding advice could be incorporated within existing policy frameworks.

The PPS had been developing a trauma-informed approach. VWCU staff and the Specialist Crime Unit Prosecutors had received tailored suicide awareness training. There was scope to extend training beyond these roles given the increasing complexity of work and potential across all teams for contact with people in distress.

3.5 The NICTS had also focused on trauma-informed approaches to its work including the delivery and development of training for staff. The NICTS recognised this as a journey to raise awareness about safeguarding and support for staff. It had focused initially on staff working within non-criminal Court operations, as this was where concerns had arisen. However, its intention was to extend learning to criminal Court staff.

3.6 Probation Officers within the PBNI had good awareness of adult safeguarding and reflected on the complexities of this in the context of criminal justice. Those they supervised might pose a risk to others and be at risk of harm themselves with Probation Officers often having to plan for the safety of others, the service user and themselves. Probation Officers were trained social workers and undertook regular mandatory adult safeguarding training. The PBNI was commencing an internal audit on adult safeguarding with a view to developing training and learning from its findings. It had already disseminated adult safeguarding learning from an internal audit on professional curiosity. Through self-assessment, it identified that adult safeguarding was not as clearly embedded as child safeguarding and was a focus for its 2026-27 Training Plan.

3.7 YJA staff received mandatory safeguarding training and was commencing an adult safeguarding refresher session to reacquaint staff on procedures given it was not an everyday area of work. Staff Inspectors met with recognised the importance of safeguarding adults at risk and the need to make referrals although they had limited experience of interacting directly with Adult Gateway HSCT Teams. The YJA supported young people over the age of 18 years in certain circumstances and social work teams were often already engaged and were the point of referral for any safeguarding issues.

3.8 Level 1 Adult Safeguarding Training (Recognising, Responding and Reporting) was delivered by the Prison Service College to all newly recruited Prison Officers including the PECCS staff. In 2022, a combined adult and child safeguarding training package[28] was implemented and formed part of induction training. Content included different types of abuse and case examples and from January 2026, was updated to include a practical exercise specific to the NIPS. It was acknowledged that the training would benefit from the inclusion of Northern Ireland specific legislation and adult safeguarding policies.

28 Accredited by Nuco Training Ltd available at ***https://www.nucotraining.com/***.

3.9 The NIPS had also focused on training established staff including Senior Officers, Officers and PECCS Managers. While waiting for the strategic position on adult safeguarding referrals to be resolved, the NIPS had acquired external Level 3 Adult Safeguarding Champion and Appointed Person Training for those at Governor and other senior NIPS grades. The organisation was continuing to roll out this training with an expectation for refresher training to be completed every two years. **Training for partner organisations and joint learning with them was identified as an area for improvement**.

3.10 Across organisations there was consensus that opportunities for joint training with statutory and Third Sector [voluntary, community, social enterprise or not for profit partners] would be beneficial, particularly when training was tailored to specific job roles, experiences and functions. Operational Recommendation 1 at paragraph 3.19 addresses the need for organisations to undertake a training needs assessment and develop a training plan, including implementation timelines and a mechanism to review the training effectiveness.

Reporting concerns

3.11 A recurring theme among those Inspectors spoke to as part of this inspection was that adult safeguarding language and thresholds were not consistently understood and were often treated as interchangeable with vulnerability. Several groups described an over-focus on consent as a reason for referrals being closed or rejected. Domestic abuse featured widely in these discussions with interviewees often describing risks to parents, older relatives and other household members, which included coercive control. Complexities between safeguarding as support and safeguarding as risk management were also apparent, especially when the person causing harm also had vulnerabilities.

3.12 There was a lack of clarity among staff about how to raise a safeguarding concern. Those in organisations without a dedicated procedure or where rollout had been relatively recent, described different approaches to raising a safeguarding concern. Associated policies included vulnerability, mental health, complaints procedures and policies aimed at supporting victims and witnesses through the criminal justice process. While the NIPS had a dedicated safeguarding policy; anti-bullying policies, Supporting People at Risk and other measures to promote safety and support were among the approaches discussed.

3.13 Inspectors acknowledged that many areas of work had relevance. Once a safeguarding concern had been recognised, anti-bullying measures, support for those at risk or special measures to give evidence at Court might form part of the response to safeguard an individual/s. However, criminal justice organisations needed to understand when other procedures were being used to safeguard and ensure clarity around the response required when the threshold for adult protection was met. This included reporting to the appropriate HSCT and, if a criminal offence was suspected, to the PSNI. Inspectors were not assured this would consistently occur.

3.14 During fieldwork, Inspectors reviewed a small number of adult safeguarding referrals within the PBNI and the NIPS establishments. Inspectors were unable to sample from the full range of referrals made by the PSNI to the HSCTs because, unless submitted to the CRU, referrals were sent by email on a 'Form 0' to Social Services and were not auditable without a manual trawl. Positive examples included instances where Probation Officers and PECCS staff had identified concerns about abuse outside of the organisation and made timely referrals to the relevant HSCT.

CASE EXAMPLE 1

A detainee spoke to a PECCS Officer about an alleged sexual assault that had occurred in a place of care they had been living prior to custody. The PECCS Officer reported the concern to the ASC for the establishment in which the person was detained. An immediate referral was made to the relevant HSCT Gateway Team who accepted the referral for screening and assessment.

3.15 Across referrals, there was learning in relation to timeliness, opportunities for recording of rationale and implementation of safeguarding measures. Police Officers did not have the same scope to consider everything when immediately responding to an incident. A number of referrals reviewed during Inspection fieldwork at PBNI suggested there was scope for learning about identification of safeguarding during earlier contact with the criminal justice system.

CASE EXAMPLE 2

The PSNI reported a serious further offence to the PBNI in relation to one of its service users. On reviewing the information provided by the PSNI, the Probation Officer identified that there was a relative of the victim who appeared to be an adult at risk and in need of protection. The Probation Officer completed a referral form on the HSCT 'APP1'. This was reviewed by the PBNI Area Manager and submitted to the relevant HSCT. The referral was assessed, which identified that the adult in question was in need of protection and this enabled supports to be put in place.

3.16 The NIPS had maintained a record of all adult safeguarding concerns reported to it. As it was unable to consider concerns about Healthcare in Prison (HiP), it had also kept a record of adult safeguarding referrals it made to HiP. This was an approach each had agreed and adopted in the absence of NIPS being able to refer to a HSCT Gateway Team. Inspectors consider adults living in prison required an arrangement in keeping with the Partnership Policy and Operational Procedures. In the meantime, adult safeguarding concerns risked being overlooked because, despite training for NIPS staff, there was no qualified HSCT Domestic Abuse Protection Officer assessing issues arising within prisons.

3.17 The NIPS had maintained a register of adult safeguarding referrals since January 2022. This identified where concerns related to an adult in need of protection had occurred, the source of referral, whether a support plan had been put in place and if the concern was referred to the PSNI. Inspectors were not assured that all cases were being referred to the PSNI when required. In the case sample reviewed, Inspectors found one case of alleged sexual assault and one of alleged physical assault where there were no police referrals and a lack of rationale as to why those decisions were made. Across cases, the quality of investigation and details of measures to safeguard the person at risk and others, including the person alleged to have caused harm, required improvement.

3.18 Those familiar with and experienced in adult safeguarding work reported confusion about the threshold for adult protection and experienced referrals with similar circumstances being accepted in some HSCTs but not others. Inspectors met with SPPG, DoH and staff from one of the HSCTs. It was noted that learning and feedback was important and, through experience with organisations, threshold recognition had improved. It was CJI's view that when reviewing the Partnership Policy and Operational Procedures a particular focus on thresholds, escalation processes, oversight and quality assurance would be beneficial (see Strategic Recommendation 1).

3.19 Inspectors have highlighted the need for better quality assurance, training (paragraph 3.10), and governance arrangements (paragraph 2.14) and recommend that:

OPERATIONAL RECOMMENDATION 1

Within six months of report publication, the Northern Ireland Courts and Tribunals Service, the Northern Ireland Prison Service, the Probation Board for Northern Ireland, the Public Prosecution Service for Northern Ireland, the Police Service of Northern Ireland and the Youth Justice Agency should:

- **review governance arrangements for adult safeguarding and monitor performance to inform decision-making;**
- **undertake a training needs assessment and develop a training plan, including implementation timelines and a mechanism to review the training effectiveness; and**
- **implement a quality assurance process for adult safeguarding activity including recording of adult safeguarding reports to other adult safeguarding partners, decision-making and review of long-term safeguarding measures.**

PSNI Central Referral Unit

3.20 The CRU received referrals about suspected abuse of adults at risk or in need of protection. Most referrals were from HSCTs, however, other organisations could make direct referrals. The PPB had implemented processes to streamline this for some organisations including from the Office of Care and Protection. CJI heard positive feedback about this. It was also positive that opportunities to improve the process of making referrals were being explored.

3.21 In cases involving adults, PSNI Officers and staff were required to contact the CRU when:[29]

'There is an allegation, or reasonable cause to suspect, the abuse of an adult at risk and in need of protection. "Abuse" is described as 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to another individual or violates their human or civil rights'. This can be physical, sexual, financial, neglect, or institutional.'

The PSNI was not specifically monitoring referrals to CRU from PSNI Officers, and this was an area for improvement. Officers who met with CJI said that interaction with CRU was rare for cases involving adults.

3.22 Table 1 shows data provided by the PSNI of the number of assessments made by the CRU over a five-year period.

Table 1: Assessments made by the CRU (2020-21 to 2024-25)

Adult 'Joint Protocol' Assessments 2020-21 to 2024-25 (PSNI CRU management information)					
	2020-21	2021-22	2022-23	2023-24	2024-25
Joint	423	461	354	305	201
Single (PSNI)	511	639	577	610	600
Single (Social Services only)	462	491	550	467	524
Adult*	31	10	1	1	0
No Further Action	42	76	48	57	57
No flag/blank	7	1	0	16	2
Total	**1,476**	**1,678**	**1,530**	**1,456**	**1,384**

*Not categorised as joint or single agency investigation
(Source: PSNI)

29 *PSNI Guidance for the Allocation of Investigations, Version issued 22/12/2020*, internal PSNI document provided to CJI as part of this inspection.

3.23 There was evidence of good supervision and in all cases, the Detective Sergeant monitored timeliness and recording of the referral, research and decision made. The CRU team reported being well supported and skilled in relation to adult safeguarding cases. A small number of referrals assessed by the CRU were reviewed by Inspectors. Most were sufficiently detailed, however, decision recording required improvement in two cases. In one of these, CJI was not assured about the decision for a 'Social Services' only investigation. It illustrated the importance of quality assurance and ongoing review to ensure decisions about alleged criminal matters were well reasoned and responded to appropriately. PPB senior leadership reported limited capacity for quality assurance of CRU adult cases. Joint quality assurance with Adult Safeguarding Social Workers was also important but resourcing across HSCTs and the PSNI was impacting the ability to do this.

OPERATIONAL RECOMMENDATION 2

Within six months of report publication, the Police Service of Northern Ireland should implement a process to quality assure its Central Referral Unit decisions in adult cases and scope options to implement regular joint quality assurance and learning with the Health and Social Care Trusts colleagues.

CRIME INVESTIGATION

3.24 Investigation of crimes alleged against adults at risk of harm or in need of protection were allocated according to the PSNI *Guidance for the Allocation of Investigations*.[30] This was intended as a guide but dependent on the circumstances of each case. Generally, PPB Adult Safeguarding Teams progressed adult safeguarding investigations where a crime had been confirmed or reasonably suspected against an adult at risk and in need of protection; the alleged offender was in position of trust (for example, a carer or family member) and the investigation was agreed as 'Joint' with Social Services by the CRU in line with the 'Joint Protocol.'

3.25 If this criterion was met, allocation to the Adult Safeguarding Team focused on:

- significant physical abuse (assault occasioning actual bodily harm and above, or there is sufficient evidence to indicate a pattern of lower-level abuse);
- sexual abuse;
- neglect (evidence of low standards of care or neglect likely to adversely impact on the health of adults in need of protection);
- organisational or Institutional abuse (organised or systematic mistreatment of adults at risk of harm caused by poor practice or inadequate care or support, which impacts the wider care setting);

30 *PSNI Guidance for the Allocation of Investigations, Version issued 22/12/2020*, internal PSNI document provided to CJI as part of this inspection.

- financial abuse; and
- whistleblowing incidents relating to any of the above.

Incidents described as 'lower-level' including common assault or theft, for example, would be allocated to District Police for investigation, following CRU assessment.

3.26 PSNI management information showed the allocations to PPB for 2020-21 to 2025-26 had declined from approximately one-third to one-fifth of Joint Protocol cases referred to and assessed by the CRU. The PSNI indicated that it was difficult to forecast caseload for the Adult Safeguarding Team, which had fluctuated due to larger investigations in 2020-21 and 2021-22.

Table 2: Adult safeguarding referrals allocated to the PPB as a percentage of all Joint Protocol (AJP1) Assessments

	PPB (No.)	PPB (%)	Total
2020-21	536	36.31	1,476
2021-22	585	34.86	1,678
2022-23	475	31.05	1,530
2023-24	425	29.19	1,456
2024-25	268	19.53	1,372

Source: PSNI management information

3.27 The PSNI described resourcing of the Adult Safeguarding Team as fairly consistent across the five HSCT areas. The team had a Detective Constable dedicated to Adult Safeguarding Policy whose focus included helping to prepare the PSNI for the forthcoming Adult Protection Bill. There were 11 Detective Constables with adult safeguarding investigations within the Adult Safeguarding Team and two focused on relevant enquires. During fieldwork for this inspection, the team had 89 files in total assigned to it (Belfast had 21 adult safeguarding files; Northern had 20; Western had 27 files; South Eastern had 13 files and Southern had eight).

3.28 Caseload pressures related to the complexity of work and the reallocation of files to the team due to pressures in other PPB areas. Investigations had been complex due to the victims' particular needs, and there were multiple victims and offenders in some cases. One case discussed had involved 17 victims and three suspects. Specialist support in more complex financial investigations was also required at times. The team had liaised with the Economic Crime Unit, which had developed a training proposal for the Adult Safeguarding Team. Inspectors viewed this as a positive development. Training and support for the Adult Safeguarding Team within the PSNI and together with stakeholder agencies such as the HSCTs would ensure consistency in approach, decision-making and learning.

3.29 The timeframe to progress cases to Court impacted victims particularly those who were in ill-health and towards the end-of-life. Pursuing special measures and expediting cases at the outset was emphasised. In its inspection of vulnerable older people's experience of the criminal justice system, CJI's made a recommendation which was accepted, that the PSNI and the PPS develop and implement an action plan to better enable vulnerable older victims of crime to give their best evidence and enable the effective progression and acceleration of cases, where appropriate. Disappointingly, **an action plan was not available as part of this inspection and CJI urges this be developed and the recommendation implemented as soon as possible**.

3.30 The PSNI noted that the allocation of other cases to the Adult Safeguarding Team had inevitably impacted the progression of its adult safeguarding work. Wellbeing support was crucial for the team, as well as monitoring and feedback on the outcomes of cases it had progressed. While police sanctions were reflected in monthly PPB reports, a sense of prosecution trends and outcomes was important for the Adult Safeguarding Team morale and its work.

CHAPTER 4: OUTCOMES

4.1 The Interim Adult Protection Board (IAPB) Data and Performance Subgroup was considering the types of information required to measure effectiveness in the area of adult protection. However, it was accepted that information about outcomes for adults at risk of harm and in need of protection was limited. The IAPB held information internally on the number of adult safeguarding referrals to HSCTs, screenings and outcomes, but this was impacted by recording variations in some areas. Figures related to Joint Protocol investigations and Achieving Best Evidence interviews were also gathered. Overall, the data needed better interrogation to discern learning from patterns and trends.

CRIME OUTCOMES

4.2 Crime outcomes were part of understanding access to justice for adult victims of abuse and could also help in examining how the behaviour of those who caused harm was being addressed. File quality, prosecution and Court outcomes were also important. None of this was being monitored specifically for adult protection.

4.3 The PSNI PPB examined monthly and yearly figures from the Adult Safeguarding Team. This included sanction outcome rates. Sanction type was not disaggregated, but police recorded sanctions included charge or summons, caution and community resolution notice. Internal PSNI figures from January 2025 showed variation by HSCT area over the previous year. Reasons for the variation were not formally analysed, however, anecdotally complex investigations with multiple victims had impacted outcomes rates in some areas. For the full calendar year prior to January 2025, Adult Safeguarding Team disposals consisted of three charge files, 38 report files and 24 no-prosecution decisions.

4.4 File timeliness and quality was also monitored and enabled leaders to identify where greater focus was required. More qualitative information was required to identify the factors impacting the progress of investigations. Updates provided to victims were measured, based on the '10-day update', which showed closer monitoring was required to bring about improvements. The PSNI indicated that updates on the progress of cases were often provided in ways not captured by the '10-day' flag, for example, in liaison with Social Workers and family members of victims. Extracting this information would have provided a fuller account of communication by Officers, however, this would require in-depth qualitative analysis across the adult safeguarding cases.

PROSECUTION DECISIONS AND COURT OUTCOMES

4.5 CJI heard from stakeholders and inspected organisations that the timeframe for a prosecution decision was lengthy and could have a disproportionate impact on adults harmed by abuse because victims tended to be older or lived with cognitive or learning needs. The PPS talked about expediting cases where concerns about deteriorating health existed, but there was no formal process to measure this or ensure all eligible cases were covered.

4.6 Prosecution decisions and Court outcomes for adult safeguarding cases were also not monitored. It was not possible for the PPS to disaggregate this data because related PSNI files were not passed to it with a specific adult safeguarding marker or flag. To give some sense of cases that had been sent to the PPS from the PSNI, Inspectors requested case file numbers from the PSNI Adult Safeguarding Team. The PPS extracted information from its management system. It was important to note the limitations of this information and that cases relating to adult safeguarding could be passed to the PPS from PSNI teams outside of the dedicated Adult Safeguarding Team.

4.7 There was no clear picture about the prosecution journey from first report to the PSNI through to decision at the PPS and outcomes. Mapping this journey was important in identifying if there were barriers to prosecuting offences where adult safeguarding risks were identified. It also identifies opportunities to help victims access the criminal justice system for example, if the issues are related to dementia or where people are living with disabilities that impact on how each organisation across the criminal justice system is engaging with them. This data could assist with a wider strategic approach that enables adults at risk, who are victims of crime, to access the criminal justice system.

4.8 The PSNI Adult Safeguarding Team case files provided to the PPS[31] from March 2023 to March 2026 showed 340 files relating to 395 suspects and 456 victims. The data provided by the PSNI and later reviewed by the PPS for further analysis and breakdown of offence types, was unverified and although limited, it provided an overview of the types of information that were not being adequately recorded for adult safeguarding purposes[32]. There was a wide range of offences, including violence against the person, theft and financial offences and property related crimes. The most frequent were common assault (119), hospital staff ill-treating a mental health patient (70), fraud by abuse of position (53), theft (36) and sexual assault (31).

31 The number of case files noted by the PPS contains files from the Muckamore Abbey Hospital investigation which occurred in 2017 therefore these figures are potentially higher than is normal for this time period and subsequently, the frequency of each offence would also be inaccurate.

32 The 'types' of offences included references to the Muckamore Abbey Hospital cases which also have made these figures unreliable as offending was not between 2023 and 2026, but files were submitted during this period.

4.9 Inspectors heard concerns from organisations and stakeholders that offences were not always suited to grasp the level of harm and abuse against adults, particularly where coercion and control had been a factor and had impacted consent. Some Police Officers recalled a significant level of advocacy was required to ensure the concern was investigated as a crime. There was optimism from some that the Adult Protection Bill would assist in addressing this, but more regular monitoring and research was required. Although there had not been a study focusing specifically on adult abuse, research had highlighted poorer crime outcome rates for older people.[33] Understanding the impact of an aging population, crime, prosecution and Court outcomes was an area that required focus to help identify opportunities and challenges in progressing cases and facilitating access to justice now and in advance of the Bill becoming the Adult Protection Act.

STRATEGIC RECOMMENDATION 4

Within six months of report publication, the Department of Justice with the Police Service of Northern Ireland and the Public Prosecution Service for Northern Ireland, should develop a costed research proposal to examine the challenges and opportunities for access to justice for adults in need of protection who have been victims of crime. This should include the scale, equality characteristics, timeliness, access to special measures, reasons for cases not progressing and outcomes. An Action Plan should plan for completion of the research and actions to remedy gaps.

33 *COPNI, A Different Crime: Offending Against Older People, March 2023*, available at ***https://copni.org/assets/general/resources/a-different-crime-2023-crime-report.pdf***.

APPENDIX 1: METHODOLOGY

Desktop research and documentary review

Reports, research and other documentation including previous inspection reports relevant to adult safeguarding were reviewed to inform development of the Terms of Reference.

Self-assessment and supplied documentation

Each of the inspected criminal justice organisations were invited to complete a self-assessment in advance of the inspection fieldwork. These addressed the main inspection areas of strategy and governance, delivery and outcomes. Self-assessments and supporting documentation were provided by the NICTS, the NIPS, the PBNI, the PSNI and the YJA. CJI Inspectors met with the PPS at the start of the inspection to help in identifying the types of information and fieldwork that would best inform the inspection.

Stakeholder consultation

Inspectors also met with and/or received information from a range of organisations involved in supporting or advocating for people at risk of harm or in need of protection in the context of criminal justice and more broadly. Inspectors met with or received information from representatives of the following organisations:

- NIACRO;
- South Eastern Health and Social Care Trust Adult Safeguarding and Gateway Team;
- The Commissioner for Older People Northern Ireland;
- The Commissioner for Victims of Crime in Northern Ireland Designate;
- The Independent Monitoring Boards;
- The Northern Ireland Human Rights Commission;
- The Northern Ireland Women's Aid Federation;
- The Office of the Police Ombudsman for Northern Ireland;
- The Prisoner Ombudsman for Northern Ireland; and
- The Strategic Planning and Performance Group (including a representative from the Department of Health).

A range of voluntary and community sector organisations and representatives of the Chaplaincy Service working within Hydebank Wood College and Women's Prison, Magilligan Prison and Maghaberry Prison also spoke with Inspectors during fieldwork undertaken in the prison establishments.

During the inspection Inspectors liaised with representatives from the RQIA to sense check the focus of the inspection and emerging findings.

Fieldwork

One-to-one interviews and focus groups were completed with the range of inspected organisations. Inspectors also reviewed safeguarding referrals within the PBNI, the PSNI (CRU referrals) and the NIPS.

A total of 38 referrals were reviewed in total consisting of seven referrals within the PSNI CRU; five in PBNI; 26 across the four NIPS establishments on three sites (eight Adult Safeguarding Referrals and four Serious Complaints in Hydebank Wood, four Adult Safeguarding Referrals and three Serious Complaints in Magilligan, seven Adult Safeguarding Referrals in Maghaberry). Inspectors were grateful for the time and information staff, partners and leaders provided.

Interviews and Focus Groups:

DoJ

- Access to Justice Directorate representatives x 2.

NICTS

- Criminal Court Operations Staff Focus Group; and
- Adult Safeguarding Champion interview.

NIPS

- Head of Prisoner Wellbeing and Adult Safeguarding Champion; and
- Governor leads for Adult Safeguarding Focus Group.

Hydebank Wood College and Women's Prison

- Peer Mentors Male Students Focus Group;
- Insiders and Ask Her Mentors for Women Focus Group;
- Senior Officers and Officers (various Functions) Focus Group;
- Voluntary and Community Sector and Statutory Partners Focus Group; and
- PSNI Liaison (met at Maghaberry).

Maghaberry Prison

- Adult Safeguarding Champion;
- Chaplains Focus Group;
- Peer Mentors Focus Group;
- PSNI Liaison Officer;
- Prison Safety and Support Senior Officer and Officers Focus Group Hub; and
- Voluntary and Community Sector Partners Focus Group.

Magilligan Prison

- Chaplains Focus Group;
- Training and Education representative meeting;
- Governors and Unit Manager (various functions) Focus Group;
- Security Governor and Senior Officer;
- Voluntary and Community Sector and Statutory Partners Focus Group;

- Senior Officers and Officers (various functions) Focus Group;
- Peer Mentors Focus Group; and
- PSNI Liaison.

PBNI

- Assistant Director Public Protection;
- Area Managers Focus Group; and
- Probation Officers and Practice Performance and Research Unit Focus Group.

PPS

- Assistant Directors and Policy Lead;
- Senior Prosecutors and Prosecutors Focus Group;
- Victim and Witness Care Unit Manager interview; and
- Victim and Witness Care Unit Staff Focus Group.

PSNI

- Contact Management Senior Leaders Focus Group;
- Support Hub Officers Focus Group;
- Custody Sergeants Focus Group;
- Local Policing Team and Neighbourhood Policing Team Focus Group x 2;
- Local Policing Team and Neighbourhood Policing Team Inspectors Focus Group;
- Central Referral Unit Detective Constables and Detective Sergeant Focus Group;
- Public Protection Branch Head of Service, Detective Chief Superintendent interview;
- Public Protection Branch Chief Superintendent Lead and Chief Inspector Lead for Adult Safeguarding interview;
- Adult Safeguarding Team Policy Lead interview;
- Adult Safeguarding Team Detectives Focus Group; and
- Economic Crime Unit Detective Constable.

YJA

- Assistant Director for Safeguarding interview;
- Practitioners, Conference Co-ordinators and Learning and Development Officer Focus Group; and
- Designated Adult Safeguarding Leads Community and Woodlands Juvenile Justice Centre Focus Group.

This Inspection was assisted by the use of Microsoft Copilot, an Artificial Intelligence (AI) powered tool, guided and reviewed by CJI Inspectors, in line with UK Government AI policy and CJI's interim AI policy.

APPENDIX 2: TERMS OF REFERENCE

An Inspection of Adult Safeguarding Arrangements in the Northern Ireland Criminal Justice System

INTRODUCTION

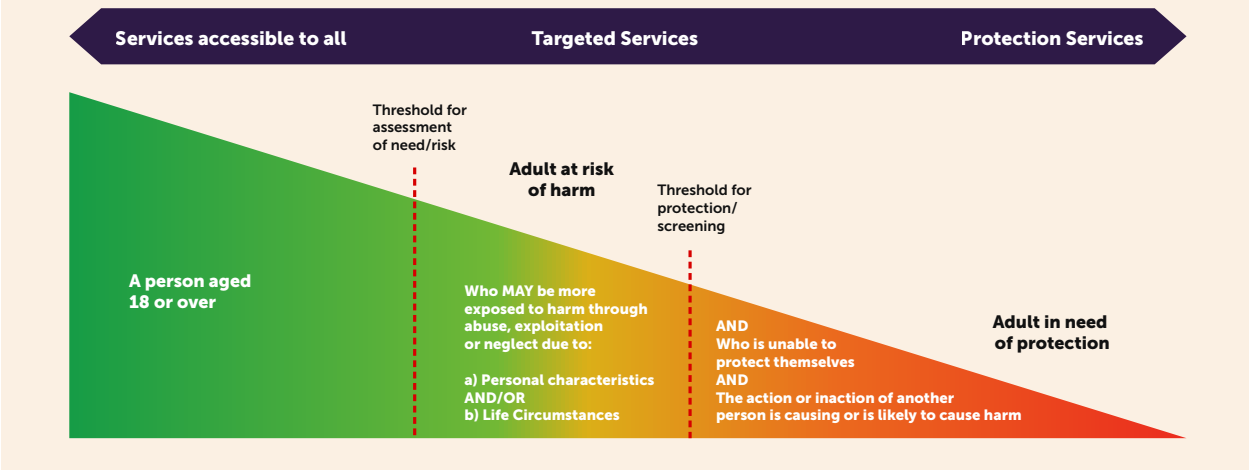
Criminal Justice Inspection Northern Ireland (CJI) proposes to undertake an inspection of adult safeguarding arrangements across the criminal justice system in Northern Ireland.

Safeguarding is everyone's responsibility. This was emphasised in the joint Department of Health and Department of Justice policy for '*Adult safeguarding prevention and protection in partnership*'.[1] It aimed to improve safeguarding arrangements for adults at risk of harm from abuse, exploitation or neglect noting that:

> *'The language of adult safeguarding previously focused on protection and used the term 'vulnerable adult.' This was widely misinterpreted, often used out of context and, for some, the term implied weakness on the part of the adult, which many found unacceptable. This policy moves away from the concept of 'vulnerability' and towards establishing the concept of 'risk of harm' in adulthood.'*

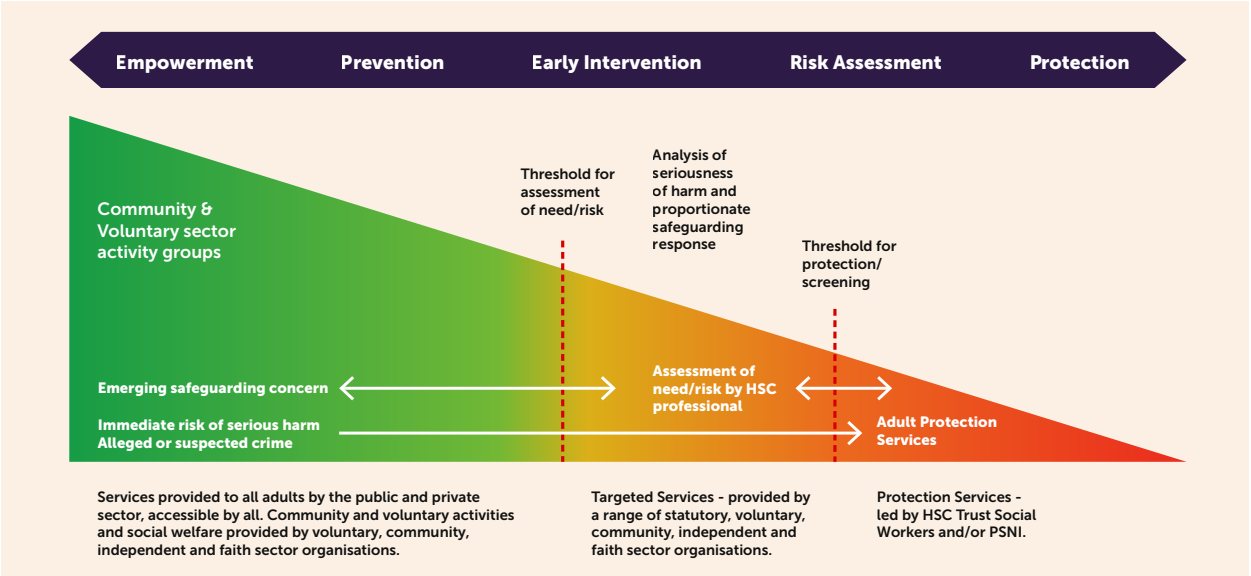
This policy set out the definition for an 'adult at risk of harm' and 'an adult in need of protection.' The definitions were located within a continuum of adult safeguarding activity as shown in Figure 1:

Figure 1: Adult Safeguarding - Definitions



Preventative safeguarding was required for adults at risk of harm and protective safeguarding when harm was likely or had already occurred. A pathway for reporting safeguarding concerns was also set out within the policy as in Figure 2.

Figure 2: The Adult Safeguarding Continuum – Prevention to Protection



Criminal justice organisations encountered emerging adult safeguarding concerns and circumstances where adults needed protection and therefore had an essential role in the collective response to adult safeguarding.

This inspection will focus on criminal justice organisations' policy and guidance about the identification and reporting of adult safeguarding concerns, arrangements for promoting staff awareness of this, processes for making adult safeguarding referrals, and promoting access to justice for adults at risk who have been harmed as a result of abuse, exploitation or neglect.

Context

The introduction of an Adult Protection Bill to the Northern Ireland Assembly in June 2025 had been a recent and significant development. The Bill, if passed, would ensure Northern Ireland was no longer the only part of the United Kingdom without a statutory basis for adult protection.[2]

The Commissioner for Older People had called for a Bill including in the investigation '*Home Truths*' in June 2018.[3] This examined care at Dunmurry Manor Care Home finding that '*the most important theme emerging from the investigation, and one which covers broad range of issues, is safeguarding*.' In August 2020 an Independent Review into the leadership and governance at Muckamore Abbey Hospital found serious adult safeguarding failings.[4] At the Adult Protection Bill's Second Stage in the Northern Ireland Assembly, the Minister of Health stated that '*Subsequent to those reports and the shocking failings at Muckamore and Dunmurry Manor, it was recognised that there was a need to review and improve the departments adult safeguarding policy*.'[5]

CJI thematic inspections covered a range of circumstances relevant to adult safeguarding. Inspections relating to domestic and sexual abuse,[6] the experiences of older people in the criminal justice system,[7] hate crime[8] and modern slavery[9] are some examples. Adult safeguarding arrangements were specifically examined during inspections of places of detention. The effectiveness of adult safeguarding processes and procedures was highlighted in the most recent published inspection of Maghaberry Prison[10] and subsequent Independent Review of Progress[11] and the inspections of Hydebank Wood Secure College[12] and Women's Prison.[13]

Inspectors had completed an inspection of the criminal justice system approach to adult safeguarding in 2015.[14] It reported changes in motion including a review of policies and procedures related to adult safeguarding, restructuring of the Police Service of Northern Ireland's (PSNI's) Public Protection Units and work to improve victims and witnesses' experiences of the criminal justice system. At that time it was decided unhelpful to make recommendations during a period of flux. While acknowledging anticipated changes arising from the Adult Protection Bill being passed, as part of our approved Inspection Programme, CJI considers it important to conduct an inspection of adult safeguarding arrangements within each of the criminal justice organisations to include considering readiness for the proposed legislation.

Aims of the Inspection

The broad aims of the inspection are to:

- examine the strategic and policy framework applicable to adult safeguarding in the criminal justice system;
- examine criminal justice organisations' contribution to multi-agency collaboration and work in this area;
- review the existence and effectiveness of adult safeguarding policy, guidance and procedures in each of the criminal justice organisations;
- assess the processes within criminal justice organisations for identifying adult safeguarding concerns and making adult safeguarding referrals, including record keeping;
- examine mechanisms to ensure organisational learning arising from adult safeguarding referrals;
- examine adult safeguarding training and support available to staff working within criminal justice organisations;
- explore criminal justice organisations' readiness for the anticipated new adult protection legislation; and
- any other matters arising during the inspection, if considered appropriate by CJI.

Methodology

The inspection will be based on the CJI Inspection Framework. The three main elements of the inspection framework are:

- Strategy and governance;
- Delivery; and
- Outcomes.

Constants in each of the three framework elements and throughout each inspection are equality and fairness, together with standards and best practice. The CJI inspection methodology can be found in ***The Inspection Process*** on our website.

Design and Planning

Preliminary research

Data and initial information have been researched online to inform the scope of this inspection.

Contact with organisations

Terms of Reference will be shared with the Probation Board for Northern Ireland (PBNI), the PSNI, the Public Prosecution Service for Northern Ireland (PPS), the Northern Ireland Courts and Tribunals Service (NICTS), the Northern Ireland Prison Service (NIPS), the Youth Justice Agency (YJA), the DoJ and other organisations as appropriate. Liaison Officers from the relevant organisations should be nominated for the purposes of the inspection.

Policies and procedures, management information, minutes of meetings and related documentation from the organisations will be requested and examined.

Delivery

Stakeholder consultation

Stakeholder organisations from the voluntary and community sector and partner inspectorates as appropriate will be consulted and invited to meet with the Inspection Team as part of the inspection.

Self-assessment

The PBNI, PSNI, the PPS, the NICTS, the NIPS, the YJA will be asked to undertake a self-assessment which will be reviewed by CJI during the inspection. The DoJ may also be invited to provide documentation where applicable.

Development of fieldwork plan

Interviews and focus groups will be conducted with the named criminal justice organisations, and relevant stakeholders to give an insight into any issues affecting adult safeguarding arrangements within the criminal justice system. At this stage, a case file review of police investigations or prosecution files relating to criminal investigations and prosecutions is not anticipated. However, a sample of adult safeguarding referrals, including those considered by the PSNI Central Referral Unit,[15] may be reviewed to help in understanding the operation of criminal justice organisations' policies and procedures in practice.

Initial feedback to agency

On conclusion of the fieldwork the evidence will be collated, triangulated and analysed and emerging findings will be developed. CJI will then present the emerging findings to the inspected organisations.

Drafting of report

Following completion of the fieldwork and analysis of data, a draft report will be shared with the inspected bodies for factual accuracy check. The Chief Inspector will invite the inspected bodies to complete an action plan within six weeks to address the recommendations and if the plan has been agreed and is available it will be published as part of the final Inspection Report. The Inspection Report will be shared, under embargo, in advance of the publication date with the inspected bodies.

Publication and Closure

A report will be sent to the Minister of Justice for permission to publish. When permission is received the report will be finalised for publication. A press release will be drafted and shared with the inspected agencies prior to publication and release. A publication date will be agreed and the report will be issued.

Indicative Timetable

Scoping/Research:	December 2025
Stakeholder consultation:	January 2026
Agency fieldwork:	February to March 2026
Draft Report to agencies:	April - May 2026
Factual accuracy feedback received:	June 2026.

The above timetable may be impacted by factors outside CJI's control. The inspected organisations will be kept advised of any significant changes to the indicative timetable.

ENDNOTES

1 *The Department of Health and Department of Justice, Adult safeguarding prevention and protection in partnership, July 2015* available at ***https://www.health-ni.gov.uk/publications/adult-safeguarding-prevention-and-protection-partnership-key-documents***.

2 See *the Adult Support and Protection Act 2007* in Scotland; *the Care Act 2014 in England*; and *the Social Services and Well-being (Wales) Act 2014*. See also Professor Williams, J., *Adult Safeguarding Legislation in Northern Ireland, March 2020* available at ***https://copni.org/publications-research/reports***.

3 *Commissioner for Older People for Northern Ireland, Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home, June 2018;* see also *Commissioner for Older People in Northern Ireland, A Call for Adult Safeguarding Legislation June 2014,* available at ***https://copni.org/publications-research/reports***.

4 *A Review of leadership and Governance at Muckamore Abbey Hospital, The Muckamore Abbey Hospital Review Team 31 July 2020* available at ***https://www.health-ni.gov.uk/publications/review-leadership-governance-muckamore-abbey-hospital***. *Subsequently there was an Independent Inquiry to examine the issue of abuse of patients at Muckamore Abbey Hospital which had concluded oral evidence and closing statement sessions in March 2025. A report was subsequently published in June 2026 (see the Muckamore Abbey Hospital Inquiry website* available at ***https://www.mahinquiry.org.uk/***).

5 *Northern Ireland Assembly, Adult Protection Bill: Official Report of the Second Stage, 30 June 2025* available at ***https://aims.niassembly.gov.uk/officialreport/report.aspx?&eveDate=2025/06/30&docID=444644#5043518***.

6 For the range of CJI reports looking at domestic and sexual abuse see ***https://www.cjini.org/report-category/domestic-and-sexual-abuse/***.

7 *CJI, An inspection of the criminal justice system's response to vulnerable older people, September 2023* available at ***https://www.cjini.org/reports/an-inspection-of-the-criminal-justice-systems-approach-to-vulnerable-older-people-in-northern-ireland/***.

8 CJI reports related to Hate Crime see ***https://www.cjini.org/report-category/hate-crime/***.

9 *CJI, Modern Slavery and Human Trafficking: An Inspection of how the Criminal Justice System deals with Modern Slavery and Human Trafficking available at* ***https://www.cjini.org/report-category/modern-slavery-and-human-trafficking/***.

10 *CJI, Report of an Unannounced Inspection of Maghaberry prison 20 September – 6 October 2022, June 2023*, available at ***https://www.cjini.org/reports/report-on-an-unannounced-inspection-of-maghaberry-prison-2/***.

11 *CJI, Report of an Independent Review of Progress (IRP) at Maghaberry Prison 31 October – 2 November 2023, February 2024* available at ***https://www.cjini.org/reports/report-of-an-independent-review-of-progress-irp-at-maghaberry-prison/***.

12 *CJI, Report of an Unannounced Inspection of Hydebank Wood Secure College 21 May – 6 June 2024, November 2024,* available at ***https://www.cjini.org/reports/report-on-an-unannounced-inspection-of-hydebank-wood-secure-college/***.

13 *CJI, Report of an Unannounced Inspection of Hydebank Wood Women's Prison 21 May – 6 June 2024, November 2024* available at ***https://www.cjini.org/reports/report-on-an-unannounced-inspection-of-hydebank-wood-womens-prison/***.

14 *CJI, Adult Safeguarding: The approach of the criminal justice system to investigating and prosecuting crimes against vulnerable adults, September 2015*, available at ***https://cjini.org/wp-content/uploads/2025/05/Adult-Safeguarding-web-FINAL-02-09-15.pdf***.

15 The PSNI Central Referral Unit was part of the Public Protection Branch and received referrals in relation to child and adult safeguarding where a crime was alleged or suspected. Its role included assessing referrals according to the Joint Protocol for the Investigation of Adult Safeguarding Cases and deciding on the allocation of a report, incident or crime (see *PSNI Service Instruction SI2517: Adult Safeguarding*, available at ***https://www.psni.police.uk/about-us/our-policies-and-procedures/corporate-policy/service-instructions***).

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