

Adult Support and Protection (Scotland) Act 2007

Perth and Kinross Multi-Agency Guidelines



Adult Support and Protection

Perth & Kinross



Perth and Kinross
Health and Social
Care Partnership

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Document Version Control

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2	Guidance updated to take account of new legislation - Adult Support and Protection (Scotland) Act 2007 Title of document changed	September 2008
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7	<p><i>Update to:</i> <i>6.2 – ATLS and SPs to screen (with conditions)</i></p> <p><i>Added: Appendix 21 – Update on Screening AP Concerns and VPRs</i></p>	March 2022



1 Introduction

This Multi-Agency Operational Guidance represents the commitment of agencies in Perth and Kinross to:

- *unite in the prevention of and protection from harm, mistreatment and neglect of adults at risk aged 16 years and over;*
- *ensure situations of actual or suspected harm, exploitation, mistreatment and neglect are identified, recorded and investigated.*

All agencies have an essential role to play in ensuring that adults at risk are protected from harm, mistreatment or neglect. Agencies have a responsibility to assess the risk of harm, mistreatment or neglect, to work together alongside the adult at risk and his or her family members and care givers, to identify actual harm and reduce the risk of harm. To achieve this requires a clear understanding of the roles and responsibilities of the organisations and agencies involved directly and indirectly in caring for adults who may be at risk. Good communication, co-operation and liaison between agencies are essential, as are clear procedures which promote the interests of adults at risk, their families and caregivers.

This multi-agency guidance has been adopted by Perth & Kinross Council as the Council's Adult Support and Protection Operational Guidance.

This Guidance is designed to ensure that there is common practice across Tayside and is consistent with the ethos of the Tayside Protocol.

The Guidance will be reviewed on a regular basis.



Tayside Protocol

The Perth and Kinross Operational Guidance should be read in conjunction with the Tayside Protocol as information contained in it is not duplicated in local guidance.

Information that may be particularly relevant are:

- *Legislative framework;*
- *Harm – categories, signs, in what circumstances harm occurs, who causes harm and patterns of harm;*
- *Dilemmas in adult support and protection;*
- *Information sharing and confidentiality;*
- *Capacity and consent*
- *Assessment, risk assessment and risk management.*



2 Partners

The agencies that have been involved in the preparation of the Guidance are:

- *Perth & Kinross Health and Social Care Partnership*
- *Police Scotland*

Those involved have drawn on:

- *Adult Support and Protection (Scotland) Act 2007*
- *National ASP Code of Practice 2014*
- *Tayside Protocol 2015*

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3 Legislative Background

The Perth and Kinross Multi-Agency Operational Guidance:

- *confirms for staff what local action should be taken when harm, mistreatment or neglect is suspected or has taken place; and*
- *clarifies the roles and responsibilities of all those involved.*

The **Social Work (Scotland) Act 1968** and the NHS and **Adult social work and social care Act 1990** give legislative power to the local authority to become responsible, in collaboration with other agencies, for the assessment of the needs of an individual for whom the local authority is likely to provide an adult social work and social care service.

The Public Bodies (Joint Working) (Scotland) Act 2014 came into force on April 1, 2016. This provided the framework for the integration of health and social care services in Scotland.

The **Adults with Incapacity (Scotland) Act 2000** provides the means to protect those with incapacity, for example, through financial and welfare guardianship. **The Mental Health (Care and Treatment) (Scotland) Act 2003** sets out duties in relation to people with mental disorders who are subject to ill-treatment or neglect. These acts cover people whose disability or illness is adversely affecting their ability to protect themselves and who are subject to harm, exploitation or neglect.

The Vulnerable Witness (Scotland) Act 2004 makes provision for the use of special measures for the purpose of taking evidence from adults who are deemed to be vulnerable witnesses.



Forced Marriage etc (Protection and Jurisdiction) (Scotland) Act 2011

This Act was implemented on 28 November 2011. The Act makes provision for protecting people from being forced to enter into marriage, or who have been married, without their free and full consent. The provisions of the Act are relevant to those working with both children and adults.

The Act introduces a Forced Marriage Protection Order (FMPO), and the court must consider all of the circumstances of the case before granting an order, and must pay particular regard to the need to secure the health, safety and wellbeing of the protected person. The court must have regard to the wishes of the protected person when considering whether to grant an Order. An Order can contain any requirement that the Sheriff thinks appropriate.

The Social Care (Self-Directed Support) (Scotland) Act 2013

This establishes a duty on local authorities to provide adults, children and families with choice over their care and support arrangements through the general principles of involvement, informed choice, collaboration, participation and dignity.

The Scottish Government, local authorities and providers are committed to significant expansion of opportunities for adults to take greater control over their support, either through a direct payment, individual service fund (or similar 'notional budget' option), directly provided services or any combination of these.

Local authorities are subject to the same duties and powers under the 2007 Act where a person chooses to direct their support, or elects to ask the Council to arrange support on their behalf. The responsibility to assess risk, inquire, investigate or, where necessary, intervene to protect remains the same. The statutory guidance accompanying the 2013 Act includes a section on the development of links between adult protection and social care assessment arrangements. It reinforces the point that enablement through self-directed support rests on a return to the core principles of social care and social work practice. It emphasises the need to support adults to identify their personal outcomes as part of the assessment process and to decide how they wish to meet those outcomes. Effective self-directed support arrangements rest on good quality assessment, support, planning and review.



They depend on the individual and where appropriate, their circles of support and any children living in the household, being fully involved in identifying, assessing and managing risks. In some instances, the subsequent choices made by an individual may increase risk but by providing the individual with greater control over their support and supporting them to make informed choices regarding potential risk, an individual can also develop and improve their ability to protect themselves.

The Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016

Wilful Neglect and Ill Treatment (Part 3) was introduced on 1 October 2017. This Act introduces a new offence of wilful neglect or ill-treatment in Scotland for adults receiving health care or social care. This consists of two offences, one applying to care workers and the other applying to care providers.

A 'care worker' is defined as care workers (employees and volunteers), their managers and supervisors, and directors or similar officers of organisations and the offence is committed where a care worker is providing care for another person and ill-treats or wilfully neglects that person. A 'care provider' is defined as a body corporate, a partnership or an unincorporated association which provides or arranges for the provision of adult health or social care or an individual who provides that care and employs, or has otherwise made arrangements with, other persons to assist with the provision of that care. Care that is only incidental to the care worker's or provider's other activities would not fall within either of these definitions.



Duty of Candour (Part 2) was introduced on 1 April 2018

The overall purpose of the new duty is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm, as defined in the Act. This duty requires organisations to follow a duty of candour procedure which will include notifying the person affected, apologising and offering a meeting to give an account of what happened. The procedure will also require the organisation to review each incident and offer support to those affected (people who deliver and receive care).

3.1 Seven Elements of the Adult Support and Protection (Scotland) Act 2007

The Adult Support and Protection (Scotland) Act 2007 seeks to address the above issues through its seven key elements:

- *principles governing intervention in an adult's affairs,*
- *definitions of an 'adult at risk' and of 'harm,*
- *statutory duties on Councils to enquire and investigate,*
- *duty of co-operation,*
- *offences,*
- *Protection Orders*
- *duty to establish Adult Protection Committees.*

The local authority Adult Social Work and Social Care Services will be the lead agency, receiving the referral and determining the actions to be taken.

Details of offences (Section 49) and Adult Protection Committees (Section 42) can be found in the relevant section of the Act.



3.2 How does Part 1 of the Act Safeguard the Adult?

There are a number of safeguards in place:

- *The principles emphasise the importance of striking a balance between an individual's right to freedom of choice and the risk of harm to that individual. Any intervention must be reasonable and proportionate. It is recognised that, at times, there will be a need to carefully weigh and consider the various principles, particularly where the adult at risk does not wish support or they themselves are the source of the risk.*
- *Statements expressed in advance about an individual's preferred care or treatment must be taken into account in line with the guiding principles.*
- *The principles must always be taken into account when an intervention under Part 1 of the Act is being considered.*
- *Protection Orders cannot be made if the court knows that the affected adult at risk has refused to consent to the granting of such an Order. The only exception to this is where the adult at risk is found to have been unduly pressurised to refuse to consent and there is no other protective action, which the adult would consent to, which could be taken.*
- *The adult at risk may refuse to be medically examined or answer questions during an interview.*



- ❑ Applications for all Protection Orders (except in emergency situations in relation to Removal Orders) will be heard before a Sheriff, where there will be an opportunity to make representations to the Sheriff. However, the Sheriff may decide not to hold a hearing where they are satisfied that this will protect an adult at risk from serious harm or not prejudice any persons affected.
- ❑ The adult at risk or someone on their behalf may apply for a Banning Order to ban a person from a specified place (e.g., the home of the adult at risk).
- ❑ An appeals mechanism allows relevant parties to appeal against the granting of, or refusal to grant, a Banning or Temporary Banning Order

3.3 Principles Underpinning the Adult Support and Protection (Scotland) Act 2007 (Sections 1 & 2)

- *Intervention must benefit the adult.*
- *Actions should be supportive and least restrictive.*
- *Interventions must have regard to:*
 - ❖ *the wishes of the adult and relevant others;*
 - ❖ *providing information and support to enable the adult to participate in the process;*
 - ❖ *the adult's abilities, background and characteristics;*
 - ❖ *not treating the adult any less favourably than any other person in a comparable situation.*



The adult should participate as fully as possible in any decisions being made. It is therefore essential that the adult is also provided with information to help that participation (in a way that is most likely to be understood by the adult). Where the adult needs help to communicate (for example, translation services or signing) then these needs should be considered.

The principles for effective communication are:

- Principle 1** *Recognise that every community or group may include people with communication support needs.*
- Principle 2** *Find out what support is needed.*
- Principle 3** *Match the way you communicate to the ways people understand.*
- Principle 4** *Respond sensitively to all the ways an individual uses to express themselves.*
- Principle 5** *Give people the opportunity to communicate to the best of their abilities.*
- Principle 6** *Keep Trying.*

[www.rcslt.org/cq/live/resources a z/asp
toolkit/toolkit_development](http://www.rcslt.org/cq/live/resources/a_z.asp/toolkit/toolkit_development)

3.4 Definitions of 'Adult at Risk' (Section 3)

'Adults at Risk' are adults, aged 16 and over who:

- *are unable to safeguard their own wellbeing, property, rights or other interests;*
- *are at risk of harm; and*
- *because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.*



All three of the above aspects must be met in order for the person to qualify as an adult at risk.

The first element of the above three-point criteria relates to whether the adult is unable to safeguard their own wellbeing, property, rights and other interests. *'Unable'* is not further defined in the Act or Guidance, but is defined in the Oxford English Dictionary as “Lacking the skill, means or opportunity to do something”. A distinction should therefore be drawn between an adult who lacks these skills and is unable to safeguard themselves, and one who is deemed to have the skill, means or opportunity to keep themselves safe, but chooses not to do so. An inability to safeguard oneself is not the same as an adult not having capacity. An adult may be considered unwilling rather than unable to safeguard themselves and so may not be considered an adult at risk.

Problematic Alcohol and Drug Use

Similarly, vulnerability or a lack of ability to safeguard, which is due to temporary problematic alcohol or drug use, would not by itself result in an individual being considered an **'adult at risk'**. Adults have the right to make choices and decisions about their lives, including the use of alcohol and drugs, even if that means they choose to remain in situations or indulge in behaviour which others consider inappropriate. Without any additional vulnerability, such as an illness or disability, adult protection intervention would not normally be appropriate. Young people aged 16-18 can be particularly easily influenced and legislation places limits on children not in place for adults such as access to alcohol.

However, the ongoing problematic use of drugs or alcohol may take place alongside (and on occasions contribute to) a physical or mental illness, mental disorder or a condition such as alcohol-related brain damage. If this is the case an adult may be considered an **'adult at risk'**. It must be stressed, however, that it is the co-existing illness, disability or frailty, which would trigger adult protection considerations, rather than the substance use itself.



A number of diagnoses are problematic when alcohol or drug use are regular features of an adult's presentation, but in each case multi-agency inquiries should be made to gather as much information as possible about an adult's condition. In addition, because an adult's underlying condition may deteriorate with ongoing alcohol or drug use, inquiries should be made each time an adult protection referral is made, and no assumption should be made about the adult's condition on the information gathered during a previous inquiry.

Where an adult at risk declines to participate

An adult may appear to meet the criteria of an **'adult at risk'** under the terms of the Act, but indicates that he/ she does not want support and/or protection. In effect the adult refuses to co-operate with inquiries being undertaken. Such a refusal to co-operate does not absolve the Council and its partners of responsibilities to make inquiries about the adult's circumstances and the degree of risk. Also, any inquiries should consider the adult's capacity to understand the risks they are exposed to and the possible consequences of their refusal to cooperate; **'undue pressure'** might have contributed to their decision to refuse co-operation. Even if there are no concerns in relation to incapacity or undue pressure, the adult's refusal to co-operate in an adult protection inquiry should not automatically signal the end of any inquiry, assessment or intervention. **Assessment of capacity does not negate duty of care.** Whilst the adult has a right not to engage in any such process, the Council and its partners should still work together to offer any advice, assistance and support to help manage any identified significant risks. It is recognised the success of any intervention where an adult does not wish to co-operate may, by its nature, be limited in scope and effectiveness. Any assistance should be proportionate to the risk identified and any need to support carers' needs should be considered.



3.5 Definitions of ‘Harm’ (Section 53)

‘Harm’ includes all harmful conduct and, in particular, includes:

- *conduct which causes physical harm;*
- *conduct which causes psychological harm (e.g. by causing fear, alarm or distress);*
- *unlawful conduct which appropriates or adversely affects property, rights or interests (e.g. theft, fraud, embezzlement or extortion);*
- *conduct which causes self-harm.*

While not specified in the Act, harm would normally be categorised to include physical, sexual, financial and psychological harm and neglect.

3.6 Self Harm

The National Institute for Clinical Excellence (NICE) defines self-harm as “**self-poisoning or injury, irrespective of the apparent purpose of the act**”. The Scottish Government Report ‘**Towards a Mentally Flourishing Scotland 2009**’ describes self-harm as a response to underlying emotional and psychological distress which can include feeling isolated, having a poor body image, economic or academic pressures, powerlessness and abuse or trauma.

Self-harm can include physical self-injury such as cutting, burning, scalding, head banging, hair pulling, biting and swallowing objects. It also includes self-poisoning through the deliberate ingestion of medicines or toxic substances.

Self-harm can also be considered in a social rather than medical context to include self-harm through refusal to take food or water, or self-harm through misuse of alcohol or drugs both illegal and prescribed.

Evidence suggests that younger people are more likely to engage in acts of self-harm than adults and that experience of a severe life event such as bereavement, ending of relationships, trauma, depression and anxiety are likely triggers for self-harming behaviour



While some people who self-harm may be subject to adult support and protection procedures, there will be some who do not meet the criteria and will be subject to different legislation.

For further information on the Tayside Multi-Agency Guidance supporting children and young people at risk of self-harm and suicide, go to the following weblink:

[www.pkc.gov.uk/media/19224/Supporting_Children_and_Young_People_at_risk_of_Self_Harm_and_Suicide_Booklet/pdf/Supporting_Children_and_Young_People_at_risk_of_Self_Harm_and_Suicide_Booklet](http://www.pkc.gov.uk/media/19224/Supporting_Children_and_Young_People_at_risk_of_Self_Harm_and_Suicide_Booklet.pdf)

For Self-Neglect – see Appendix 5.

3.7 Threshold of Harm

When agencies come into contact with adults who have suffered or likely to suffer from harm, there is a duty to report concerns.

If a person is harmed, disadvantaged or suffers from detriment from the wilful or unintentional behaviour of another or themselves, this should be regarded as having met the threshold.

This may be from physical, sexual, emotional or financial harm or neglect. Harm can arise as a result of one incident or a series of incidents or cumulative concerns over a period of time. The level of risk should be subject to continual review.

3.8 Young People in Transition

The definition of an adult at risk includes people aged 16 and over with disabilities and/or mental disorders, illness, or physical or mental infirmity and who are at risk of harm from themselves or others. Adult Protection practitioners should pay particular attention to the needs and risks experienced by young people in transition from youth to



adulthood, who are more vulnerable to harm than others. As other legislation and provisions exist which include persons up to 18 (and sometimes up to age 25), support under these other provisions may be more appropriate for some young persons. Further the responsibilities of the Council and other agencies for persons aged 16-18 will extend beyond adult protection legislation.

Young people may already be receiving services from a range of children's services, or as 'looked after' children. This is not to say that they will or will not become 'adults at risk' in terms of the act simply because they have reached a particular age. Each case will need to be considered individually.

Part 4 of The Children and Young Persons (Scotland) Act 2014 may impact on adult protection processes for young people when fully implemented.



4 Step-by-Step Guide

Steps 1-5 cover the likely actions to be taken by staff from any agency that have concerns about the welfare of an adult at risk. Steps 6-10 cover the actions to be taken after a referral has been made to the Perth & Kinross Council Adult Social Work and Social Care services.

Step 1

Concerns or initial referral about an adult at risk

1.1 Person Responsible

The staff member who witnesses, suspects or receives information about an adult at risk being subject to harm, mistreatment or neglect.

1.2 Action to be Taken

- *If the person requires urgent medical attention, go to Step 3.*
- *If the person does not require immediate medical attention and you suspect or have witnessed harm, mistreatment or neglect, speak to the person about your concerns. Ask the person what has happened (including whether it has happened before), who was involved, what the person thinks about the situation and what they want done about it. Also try to ascertain any potential risks to others.*
- *If the person chooses to disclose a previous incident to you, you must listen to what they have to say and obtain all the relevant information. It is important that sufficient information is obtained to allow your line manager to assess the situation without the need to re-interview the person.*



- *Record your conversation carefully and, if possible, ask the person to agree that you have made an accurate record of the conversation. Record the person's actual words in relation to their description of the event and their feelings about the outcome. Include the date and the time that the record was made.*
- *Tell the person that you are going to report the details of your conversation to your line manager. Go to Step 4.*
- *If the person does not give consent to your proposed actions, go to Step 2.*



Step 2

When an adult at risk does not give consent to action to being taken

2.1 People Responsible

Staff member and line manager

2.2 Action to be Taken

If the adult at risk does not want any action taken, his or her wishes should be respected unless any of the following applies:

- *it is not clear if the person has capacity;*
- *he or she or others are at risk;*
- *it appears likely that a criminal offence has been committed;*
- *it is a requirement of legislation;*
- *there are public health concerns;*

If there is a child at risk, contact should be made with the Child Protection Team in accordance with Inter-Agency Child Protection Guidelines.

If the person is a resident of a care home or a patient in a hospital, it is important that any suspected or actual incidents of harm, mistreatment or neglect are reported in order to protect other residents or patients regardless of the adult at risk's wishes. In these circumstances, it must be explained to the person that the referral has to be passed to the Adult Social Work and Social Care Service.



Step 3

When immediate medical assistance or Police involvement is needed

3.1 Person Responsible

Staff member

3.2 Action to be Taken

- *Contact the appropriate emergency service particularly if an adult at risk appears to be in immediate need of medical attention or if there is evidence of physical or sexual harm. Uncertainty about consent and capacity should not prevent the provision of urgent medical assistance.*
- *Inform the Police if a crime has or may have been committed.*
- *Staff must be aware of the need to preserve evidence.*
- *All action taken must be recorded and discussed with a line manager or an alternative manager. Go to Step 4.*
- *Staff members should not put themselves at risk.*



Step 4

Consultation with a Manager

4.1 People Responsible

Staff member and line manager

4.2 Action to be Taken

The staff member will discuss the suspected or actual harm, mistreatment or neglect with the line manager as soon as possible. If the line manager is not available, the staff member will discuss the concerns with a suitable alternative manager. The full facts and circumstances of the situation together with all available options and courses of action should be identified and discussed.

If this incident concerns any client in a registered care setting who is subject to harmful conduct by another client, visitor to a care setting or staff, it must be reported to the Council. The Council will make enquiries to decide if and what further action needs to be taken. A Plan of Action should be the outcome of this meeting. The following points, amongst others, should be considered:

- *an immediate referral to the Adult Social Work and Social Care Service;*
- *the person's level of capacity and consequent involvement in actions, choices and decisions;*
- *if the staff member's organisation is external to Perth & Kinross Council, contact should be made with the Adult Social Work and Social Care Service Access Team so that the concern can be discussed, and appropriate action taken;*
- *if the concern raised is from another service within Perth & Kinross Council, staff should report to the line manager, who should discuss the concerns with the Adult Social Work and Social Care Service Team.*



Step 5

Referral to the local authority Adult Social Work and Social Care Service

5.1 Person Responsible

The staff member making the referral.

5.2 Action to be Taken

The staff member making the referral to the Adult Social Work and Social Care Service should include all the relevant details relating to the case:

- *name, address, date of birth, ethnic origin, gender, religion, type of accommodation, family circumstances, support networks, physical health, any communication difficulties, mental health and any associated statutory orders, or whatever information is available;*
- *the staff member's job title and the reason for their involvement;*
- *the nature and the substance of the allegation or concern;*
- *details of any care givers and/or significant others;*
- *details of the alleged perpetrator, where appropriate, and his or her current whereabouts and likely movements over the next 24 hours, if known;*
- *details of any specific incidents (e.g. dates, times, injuries, witnesses, evidence (such as bruising));*



- *background relating to any previous concerns;*
- *any information given to the person, their expectations and wishes, if known;*
- *a record must be kept of all actions taken and decisions made.*



Step 6

Receiving a referral into the local authority Adult Social Work and Social Care Service

Adult Protection referrals must take priority over all other work. Referrals must be the subject of an immediate assessment.

The circumstances, in which the duty to make inquiries arises, vary. Concern that a person may be an *'adult at risk'* can arise in relation to new referrals, reports or allegations including anonymous referrals, about a person who is not currently known to Adult Social Work and Social Care Service. A person who is a current service user may, because of an incident or a change in circumstances, become an *'adult at risk'* when previously they were not.

By whatever means we come to know or believe that a person is an adult at risk, the statutory duty to make inquiries applies. The duty to inquire arises whether or not the adult is aware that concerns have been raised, and is not contingent on the adult consenting to a referral.

6.1 People Responsible

The staff member receiving the referral and the Team Leader.

6.2 Action to be Taken

The staff member receiving the referral should ensure that the details in Step 5 are covered. The staff member should discuss the situation with the Team Leader or with a suitable alternative manager as soon as possible that day.

All adult concern reports should be screened as adult protection referrals and the Team Leader must evidence that the screening process has taken place within 24 hours. Please note, ATLS and senior practitioners are able to screen adult protection referrals under certain conditions (see Appendix 21 for those conditions).

The Team Leader has discretion not to proceed with the adult protection process for the referrals who obviously do not meet the criteria of adult at risk or if the person is able to safeguard themselves, for example:



- *information provided that clearly shows that appropriate steps have been taken and supports are in place. Adult self-harming but Police have contacted health personnel, GP and specialist services, arranged follow-up and have social support. Adult aware and compliant with actions to be taken. Links to the Tayside guidance for supporting young people at risk of self-harm and suicide can be found on the PKC webpage on adult protection*
- *adult who was preparing tea and has burnt his food. Coped with smoke and Fire Brigade but report submitted because of physical disability;*
- *domestic incident that has been resolved.*

Other referrals are to be subject to inquiry under the Adult Support and Protection legislation.

Inquiry

In general, after notification of an adult protection concern, there is an initial information gathering phase by the Council Officer/Council nominee which may involve a visit, assessment of possible risks and will indicate the likelihood of harm being perpetrated or if there are unexplained/complex issues that need to be further explored. This will either proceed to an investigation, be dealt with using other legislation or not require any further action

If the case is open to a worker in another team, the referral is forwarded to the Adult Social Work and Social Care Team Leader who will change the contact outcome reason dependent upon their screening.



If the case is not known the Team Leader of the Adult Social Work and Social Care Service Access Team will process.

The Team Leader must put a contact on IT system explaining the decision-making around the screening and initial risk assessment of the referral information and stating when contact will be made and by whom.

The Team Leader will allocate the case within 24 hours based on known information and complexity. If information is collected under Sections 4-6 of the Act, the case can be allocated to staff member TAS Level 6 but any action involving Section 7 or above must be allocated to a Council Officer.

The Team Leader must allocate the case to a Council Officer (SW) with at least twelve months' experience and relevant training. The Team Leader should take into account the current workers who are involved, if any.

The Council Officer (SW) who starts working with the adult at risk should be able to continue to do so during the investigation, protection and care planning stages. The adult at risk should be allocated within 24 hours or one working day.

Legal status sent to Admin for recording.

The IT system must be checked to ascertain if the person or the alleged perpetrator is known to Adult Social Work and Social Care Service. If known to Public Protection Team the Key Worker should be notified to ensure that any appropriate statutory measures are taken. If the alleged perpetrator is under 16 years of age or a vulnerable adult, Children's Services or the appropriate locality team should be contacted to check if a worker is to be allocated to the alleged perpetrator in his or her own right. If the alleged perpetrator is another service user, their Key Worker should be notified.



At the initial information gathering stage, relevant agencies (including the person's GP) should be contacted for more information. Police Scotland should be contacted to ascertain if the person is known to the Police and to decide if a joint visit is appropriate.

If during the course of an inquiry, information is obtained that the alleged perpetrator of harm is a person employed by a statutory, private or voluntary care agency, information should be shared with the line manager of that organisation in order that appropriate risk assessment can be undertaken, and management plan put in place.

If the staff member is a victim of harm, confidentiality should be maintained, and information should not be shared with the employing agency.

If there is a child in the household or involved who may be at risk, the child protection team must be informed within 24 hours.

Sufficient information must be gathered to establish whether the person referred meets the criteria for an '*adult at risk*' (defined in 3.4 previously) and that the circumstances constitute '*harm*' (defined in 3.5 previously). This may include a visit. Frontline staff must present areas of concern to the Team Leader based on evidence gathered and professional judgement.

The Team Leader is the Lead Officer responsible for the inquiry/investigation and will direct and co-ordinate any actions necessary to protect the adult at risk and to support and advise the member of staff. In cases where the adult at risk has a mental disorder or if the alleged perpetrator is a welfare or financial guardian, it may be appropriate to involve a Mental Health Officer (MHO).

Strategic discussions will take place and will be documented in profile notes using strategic discussion code in relation to case discussions, decisions made, reasons for decisions and naming individuals responsible.



There will be at least one strategic discussion with the Locality manager prior to moving forward to an Adult Protection Case Conference.

If a network/planning meeting is required in more complex cases, the initial inquiry/investigation form must be completed and a positive risk taking form if required.

A network meeting may be convened if a person is not deemed to be an adult at risk but there are risks highlighted or there have been 3 or more adult concerns notified and the person is not engaging with services.

Adult Protection Inquiries are recorded using the Adult Protection Inquiry form which standardises practice and will give sufficient information to justify further action/no further action. An ASP inquiry should be completed within 10 working days.

This is recorded on the Adult Protection Inquiry form which should be fully completed online including positive risk assessment if relevant. The text from Police Vulnerable Person report should not be cut and pasted to the Adult Protection form. The Adult Protection form is forwarded to Team Leader for verification and signature prior to passing to Locality Manager.



Network Meeting

Inter-agency meeting held when there is uncertainty about whether circumstances require intervention though Adult Support and Protection. The purpose of the meeting is sharing information and developing a joint approach to proceeding with the intervention/support in an appropriate way under relevant legislation. Clients/carers will not be invited to this meeting. If it is agreed that the person is not an adult at risk and does not wish intervention, it may be appropriate to take no further action. This meeting will be chaired by the Locality Manager/Team Leader depending on available information, complexities of case and level of risk.

The meeting will be minuted with an agreed action plan in most cases indicating joint responsibility and accountability.

If proceeding to investigation, worker must send Adult Protection Hazard Alert Activation Request for adult at risk by email to IT system helpdesk.

Investigation

Following initial information gathering, if the adult is an adult at risk an adult protection investigation will be initiated. This is a multidisciplinary process led by the Council Officer in which all aspects of the situation are examined and reported on using the Adult Protection Investigation form. This may culminate in an Adult Protection Case Conference. Where there is a need to use any powers under the Act, this would be regarded as an investigation.

An ASP investigation must be completed within 20 working days.

Any allegation concerning a member of staff must be reported to the appropriate Line Manager.



Establish:

- (a) whether any action is needed immediately (e.g. does the adult at risk need to be removed to a place of safety and/or require medical assessment or attention?) or;*
- (b) whether immediate action would cause more distress or would pose a greater risk.*

Consideration must be given to the mental capacity of the adult at risk. The Act covers adults with incapacity but there may be a need to clarify capacity and to decide measures to be taken.

Visits will be arranged depending on the situation:

- critical - visit the same day;*
- urgent - visit within 48 hours;*
- non-urgent - visit within two weeks at the discretion of the manager*

The Team Leader should allocate a second worker to support the Council Officer (SW) on the visit if required. The roles of the first and second workers should be discussed and ascertained prior to the visit taking place.

There should be a discussion about whether a referral to or a consultation with another agency or agencies is appropriate (see Appendix 7 for referral to the Police).

On completion of inquiry/investigation, the Council Officer should inform referee of outcome.



Step 7

Assessment and decision-making

7.1 People Responsible

The allocated Social Worker, the Team Leader and the Locality Manager.

7.2 Action to be Take

-  *The Council Officer (SW) should undertake an investigation including an assessment of risk. This should involve staff from other agencies, as appropriate, in the gathering of information. Certain public bodies have a duty to co-operate under Section 5 of the Act. The investigation should take account of any previous concerns or reports about, or incidents involving, the adult at risk. Prior to the interview, consideration should be given to ensuring a safe interviewing environment; the use of communication aids and the use of an interpreter or of a support person (see Appendix 8). The person's living arrangements should be seen.*
-  *The visit will be made to the adult at risk to ascertain his or her views about the situation and to determine the level of risk. Advocacy should be offered to the adult at risk if progressing to an investigation under the Act. Carer should also be offered advocacy if relevant regardless of whether alleged perpetrator or not.*



- *The Team Leader should ensure that the Social Worker has the support he or she requires during the investigation process. Supervision will be ongoing throughout the investigation and decisions will be clearly documented and attributed. Consider if any information obtained in the referral or during the course of the investigation should be communicated to the Police.*
- *If the adult at risk of harm is under the guardianship of the Chief Social Work officer, the Social Worker to whom the Guardianship duties have been delegated can carry out the investigation if they were not involved in the incident.*

7.3 If Access is Gained

- *The Council Officer (SW) should interview the adult at risk and any other adult present, as appropriate. The adult at risk should be assisted to participate as fully as possible in the proceedings. He or she must be informed before the interview that they are not required to answer any questions (Section 8).*
- *The Council Officer (SW) should conduct the interview and the support worker should take detailed notes. Both workers should observe the reactions of the adult at risk and the dynamics of personal relationships. They should assess the environment. Depending on the circumstances, it may be appropriate to view the sleeping arrangements. It may be appropriate to consider advocacy and to discuss this with the adult at risk.*



- *The Council Officer (SW) should complete the Inquiry/Investigation form which will include some professional analysis of the information gained in the process of the investigation.*
- *There will be ongoing discussions with the Team Leader and with the Locality Manager, as appropriate. This should be documented as strategic discussion on IT system. The issues that are likely to be considered will be:*
 - *adherence to the principles of the Act;*
 - *if intervention is necessary;*
 - *if an MHO is required, especially if alleged perpetrator is welfare attorney or guardian;*
 - *if the Police should be consulted (see Appendix 7);*
 - *other relevant legislation;*
 - *level of risk;*
 - *duty to consider advocacy and other services;*
 - *workers' safety;*
 - *need for a Case Conference;*
 - *any undue pressure (see Appendix 13);*
 - *need for medical examinations (see Appendix 9);*
 - *need to access records (see Appendix 10);*
 - *Protection Orders (see Appendix 17).*
- *If alleged perpetrator is known to agencies, e.g. another resident in a care setting, the named worker must be informed so that risks can be assessed, and a risk management plan is put in place. This also applies when another local authority is funding the placement*



- *The Locality manager will decide whether an Adult Protection Case Conference should be convened. Consideration should always be given to holding an Adult Protection Case Conference, particularly in situations where there is actual harm, or the threat or opportunity of ongoing harm. This also applies where the individual concerned has little or no insight into the risk to which he or she may be placing him or herself or, indeed, others. The Case Conference should be held within ten days of the investigation being completed.*
- *The Locality manager may make a decision not to hold a conference when sufficient information is available to indicate that there is no risk to the adult. He or she should record why this decision has been made.*
- *When making a decision about whether or not to hold a conference, the Locality manager must take account of any previous referrals and/or concerns about the welfare of the adult at risk. If more than two previous notifications of harm have been received which have resulted in no conference being held, the Locality manager should give full consideration to now holding a Protection Case Conference to allow agencies to come together to share information and concerns*



- *The alleged perpetrator should be informed of the allegations and that the Council has and will retain personal information on him or her except in the following circumstances:*

- ◆ *where to disclose to the alleged perpetrator may put the client or any other person at risk;*
- ◆ *where to disclose to the alleged perpetrator would be likely to jeopardise the prevention or detection of a crime.*

If either of these exceptions apply, it must be recorded in profile notes.

7.4 If Access is Not Gained

- *The Council Officer (SW) should discuss other options for entry with the Team Leader, e.g., through contacting relatives or other professionals.*

If these other options are not successful, a warrant for entry, under Section 37 of the Act, should be considered.

- *Consideration should be given as to whether access can be gained under other legislation, e.g., Mental Health (Care and Treatment) (Scotland) Act 2003.*
- *If all options have been considered and have been exhausted, Legal Services should be contacted to discuss an application for a Protection Order. Applications will be made by Legal Services on the basis of the information that has already been gathered.*

If any proposed action limits a person's ability for free movement, the following action should be considered and documented.



Restriction or Deprivation of Liberty

Scottish law and practice in relation to the care and treatment of people with mental health issues and learning disabilities respects their right to liberty and security under Article 5 of the European Convention of Human Rights (ECHR) and Article 5 of the Human Rights Act 1998.

When someone with a mental illness (including dementia) or learning disability may require care in conditions which amount to deprivation or restriction of liberty it is important to ensure that human rights are respected. It generally deals with people unable to consent to care arrangements, but can apply to people who can take their own decisions.

Where the proposed action will result in a restriction or deprivation of liberty, staff should ensure that:

- *action is necessary;*
- *action is proportionate to risk identified;*
- *there is a legal basis that enables the action proposed;*
- *mental capacity assessment;*
- *best interests assessment, which determines if a restriction or deprivation of liberty is in the person's best interests in order to keep the person from harm and is a reasonable response to the likelihood of the person suffering harm and the likely seriousness of that harm.*



Step 8

Adult Protection Case Conference

8.1 Person Responsible

Locality Manager

8.2 Purpose

A Case Conference is a multi-disciplinary meeting, chaired by a Locality Manager, at which information relevant to concerns about harm or risk of harm is shared and considered. The meeting assesses risk, makes decisions on the actions which will need to be taken, and, where appropriate, agrees an Adult Protection Plan or reviews a plan that is already in place. The plan will include details of who will do what and when.

Adult Protection Case Conference

A multi-disciplinary meeting of relevant people including the adult at risk and carer, and sometimes the alleged perpetrator at which all information about all aspects of the situation will be shared with a focus on the likelihood of recurrence of incidents of harm and prevention leading to an Adult Protection Plan. The investigation report will be made available to the meeting and will be presented by the Council Officer. An adult protection plan will be devised indicating joint responsibility and accountability. The reporting questionnaire will be completed at the end of the meeting and Council Officers should have relevant data to hand although the discussion of the meeting will have a bearing on what is recorded. Consideration should be given to whether attendees retain a copy of the investigation report. A review date will be set within a period of 3 months.



8.3 Status

There are no statutory provisions relating to Case Conferences. However, all research points to the importance of good communication and information sharing when dealing with an adult at risk investigation.

8.4 When

An initial Adult Protection Conference should be held within ten working days of the completion of an investigation by Adult Social Work and Social Care Services.

8.5 Adult Protection Plan

The Adult Protection Plan will be based on the discussion and decisions made at the Adult Protection Case Conference. The plan should cover:

- *arrangements and supports in place;*
- *people's respective roles in the Adult Protection Plan;*
- *Nominate responsible worker as single point of contact;*
- *there should be regular visits to the adult at risk unless otherwise agreed and minuted;*
- *support for the client, e.g. victim support, advocacy;*
- *if no existing chronology, consideration should be given to including this work in the protection plan;*
- *any legal steps to be taken to protect the adult.*



8.6 Contingency Plan

Arrangements for immediate action for possible change in circumstances to be agreed.

For further information about organising, chairing and conducting Adult Protection Case Conferences, see Appendix 14.



Step 9

Implementation of Adult Protection Plan

9.1 People Responsible

Team Leader

9.2 Action to be Taken

- *The Team Leader will monitor implementation of the Protection Plan to ensure that actions are carried out within timescales.*
- *The Team Leader will ensure that ongoing risk assessment will be carried out to take account of changing circumstances and needs.*



Step 10

Adult Protection Case Conference Review

10.1 Person Responsible

Locality Manager

Adult Protection Case Conference Review

Following the Adult Protection Case Conference the review will follow the same format and will take place within 3 months. The meeting will assess the impact and effectiveness of the Adult Protection Plan and decide if further action is required. The updated risk assessment and report will be made available to the meeting and will be presented by the Council Officer. The reporting questionnaire will be completed at the end of every review meeting and Council Officers should have relevant data to hand although the discussion of the meeting will have a bearing on what is recorded.

10.2 Action to be Taken

Adult Protection Case Conference Reviews should take place within 3 months or more frequently if required.

An updated report with risk assessment should be completed prior to review by Social Worker.

The Review will consider the changes that have been made and will re-assess the level of risk for the adult at risk.

If there is still significant risks the case will be monitored by the responsible council officer and regular Adult Protection Reviews.

If the risks are low the case does not need to remain under adult protection procedures.



5 Assuring the Quality of Work with Adults at Risk

It is important that all agencies working with adults at risk assure the quality of the work undertaken by their agency and jointly with others. All agencies will use this multi-agency operational guidance to set standards and to monitor the quality and effectiveness of work undertaken to protect adults at risk.

5.1 Person Responsible

Locality Manager

5.2 Action to be Taken

- *The Senior Managers should ensure that no open case which includes allegations of harm to an adult at risk is closed until the following steps have been taken:*
 - *the adult at risk has been spoken to alone;*
 - *the adult at risk's accommodation has been seen;*
 - *the views of relevant professionals have been sought and considered;*
 - *there is evidence that the adult at risk's welfare will be safeguarded and promoted should the case be closed;*
 - *the adult at risk and all other interested parties are aware of how to re-refer if necessary*
 - *the case file is up-to-date and complete and it includes a closure summary that outlines why no further intervention is required.*



- 5.3** The Senior Manager should ensure that when a professional from another agency expresses concern about how the Senior Manager's agency is handling a case, the Senior Manager reviews the file, meets and speaks to the professional concerned, and records in the case file the outcome of the discussion.
- 5.4** The Senior Manager should ensure that all Case Conferences, reviews, meetings and discussions concerning the adult at risk should involve the following basic steps:

- *a list of action points must be drawn up, each with an agreed timescale and the identity of the person responsible;*
- *a clear record of the discussion must be circulated to all those invited, whether or not they were present, and to all those with responsibility for an action point;*
- *a mechanism for reviewing the completion of the agreed actions must be specified, together with the date upon which the first such review is to take place;*
- *the setting out of any supplementary actions that may be required as a contingency in the event of a breakdown in care arrangements or other changes in circumstances.*

5.5 Performance Management

The Adult Protection Committee will develop, maintain and review a framework for the inspection of case files, records (including supervision notes), and Case Conference minutes. The framework should also include audits of practice, supervision and monitoring of performance information.



6 If the Adult at Risk Moves to Another Area During the Inquiry

Action should be taken to establish the whereabouts of the adult at risk. The local authority where the adult now resides should be given information about the concerns and what action has been taken. An agreement should be reached between Perth & Kinross Council and that local authority about any future action and roles and responsibilities. This may include convening or attending an Adult Protection Case Conference.

7 If the Alleged Perpetrator Moves

The Police should be informed if an alleged perpetrator moves. If their whereabouts are known, the local authority where they now reside must be informed so that appropriate decision-making can be made regarding any required action in relation to risk to adults, children and the community.



8 Support to Staff

The demands of working with adult protection cases must be acknowledged.

Supervision and support should be provided to staff members by the Team Leader and Service Manager.

Action to protect staff in performing their duties could include joint visits with Police or other colleagues.

Safety issues throughout investigation and monitoring period should constantly be under consideration.

During the process of investigation, the manager may need to debrief staff, clarify levels of responsibility and offer advice and assistance on procedures and recording.

In cases where issues have been raised in relation to practice, a Significant Event Analysis should be considered to allow for review, analysis, reflection and to assimilate knowledge to improve future practice.



9 Action to be Taken if a Person in Receipt of Adult Social Work and Social Care Services is an Alleged Perpetrator

An allegation of harm that has been perpetrated by someone who is themselves a person in receipt of Adult Social Work and Social Care services would result in an adult protection inquiry if the person allegedly harmed is an adult at risk.

The Team Leader should consider allocating a separate Social Worker for the alleged perpetrator if required. If the alleged perpetrator has dementia, consideration should be given to having a mental health nurse as second worker. Specific decisions that need to be made by the Team Leader are:

- *how the action will be co-ordinated;*
- *identifying who will be involved in the investigation.*

If a person in receipt of Adult Social Work and Social Care services is identified as a potential perpetrator, this should be stated as part of their care plan to ensure safe delivery of care. This should include:

- *a contingency plan if appropriate;*
- *monitoring and reviewing arrangements;*
- *if alleged perpetrator is known to agencies, e.g. another resident in a care setting, the named worker must be informed so that risks can be assessed, and a risk management plan is put in place. This also applies when another local authority is funding the placement.*

All relevant professionals, family members and carers should be involved in the arrangements.



Appendix 1

Harm in Various Settings

Harm in a Regulated Care Setting

The Council has been given powers and duties in relation to adult protection concerns but managers of care services have a responsibility to ensure that care provided within their setting meet national care standards and the requirements of national care contracts.

The responsibility for informing the Care Inspectorate of any adult protection concern lies with the registered service but Council staff should ascertain whether this has been done.

The actions below are in addition to the normal adult protection process.

Issues of concern may arise because of the behaviour between one client to another, behaviour of visitors to the care setting to a client, behaviour of staff to a client, or a culture of poor practice due to systemic issues related to management processes and style.

If any client in a registered care setting is subject to harmful conduct by another client, visitor to a care setting or staff, it must be reported to the Council. The Council will make inquiries to decide if and what further action needs to be taken. If more than 2 clients are involved, the Large-Scale Investigation procedure is to be used.

This may be due to widespread issues where it is not possible to identify an individual staff member as it relates to systematic failures, e.g. neglect, moving and handling issues, lack of staff training.

Harm Within Perth & Kinross Council Establishments

An appropriate inquiry will be undertaken by the Council Officer who will discuss findings with the Service Manager and a decision will be taken whether to proceed with an adult protection investigation according to operational guidance. The usual parameters about involvement/discussion with Police will apply.

Consideration will be given to the immediate safety of the client and the suspension of staff where necessary. The Care Inspectorate will be informed by the Unit Manager/Home Care Manager.

Depending on the outcome of the investigation, appropriate disciplinary procedures will be implemented. All disciplinary action required will remain the responsibility of the employing agency.

Where systemic and cultural issues have been identified as contributing to the harm, an action plan will be put in place and monitored by the Service Manager until there is evidence of improved practice.

Contract & Monitoring Officer will be informed. Staff will record any concerns on the profile note in IT system organisational record.

Harm Within External Agencies including Private and Voluntary Care Settings

When information is reported to the Council, a discussion will take place between the appropriate Council Team Leader and the referrer where appropriate.

If the referral has been received from the Care Inspectorate, a discussion will take place on how to proceed in relation to the responsibilities of each organisation.



If the referral has been received from the care setting, a discussion with the manager will consider the immediate safety of the client, they will be advised to contact the Care Inspectorate and informed of likely interventions by the Council.

The Council Team Leader will inform their Service Manager (strategic discussion) of the adult protection concern and the usual parameters about involvement/discussion with Police will apply.

It may be necessary to discuss with Head of Service if admissions/referrals to care setting require to be suspended and whether this is to be notified nationally. Care Home Owner/Organisation should be kept fully informed of all actions taken.

Other Councils who have placed clients in the care setting will be notified of the situation. Investigation would be initiated where necessary.

As part of the investigation, discussion will take place with the manager of the care setting about implementation of the HR procedures if staff are implicated in allegation(s).

Where systemic and cultural issues have been identified as contributing to the harm, an action plan will be put in place and monitored by the Care Inspectorate/Service Manager until there is evidence of improved practice. Council should consider if all clients using the service require to have their care plan reviewed. When practice reflects satisfactory standards, moratorium on admissions should be lifted.

Contract & Monitoring Officer will be informed. Staff will record any concerns on the profile note in the IT record.

Harm Within NHS Settings

When information is reported to the Council, a discussion will take place between the appropriate Council Team Leader and the referrer where appropriate.

When the referral has been received from the NHS setting, a discussion with the manager will consider the immediate safety of the person and others in the same setting.

The Council Team Leader will inform their Service Manager (strategic discussion) of the adult protection concern and the usual parameters about involvement/discussion with Police will apply.

As part of the investigation, discussion will take place with the NHS manager about implementation of the HR procedures if staff are implicated in allegation(s).

A copy of the report/findings should be forwarded to:

- *Senior Charge Nurse/Ward Manager/Head of Nursing*
- *Director of Nursing, NHS Tayside*
- *Medical Director, NHS Tayside*
- *NHS Lead for ASP*

If the inquiry shows poor culture of care involving people with mental illness, the MWC should be informed.

For wider concerns out with the mental health setting, Health Improvement Scotland and the Care Inspectorate.



Appendix 2

Identification of Concerning Behaviour

Behaviour Causing Concern Guidance

When there is a group of people sharing the same accommodation with differing needs and illnesses, there is a potential for incidents between residents. This may occur for many reasons and can include residents who have cognitive impairments. This does not negate the duty to report as they have the potential to cause harm to another person.

The impact on the person can range from low to high.

Early identification and action is essential to ensure client safety and reduce chance of re-occurrence. It is important that a reporting structure is in place, so all the relevant agencies have the right information. However agencies must also take responsibility for risk assessment and risk management within their premises and early identification of possible issues and taking action can mitigate future harm. The use of the ABC (Antecedents, Behaviour and Consequences) chart can be helpful in identifying triggers, time of day, other residents involved etc.

In relation to adult protection concerns, Social Work/Social Care and the Care Inspectorate need to be informed after initial risk assessment that shows the impact on the adult at risk is medium or high. Consideration should be given to contacting GP if medical assessment is required or the Care Home Liaison team.

If impact on the client is low, the agency should ascertain if an action plan is needed to reduce risk of re-occurrence and ensure there is monitoring in place.

The following should be reported:

- *Any assaults between residents (unless robust risk management plan and reporting threshold agreed).*
- *ALL hospital admissions as result of harm perpetrated.*
- *Any altercation between residents where there are concerns or harm to other residents due to the behaviour of a resident.*
- *Obvious injury - cut, bruise, fracture, any blow to the head, falls as a result of harm.*
- *Ongoing incidents/continuously being targeted even if low impact outcome.*
- *Money taken off client.*
- *Bullying/threatening behaviour.*
- *Inappropriate intimate behaviour.*
- *Resident leaving premises - not sanctioned.*

If you are unsure if an incident meets the criteria for adult protection please contact your local Access Team on **0345 301120** to discuss.



Behaviour Causing Concern Flowchart



ABC CHART (ADAPTED FROM JAMES 2011)

Patients Name

Distressed Behaviour

2. Date & Time

3. Where was the distress observed?

4. Who was there at the time?

5. What was going on for the person prior to the incident (A— antecedent)

6. What did you observe the person do? (B — actual behaviour)

7. Record what the person said during the incident?

8. What made the situation better? (C - consequences)

9. What emotion were they expressing before the incident?

- | | | | |
|------------|---|-------------------|---|
| Angry | — | Frustrated | — |
| Anxious | — | Happy | — |
| Bored | — | Irritable | — |
| Content | — | Physically Unwell | — |
| Depressed | — | Restless | — |
| Despairing | — | Sad | — |
| Frightened | — | Worried | — |

10. What emotion were they expressing during the incident?

- | | | | |
|------------|---|-------------------|---|
| Angry | — | Frustrated | — |
| Anxious | — | Happy | — |
| Bored | — | Irritable | — |
| Content | — | Physically Unwell | — |
| Depressed | — | Restless | — |
| Despairing | — | Sad | — |
| Frightened | — | Worried | — |



Care Home Liaison Team Referral Form

NHS

Tayside

CARE HOME LIAISON TEAM REFERRAL FORM

Residents Name _____ DOB: _____

Care Home _____ GP Name/ Practice _____

Residents Previous Address _____

Routine referral _____

Urgent referral

There has been a *rapid* change in the patient's behaviour

There has been a *gradual* change in the patient's behaviour

THINK DELIRIUM

- **Delirium** - Dipstick urine, check temperature and bloods e.g. F8C, U&E, LFT, TFT, ESR, CRP, Glucose,
- **Dehydration** — check above blood levels; especially U&E. Commence on fluid balance chart
- **Medication**—side effects? Has a new medicine been started?
- **Medication withdrawals** — e.g., benzodiazepines, opiates
- Hypoxia — cyanosis, laboured breathing pre-existing conditions e.g. COPD

Refer to GP ASAP

Exclude Physical causes

- **Pain** — complete appropriate pain assessment tool e.g., Abbey Scale
- **Hunger** — monitor and complete fluid and diet charts
- **Constipation** — monitor bowel habits
- **Tiredness** — chart sleep pattern
- **Sensory Impairment** — sight & for hearing deficit - refer to sensory impairment service for assessment and advice (where applicable)

Carry out recommended action(s) then refer to GP/appropriate services if no improvement in the patient's condition

Exclude Environmental and other causes

- **Staff** - consider approach, verbal and/or non-verbal communication, adequate numbers of staff.
- **Inflexible routines** — e.g. toileting, bathing, bedtimes
- **Task orientated care** - Lack of person-centred care not knowing the person
- **Client group** - Do other residents trigger behaviours?
- **Continuity of staff** - Therapeutic relationships Team continuity
- **Noise levels** - Over stimulation/elevated noise levels can be antagonistic
- **Lack of social stimulation**
- **Inappropriate music** — ensure appropriate to the client group
- **Environment/layout** Is it conducive to the specific client group? Is there adequate wayfinding / signage to promote orientation

Liaise with manager to resolve issues; seek advice from Care Home Liaison Nurse if required



All residents' presentations **should be discussed with their GP** prior to referral —
Please include a note of recommended treatments/ investigations and the results if possible.

Have environmental factors, staffing and unit routines been discussed with manager.
Please indicate issues discussed and changes implemented.

For behavioural issues, please complete ABC charts for 1 week prior to referral and continue with these until seen by Care Home Liaison Nurse

Reasons for referral — Please include techniques tried to improve the situation.

Please tick this box to confirm that consent for this referral has been obtained from the patient or their Power of Attorney/
Guardian

Completed by	Name (Print)	Date
	Signed	

Please return completed forms to Medical Records Department
Murray Royal Hospital
Muirhall Rd
Perth
PH2 7BH



Appendix 3

Multi-Agency Chronologies



**POLICE
SCOTLAND**

Document Version Control

Version Number	Version Information	Date	Approved By
1	Multi-Agency Chronologies	January 2014	APC & Sub-Groups
2	Information checked	December 2015	APC
3	Information checked & updated Appendices updated Logo changed	June 2018	APC & Sub-Group



1 Introduction

This paper has been produced to provide guidance on the use of chronologies to practitioners and professionals involved or working with people over the age of 16.

2 Policy Documents

Care Inspectorate - Practice Guide to Chronologies

Social Work Inspection Agency (SWIA) Practice Guide - Chronologies: Improving Practice in Scotland, January 2010

Tayside Practitioner Guidance: Chronologies

3 Definition

A list in date order of all the major changes and events in a person's life.

4 Purpose

The key purpose of a single agency chronology is to provide an easily accessible summary of information.

An integrated chronology will be used when two or more agencies are involved and there are concerns relating to risk, complexity of cases and long-term ongoing multi-agency involvement.

When compiling a multi-agency chronology in cases where risks are high, it is recommended that a network meeting is convened for agencies to share relevant information and agree the chronology.

5 Nine Key Characteristics

(a) Tools in assessment and practice

- *Identifying and recording key events.*
- *Must be accurate and in date order.*
- *Takes account of effect on person.*
- *Entry should be succinct - if every contact is recorded, it dilutes value.*

(b) Not an assessment but part of an assessment

- *Professionals must state why they attach significance to some issues and not others.*
- *Chronologies are a key part of assessing and managing risk.*

(c) Working tool that promotes engagement with people who use services

- *Can be a valuable tool but can be time-consuming.*
- *Not useful if not analysed.*
- *Should be shared and discussed with person for accuracy.*

(d) Based on up-to-date, accurate case recording

- *Must distinguish between fact and opinion/impression.*
- *Contents of chronology are linked to assessment and may change as knowledge or identification of risk changes.*



(e) Should contain sufficient detail but not substitute for case recording

- *If staff are concerned about a person they can tend to record everything.*
- *Can become repeats of case files - too long and detailed.*
- *Can be arduous to complete and once completed, can't see the wood for the trees.*
- *Less is best.*

(f) Should be flexible

- *What event re significant and in what circumstances.*
- *Working tool, not an end to itself.*
- *As needs become more complex, vulnerability can increase, and everyday events can carry more significance.*

(g) The importance of review and analysis

- *A chronology that is not reviewed is of limited significance.*
- *Supervision can be an opportunity to review.*
- *Peer support - ask peer to read your chronology and comment on patterns, timescale and risks.*

(h) Different types of chronologies are needed for different reasons

- *Current can help manage risks.*
- *Retrospective - can help make sense of what happened in the past and if it could have been prevented.*

(i) Single agency and multi-agency chronologies set different demands and expectations

- *Single agency - brief description and summarised account of events in date order.*
- *Integrated - part of multi-agency intervention, has to be relevant and proportionate to support that intervention.*
- *Multi-agency - protection or serious wellbeing concerns, high risk situations - needs a lead professional.*

6 Starting and Maintaining a Chronology

Entries in the chronology should be in neutral language suitable for professionals and the individual to read and should contain factual information with sources clearly identified. All agencies must maintain records on their involvement.

The minimum standard of chronology recording requires information to be clear, concise and sufficient to enable analysis and assessment of risk. It is important that source of information is noted.

Adult Social Work and Social Care will maintain a single agency chronology for every open case.

Chronology is an ongoing process. If an event occurs on an open case it should be recorded.

Events that should be recorded:

- *Subject to any legislation and dates - ASP, MH, AWI*
- *Granting of legal powers - attorneys, guardianship*



- *Event/trauma relating to health or lifestyle that has had an ongoing impact on the individual*
- *Admissions to care/respite/hospital*
- *Engagement/non-engagement with service provision*
- *Diagnosis of physical and mental illness*
- *Police vulnerable person reports*

NHS staff will create and maintain a single agency chronology for patients who meet the following criteria:

- *Severe and enduring mental illness on caseload of CMHT*
- *Mental health/emergency in-patient admissions*
- *Major health events*
- *Trauma (e.g. self-harm, suicide attempts)*
- *Risks (to self or others)*
- *Vulnerability*
- *Detention under the Mental Health Act*
- *On Care Programme Approach*

- *Subject to AWI and/or ASP processes.*
- *Children issues/children on child protection register*
- *Family issues*
- *Personal issues*
- *Deaths of relevant others*
- *Criminality*
- *Referral to other services*
- *Financial issues*
- *Allergies diagnosed*

Police will initiate a single agency chronology in relation to:

- *criminality;*
- *adult and child concern reports;*
- *relevant intelligence.*

Retrospective +/- or inter-agency chronologies can be done in cases where there is:

- *concern about safety/protection;*
- *serious wellbeing concern;*
- *cases where there is an identified high or unacceptable level of risk.*

The length of time of retrospective chronologies will depend on individual cases and in agreement with Line Managers.

If background information shows the involvement of other agencies, it will be appropriate to contact them for information that is relevant to the chronological history, e.g. Fire Service, Ambulance, GPs, housing.

All agencies have a responsibility to create and maintain single agency chronologies where appropriate, to participate in creating a multi-agency chronology to facilitate fast efficient multi-agency response when an adult is at risk of harm.



7 NHS Sample Single Agency Chronology - Miss X, NHS

Date	Incident/Event	Action Taken
May 2013	Moved from staffed residential unit to own tenancy in 2003.	
June 2016	Admitted to Day Hospital for further assessment and medication review. Continues with weekly CLDN contact.	Monitored by nursing staff.
Sept 2016	Increase in calls to CLDN re agitation and anxiety. Began calling NHS 24 re physical complaints.	Emergency clinic appointment with Psychiatrist. Attended PRI and as required anti-psychotic administered.
Oct 10 th 2016	Phone call to Police complaining of an alleged incident (sexual).	Referred to Victim Support and Police continue to liaise with LD team.
Oct 11 th 2016	Phone call to CLDN increased hallucinations and paranoid thoughts.	
Oct 12 th 2016	Visit from Victim Support. Increased calls to GP and Psychiatrist.	Medication being reviewed.
Oct 13 th 2016	Adult Care Social Work team involved re Adult Protection issue.	ASP Inquiry
Oct 14 th 2016	Panic alarms installed in house.	
Oct 18 th 2016	Discharged from Day Hospital at own request.	Victim Support still involved.
Oct 20 th 2016	Phone call stating she had self-harmed and threatening further harm.	Support offered to attend A&E but refused to attend. Psychiatrist informed.
Oct 31 st 2016	Increase in calls and voicemail messages with increased paranoid ideation.	
Nov 4 th 2016	Contacted Police re items missing from house.	Police visited.
Nov 2016	Increased calls to Police, NHS 24, CLDN and GP.	
Nov 24 th 2016	Advised by medical staff of admission to Murray Royal Hospital via GP.	Awaiting bed at LDAU Carseview.
Nov 28 th 2016	Discharged from MRH.	
Dec 6 th 2016	Social Work and MHO assessment commenced.	
Dec 2016	Further increase in calls to services.	
Dec 12 th 2016	Visited by Community Mental Health nurse (Out of Hours).	
Dec 15 th 2016	Call from neighbour concerned re behaviours.	
Dec 16 th 2016	Case Conference held.	Consistent plan in place over all services.
Dec 20 th 2016	Re-admitted to MRH.	
Jan 2017	Detained under Mental Health Act.	Transferred to LDAU Carseview.



Date	Incident/Event	Action Taken
Jan 2017	MHO involved detention has now lapsed.	
Feb 20 th 2017	Discharged to home.	Continued CLDN involvement.
Mar-July 2017	Increased calls to Police, NHS 24, CLDN and CMHT (Community Mental Health Team).	Anti-psychotic medication increased.
July 20 th 2017	Arrived at MRH accompanied by Police. Whilst undergoing assessment staff member was assaulted and client absconded. Police involved in search.	Bed obtained at hospital. CLDN - emergency visit.
Sept 2017	Day passes arranged for home visits.	Discharge plan being discussed.
Sept 2016 - Mar 2017	Mental Health continues to deteriorate.	Trials of other anti-psychotic meds.
Mar 2017 - Present day	Mental Health deteriorated to point where it was necessary to detain Miss X under Mental Health Act.	

8 Local Authority: Mandy Smith - Chronological History, DOB: 11/6/90

Date	Referral Source	Concern Raised	Action Taken
23.10.15	Self	Allegation of rape by mother's partner.	Police interview - she denied rape allegation.
10.12.15	Self	Male student sent indecent photos.	Refused to make complaint to Police.
4.1.16	Self	Rang OOH - met male who took her to B&B for sex.	Incident unfounded.
24.1.16	Self	Allegation of sexual assault.	Police investigation NFA.
22.3.16	Self	Assault by family friend.	Police investigation NFA.
8.8.16	Self	Drinking heavily and taking drugs. Boyfriend violent towards her.	Broken up with boyfriend.
21.8.16	Self	Fallen out with mother who hit her and staying with friend in Perth.	AP Inquiry - claims were unsubstantiated.
17.9.16	Self	Mandy taking drugs influenced by friends.	ASP Inquiry - no evidence of drug taking.
19.9.16	Self	Sister had stolen her laptop.	Said later sister had borrowed it.
16.11.16	Self	Rape allegation while under influence of alcohol.	Police investigation NFA.
12.12.16	Self	Taken tablets as struggling and fell out with family.	Taken to PRI.
24.12.16	Social Worker	Various reports of self-harm.	Appointment with Dr.
14.1.17	Care Worker	Disclosed she was considering suicide on Perth Bridge.	Phoned a friend and changed her mind.



Date	Referral Source	Concern Raised	Action Taken
23.1.17	Self	Threatening phone call re smashing her windows.	Reported to Police.
6.2.17	Family	Allegation got into car with man she did not know, asked a friend to buy drugs and attacked a man.	AP Inquiry - none of these allegations substantiated.
28.2.17	Mother	Being threatened by former friends.	AP Inquiry - advice on how to respond.
19.3.17	Self	Disclosed feelings of suicide.	Referred to Dr.
28.3.17	Social Worker	APCC held.	Refer to psychology.
4.4.17	Care Agency	Expressing suicidal ideation.	Follow up by OOH.
28.4.17	Self	Concerns over financial abuse as application for loan received.	Home visit to discuss.
6.5.17	Social worker	Review APCC held - finances, depression & family issues.	DWP appointee-ship to continue, referred to Psychology.
10.5.17	Self	Alleged sister assaulted her.	Refused to make complaint to Police.
22.5.17	Self	Contact Police to report neighbour entered her house due to dispute re noise level.	Police spoke to neighbour.
13.6.17	Self	Suicide ideation.	Attend Psychology & advice on keeping safe.
16.6.17	Self	2 friends stolen money from her.	Report to Police & advice on keeping safe.
15.8.17		Review APCC held	Ongoing monitoring - not ASP.
18.9.17	Self	Allegation of being chatted up and touched inappropriately.	Removed herself from situation.
16.10.17	Police VPR	Contacted Police as 2 ex-friends tried to visit her.	Advice on keeping safe NFA.
21.10.17	Self	Assaulted by female.	Police contacted. Sought medical attention.
23.10.17	Self	Withdrew allegations of assault amid claims she was pressured into doing so by Police.	Welfare visit to check.
27.10.17	Police VPR	Detailed alleged assault and noting "changed her version of events several times".	NFA.
21.11.17	Self	Complaint ex-friend abusive to her on Facebook.	Police - she also abusive to person on Facebook.
28.11.17	Police VPR	Complaints ex-friends threatening her	No evidence
2.2.18	Worker	Discussed at multi-agency meeting	Referral made to South CCIG



Date	Referral Source	Concern Raised	Action Taken
26.2.18	Worker	Discusses at CCIG.	Befriending service, woman's group & work experience.
6.3.18	Police TC to OOH/Agency	Self-disclosure that male held her down and forced her to take tablets.	ASP Inquiry.
16.4.18	Worker	Capacity assessment by Dr.	Has capacity to make informed decisions.



Appendix 4

Large-Scale Investigation Protocol



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Document Version Control

Version Number	Version Information	Date	Approved By
1	Large-Scale Inquiry	2010	APC & Sub-Groups
2	Large-Scale Inquiry updated	April 2013	APC & Sub-Groups
3	Large-Scale Investigation updated and changed	January 2014	APC & Sub-Group
4	Legislation and action for offence of Willful Neglect and Ill Treatment Processes updated in relation to communication, documentation and timescales. LSI audit and survey feedback included in relation to protection plans and partnership working.	December 2017	APC & Sub-Group



Definition of a Large-Scale Investigation

A Large-Scale Investigation is a multi-agency response to circumstances where there may be two or more adults at risk of harm within a care setting (this may be either residential care, day care, home-based care or a healthcare setting).

Purpose

The purpose of this protocol is to:

- ensure that Large-Scale Investigations are carried out consistently by relevant agencies;
- offer a framework for an alternative process to holding large numbers of individual Adult Support and Protection investigations and ensure that there is adequate overview/co-ordination where a number of agencies have key roles to play;
- clarify responsibilities for following the protocol amongst partner agencies for overseeing Large-Scale Investigations in Tayside.

Scope

All adults at risk of harm, as defined by the Adult Support and Protection (Scotland) Act 2007, in regulated care settings within Tayside.

Legislation

- Adult Support and Protection (Scotland) Act 2007 and Code of Practice 2014
- Adults with Incapacity (Scotland) Act 2000
- The Social Work (Scotland) Act 1968, Section 12, Section 6
- Human Rights Legislation
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Regulation of Care (Scotland) Act 2001
- Criminal Law
- Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 - Part 3
- Wilful Neglect and Ill Treatment Offence

Relevant Agencies

- Perth & Kinross Council
- Health and Social Care Partnership
- Police Scotland

- The Care Inspectorate
- Health Improvement Scotland



1 Introduction

The Adult Support & Protection (Scotland) Act 2007 (The Act) introduces a duty for Councils to make inquiries where it is known or believed that an adult may be an adult at risk of harm and that protective action may be required. The Act gives the Council the lead role in adult protection investigations in all settings, including in NHS and care home premises.

This protocol adheres to the Tayside protocol which has been agreed by Angus Council, Perth & Kinross Council, Dundee City Council, NHS Tayside, the Police and the Care Inspectorate who will be the key agencies involved.

A large-scale adult protection investigation would be required in a situation where a number of adults at risk have or may have been harmed:

- *in a care home, hospital or receiving a service from a particular resource;*
- *and the same perpetrator is suspected; or*
- *a group of perpetrators are suspected;*
- *where the nature or degree of harm or neglect raises questions about the standard of care and the possibility of multiple victims.*

Such situations will involve a wide range of agencies and possibly a number of individual adult protection inquiries and investigations. It is important that all aspects of the investigation are planned, and all agencies and individual professionals are clear about their respective roles and responsibilities.

2 Receiving a Referral

Concerns about an adult at risk of being harmed in a care setting or resource can be raised from many sources including:

- *family/friends making a complaint about standards of care;*
- *whistle-blowing within an organisation;*
- *Procurator fiscal investigating a death;*
- *service user's admission to hospital;*
- *concerns highlighted via regulatory process;*
- *the Care Inspectorate;*
- *visiting Professionals.*

In receiving information about individual cases of suspected and actual harm in a care setting, it is important to consider possibilities that other adults may be at risk. Data checks should be made, and consultation held with other agencies. It is important to consider whether other service users may have been harmed and whether previous concerns have been raised.

If there have been more than 3 separate incidents in a 3 month period, consideration should be given to convening a network meeting.

3 Initial Inquiries

When a report is received about an "adult at risk" within a care setting the Team Leader should have a strategic discussion with the Service Manager immediately. This should consider whether there may be other adults at risk of harm. If this is the case a Large-Scale Investigation should be recommended and in these circumstances, this protocol must be followed. At onset of Investigation a note must be sent to Head of Service and ASP Co-ordinator to inform them of pending inquiry and the concerns raised. If there are concerns raised that have not resulted in harm but need to be addressed, the Care Inspectorate and the Contracts & Monitoring Team should lead on an action plan.

The Team Leader and Service Manager should agree an initial action plan that day or within 24 hours. The Team Leader will contact the Police and Care Inspectorate to inform them of the case and discuss if they have a role in the initial action.



3.1 Strategic Meeting - Team Leader and Service Manager

If there is evidence that allegations relate to lack of appropriate care from care organisations that might warrant a Large-Scale Investigation, the Team Leader will consult with the Service Manager, Social Work & Social Care or Community Safety. If the suspected harm is in an NHS setting then the manager of P&K CHP/NHS Tayside should also be consulted.

The meeting should:

- 1 consider whether any immediate protective action is required should individuals be at risk of imminent harm;
- 2 consider the need for any individual ASP Case Conferences which need to be undertaken for adults considered to be at particular risk. If individual adult protection case conferences are convened separately, then normal adult protection operational procedures will be followed;
- 3 review the circumstances and make a decision as to whether a Large-Scale Investigation should be initiated under Adult Support and Protection Guidelines, and/or pursued through the Care Inspectorate existing regulatory role and/or through criminal investigation;
- 4 Team Leader will consult with the relevant manager of the care home/care setting/service under investigation. It is important that there is a joint understanding of the issues raised and the proposed action. It is important that issues and actions are taken forward in partnership. This may include considerations of Human Resource actions such as suspension or re-deployment of staff in line with employing agency policy;
- 5 consider making a report to the Police if an offence appears to have been committed (including ill treatment and neglect under the Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016) if they are not already involved;
- 6 consider information provided by the Care Inspectorate which will include all previous concerns/reports and complaints received by them;
- 7 Head of Nursing, NHS should be informed of any LSI that involves nursing issues and if it is relevant that a NHS staff member can undertake the role of the second worker. Depending on the issues raised it may be appropriate to notify head of pharmacy NHS (medication errors) and head of Care Home Liaison team if clients with dementia are affected;
- 8 identify key tasks to be undertaken; the persons who will undertake these tasks; and agreed timescales for completion. This will include any immediate protective measures for individuals (where not already addressed). This action plan is recorded on the protection plan under the AIS assessment tab;
- 9 discuss any staffing/resource issues to proceed with the investigation that cannot immediately be resolved should be discussed with the Service Manager, Social Work & Social Care;
- 10 agree questionnaire template and recording form needed, e.g. Large-Scale Investigation Form;
- 11 considerations should be given as to whether the concerns are serious enough to suspend admissions pending improvements in the service/care setting or resolution of an emergency situation. The Head of Service, Social Work & Social Care and general manager of Health and Social Care must be fully consulted and informed. Should such a decision be made other Scottish local authorities should be informed;
- 12 inform Contract Compliance Officer:
 - Consider whether a media strategy is required.
 - Agree a timescale for completion of investigation which should be within 28 days.



Where the concerns relate to criminal activity (or possible criminal activity) the meeting will need to ensure that:

- any agreed action plan focuses on the immediate protective measures required; but that
- the action plan will otherwise be primarily informed by the requirements of the Police to conduct a criminal investigation in liaison with the Procurator Fiscal. This may impact on timescales.

This discussion must be recorded on the IT system under strategic discussion. No part of investigative duties can be delegated to the organisation under investigation.

4 Investigation

- 1 Urgent specialist assessments should be sought where necessary to assess the needs and delivery of practice to an individual/s. This may be in areas such as moving and handling, nutrition and medication management.

The information from the specialist assessments will be used to inform the investigation and to ensure the immediate restoration of an acceptable level of service to the adult(s) at risk.

- 2 Identify if any of the adults at risk are funded by other local authorities and when they should be informed of the inquiry. The authority in which the adult resides will be responsible for investigating the concerns, but the placing authority will be informed of/involved in the protection plan and will be responsible for informing relatives and relevant others.
- 3 There is a duty under the Act to consider the importance of independent advocacy and other services. Service users, or their primary carer/nearest relative, should be given information about independent advocacy in all cases and assistance should be offered to access independent advocacy. If the service user lacks capacity or has limited capacity, consideration should be given to non-instructive advocacy.
- 4 Once assessments/reviews have been undertaken by the appropriate professionals and any immediate risks have been addressed, then outstanding concerns should be discussed with the lead Council officer.
- 5 On completion of all inquiries the Council officers will summarise the information on the large-scale inquiry form and forward to Team Leader for discussion.

5 Next Steps

Once the investigation has been completed, the Team Leader will have a discussion with the Service Manager and decide if an initial LSI meeting is required. If the decision is not to proceed to an initial LSI meeting, it should be recorded as a strategic discussion and the reason why this decision has been taken, e.g. no other adult at risk identified. The Large-Scale Inquiry form is signed by both Team Leader and Service Manager and forwarded to Adult Support & Protection Co-ordinator and Head of Service, Social Work & Social Care. The manager of the organisation is informed of the outcome, reasons why and any actions to be taken forward.

5.1 Initial LSI Meeting

An initial LSI meeting will be arranged by the Service Manager/Team Leader who will identify the key professionals who are required to attend. This should occur within 10 working days.

This may include:

- Care Inspectorate

- Police

- NHS

- Contracts Compliance Officer

- Manager of organisation

- Council officers

- Specialist assessors



A copy of the LSI report **MUST** be circulated to all parties attending at least 24 hours prior to the meeting. See template (see Appendix 1).

The purpose of this meeting is to discuss the findings of the investigation and make decisions about actions required to ensure the support and protection of adults at risk in the care setting under investigation.

- 1 The lead Council officer will present the investigation report to the review meeting and the conclusions and recommendations contained therein.
- 2 The representative of the Care Inspectorate will present any findings from any parallel investigation of the service involved in the investigation, where applicable.
- 3 While it may not be possible to divulge the detail of any Police investigation, any information out with this requirement which supports decision-making to protect adults at risk should be shared by the Police.
- 4 Consider the ongoing management of the service involved. If risks remain, an action plan to address these concerns and monitoring arrangements will be agreed. This is inputted on the plan under the AIS assessment tab and updated when actions have been completed.
- 5 If the ASP process is ongoing and concerns remain, a LSI review meeting must be held to ensure progress is being made.
- 6 Consideration should be given as to whether the outstanding concerns raised by the investigation(s) are serious enough to suspend admissions pending improvements in the service/care setting or resolution of an emergency situation. Consideration should be given whether other local authorities should be informed of concerns in this care setting.
- 7 Agree how information should be disseminated to service users and families.
- 8 Agree how public relations and media considerations will be managed across and within agencies.
- 9 Meeting should be minuted and the action plan circulated to all participants. This plan should provide the basis for subsequent monitoring. It should be clear if the ASP process is ongoing or ceased.

5.2 Review LSI Meeting

A review meeting must be held within 3 months of initial meeting or more often if required to ensure progress is being made.

- 1 An updated protection/improvement plan is presented by the keyworker outlining progress made and issues still outstanding or any new issues identified.
- 2 If progress is not improving consideration should be given to the ill treatment and wilful neglect offence. Legal staff should be involved in this discussion.
- 3 Decide if there is a need for another meeting and ongoing monitoring.
- 4 Decide if there needs to be ongoing ASP processes.
- 5 If no longer need for ASP process.

5.3 Completion of ASP Process

- 1 It must be recorded on the minute if there is no longer any need for the ASP process.
- 2 Head of Service, Social Work & Social Care will be informed of outcome.
- 3 Independent Chair of Adult Protection Committee is advised where appropriate.
- 4 Other LA to be informed if letters/moratoriums sent at beginning of process to inform of outcome of LSI.



6 Media Strategy

- 6.1** *Where any media interest is likely, the chair of the group and the appropriate communication officers from the relevant agencies should agree a joint media strategy. The Executive Director of Housing & Environment, Head of Service, Social Work & Social Care and senior managers will need to be appraised and may decide to direct/ manage this process.*
- 6.2** *The Service Manager Social Work & Social Care should consider the need to inform the chair of the Perth & Kinross Adult Protection Committee of any Large-Scale Investigations.*

7 Closure

- 7.1** *The Service Manager should ensure that those invited to the network meeting, the senior and local manager of the organisation (if the investigation concerned a registered service), Care Inspectorate and the Police are advised of the outcome in writing by sending the minutes that clearly document that ASP is no longer required.*



Large-Scale Investigation Form

Date	
Name of Organisation	
Manager of Organisation	

Adults Who May Be At Risk of Harm

Name	ID Number

Involvements

Agency	Name	Designation
Perth & Kinross Council		Council Officer
Perth & Kinross Council		Team Leader
Perth & Kinross Council		Service Manager
Care Inspectorate		
Police		
Contracts Compliance Officer		

Presenting Concern

Outline referral and concerns raised



Structure of Large-Scale Investigation*Outline how LSI to be conducted, include which staff involved, who to be interviewed, agreed questions***Other Professionals Involved/Consulted****Outcome of Investigation***Main concerns identified/themes***Assessment of Risk****Recommendations***List areas that need to be addressed in Improvement Plan***Any Other Areas/Information/Comments**

Network meeting required?	Yes/No
---------------------------	--------

Date of network meeting	
-------------------------	--

Meeting not required?	Yes/No
-----------------------	--------

Reason	
--------	--

Action plan completed?	Yes/No
------------------------	--------

Date	
------	--

Responsible person	
--------------------	--

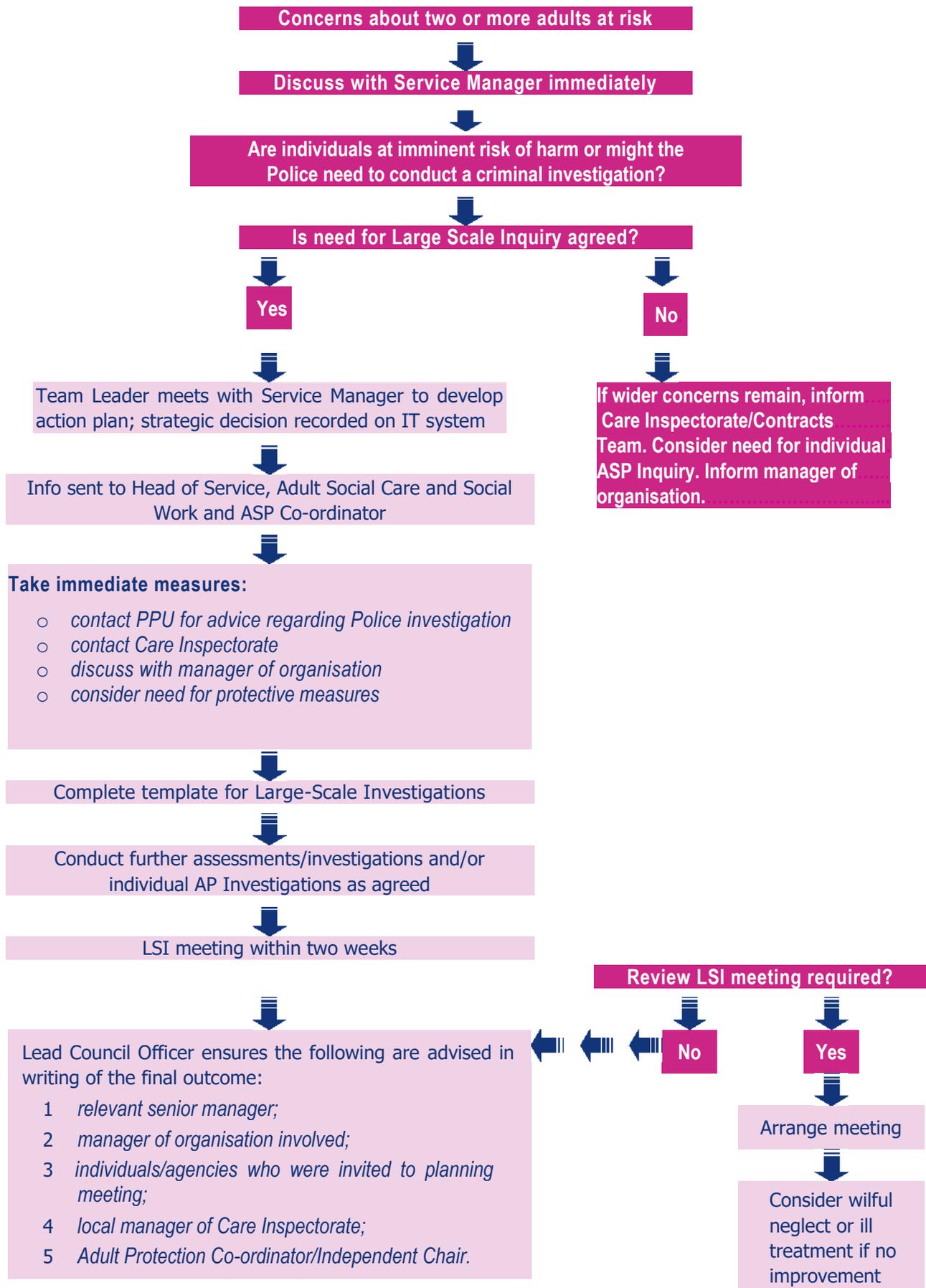
Social Worker signature _____ Date _____

Team Leader signature _____ Date _____

Service Manager signature _____ Date _____

Forward completed form to Head of Service and Adult Support & Protection Co-ordinator.

Flowchart Depicting Large-Scale Investigation Under Adult Support and Protection Guidelines



Appendix 5

Self-Neglect and Hoarding



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Document Version Control

Version Number	Version Information	Date	Approved By
1	Self-Neglect	June 2015	APC & Sub-Groups
2	More information added re hoarding and non-engagement	November 2016	APC & Sub-Groups



Self-Neglect

Self-neglect differs from the other forms of harm as it does not involve a perpetrator. Self-neglect is included in the Adult Support and Protection (Scotland) Act 2007 which places a statutory duty to make inquiries if it is suspected that someone may be at risk of harm.

1 What is Self-Neglect?

Self-Neglect is the inability (intentional or unintentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and wellbeing of the individual and potentially to their community.

Extreme self-neglect can be known as **Diogenes syndrome**. Diogenes syndrome is a disorder characterised by extreme self-neglect, domestic squalor, social withdrawal, apathy, compulsive hoarding of garbage, and lack of shame. Sufferers may also display symptoms of catatonia.

An individual may be considered as self-neglecting and therefore maybe at risk of harm when they are:

- *either unable, or unwilling to provide adequate care for themselves;*
- *unable to obtain necessary care to meet their needs;*
- *unable to make reasonable or informed decisions because of their state of mental health, or because they have a learning disability or acquired a brain injury;*
- *refusing essential support without which their health and safety needs cannot be met, and the individual does not have the insight to recognise this.*

2 Causation/Associated Factors

There is recognition that self-neglect can have complex causes and manifestations.

It is seen as predominantly occurring in older people, but it may be that older age represents a time when behaviours that earlier had been functional have now become dysfunctional as individuals become less able to manage their consequences.

There is no clear causation, but associated factors include:

- *diminished social networks;*
- *poor physical health;*
- *poor mental health;*
- *impaired physical functioning;*
- *impaired cognitive functioning;*
- *lack of access to social or health services;*
- *the economic resources available;*
- *living in grossly unsanitary conditions;*
- *suffering from malnutrition to such an extent that, without intervention, the adult's physical or mental health is likely to be severely impaired.*

3 Perception of People Who Self-Neglect

Research (Braye, Orr, Preston-Shoot 2011) show emerging themes of people who self-neglect which are:

- *pride in self-sufficiency*
- *sense of connectedness to place and possessions;*
- *exhibit behaviour that attempts to preserve the continuity of identity and control.*



4 Professional Response

Professional responses are challenging as there is no certainty in research of the understanding how the range of factors involved might lead to particular behaviours or be amendable to intervention.

Professional response can be based on varying factors:

- *differentiation between the inability to care for oneself and the perceived capacity to understand the consequences of one's action;*
- *professional tolerance is higher when seen as a lifestyle choice rather than arising from physical and mental health impairment;*
- *mental competence in that people are unwilling to meet basic daily living needs;*
- *executive dysfunction which is:*
 - ◆ *the inability to perform activities of daily living even though the need for them may be understood;*
 - ◆ *not only having the ability to understand the consequences of a decision but also the ability to execute the decision and adapt plans;*
- *inability of the person to recognise unsafe living conditions.*

In situations of self-neglect there is little evidence of effective interventions, but some clear signposts do emerge.

(a) Assessment

A comprehensive assessment is essential that assists practitioners in identifying capabilities and risk.

Equally, relationships and professional judgement remain valued as effective means of conducting assessment that includes interviewing technique, cultural expectations and individual personality characteristics.

The guiding principles in cases of self-neglect should be:

- **Assessment of capacity does not negate the duty to act for an individual's wellbeing.**
- *Value of beneficence in contributing to dignity stress principle of doing least harm.*
- *Balance between respect for autonomy and perceived duty to preserve health and wellbeing.*

(b) Intervention

Absence of capacity opens up various legal options.

However when a person has decision-making capacity, practitioners have to rely on negotiation and relationship-building skills.

Consensus and persuasion respects a person's autonomy and seeks to avoid counterproductive alienation when intrusion is likely to be resented.

Intervention should not address self-neglect specifically but deal with those concerns expressed by the individual themselves which might include health issues, lack of support networks or various activities of daily living.

This approach may assist people to manage risk in their lives and might address practitioner concerns about avoiding paternalism and promoting choice and Human Rights.

(c) Multi-Agency Framework

Because of the complex issues involved multi-agency involvement, collaboration and shared responsibility is essential.

Assessment of capacity does not negate duty of care. No case should be closed until a multi-agency meeting has been held to explore options for intervention that will improve outcomes.



(c) Law

Knowledge of legal frameworks for intervention, either when the individual lacks capacity or where expressed wishes are overridden because grounds for lawful removal are met is important. The legal rules on intervention, involving mental health and mental capacity, human rights and information sharing, public health and social care legislation can be complex and may require consultation with legal department.

Legislation that may apply:

- *Adult Support and Protection (Scotland) Act 2007*
- *Mental Health (Care and Treatment) (Scotland) Act 2003 - Section 33*
- *Adults with Incapacity (Scotland) Act 2000*
- *Public Health etc (Scotland) 2000 Act*
- *Housing (Scotland) Act 2006 if house is owned by LA*
- *Anti-Social Behaviour etc (Scotland) Act 2004 - ASBO may be applicable but hard to enforce*
- *Environment Protection Act 1990 has an abatement order, but this is more aimed at commercial premises not individuals and hard to enforce*

Hoarding

Hoarding can result in self-neglect.

Hoarding is the excessive collection and retention of any material to the point that it impedes day-to-day functioning. Pathological or compulsive hoarding is a specific type of behaviour characterised by:

- *acquiring and failing to throw out a large number of items that would appear to hold little or no value and would be considered rubbish by other people;*
- *severe cluttering of the person's home so that it is no longer able to function as a viable living space;*
- *significant distress or impairment of work or social life (Kelly 2010).*

There are 3 types of hoarding:

- **Inanimate Objects**
This is the most common and could consist of one type of object or a collection of a mixture of objects such as old clothes, newspapers, food, containers or papers.
- **Animal Hoarding**
Animal hoarding is on the increase. This is the obsessive collecting of animals, often with an inability to provide minimal standards of care.
- **Data Hoarding**
This could present with the storage of data collection equipment such as computers, electronic storage devices or paper. A need to store copies of emails, and other information in an electronic format.

Other distinctive features include:

- **Fear and Anxiety**
Compulsive hoarding may have started as a learnt behaviour or following a significant event such as bereavement. The person hoarding believes buying or saving things will remove the anxiety and fear they feel. The hoarding effectively becomes a safety blanket.
- **Long-Term Behaviour Pattern**
Possibly developed over many years or decades of "buy and drop" and an inability to throw away items without experiencing fear and anxiety.



- **Excessive Attachment to Possessions**

People who hoard may hold an inappropriate emotional attachment to items.

- **Indecisiveness**

People who hoard struggle with the decision to discard items that are no longer necessary, including rubbish.

- **Socially Isolated**

Some hoarders will typically alienate family and friends and may be embarrassed to have visitors. They may refuse home visits from professionals, in favour of office-based appointments.

- **Large Number of Pets**

People who hoard may have a large number of animals that can be a source of complaints by neighbours. They may be inclined to take in strays.

- **Mentally Competent**

People who hoard are typically able to make decisions that are not related to the hoarding. That said, hoarding is now considered a stand-alone mental disorder and can also be a symptom of other mental disorders.

- **Extreme Clutter**

Hoarding behaviour may prevent several or all of the rooms being used.

- **Self-Care**

A hoarder may appear unkempt and dishevelled, due to lack of usable toileting or washing facilities in their home. Some hoarders will use public facilities, in order to maintain their personal hygiene and appearance.

- **Poor Insight**

Hoarders typically see nothing wrong with their behaviour and the impact it has on them and others.

Mental Health Issues

Hoarding disorder used to be considered a form of obsessive compulsive disorder (OCD) but is now considered a stand-alone mental disorder. It can also be the symptom of other mental disorders. Hoarding disorder is distinct from the act of collecting, and is also different from people whose property is generally cluttered or messy. It is **not** simply a lifestyle choice. The main difference between a hoarder and a collector is that hoarders have strong emotional attachments to their objects which are well in excess of their real value.

Hoarding does not favour a particular gender, age, ethnicity, socio-economic status, educational/occupational history or tenure type.

Scottish Fire and Rescue

Hoarding is a fire hazard. Many occupants die in fires in these homes, and this can have a devastating impact on neighbours and the wider community.

As part of a commitment to building a safer Scotland, the Scottish Fire and Rescue Service offers a free home safety visit to all people in Perth and Kinross and will work closely with the Council to promote fire safety, and intervene in cases of hoarding and other fire safety issues.

Issues identified with hoarding:

- *Forced clean-up is not an optimal response and rarely works in the longer term.*
- *Meaningful engagement is the most effective tool - trusted person to engage with to affect change.*
- *Where animal hoarding is involved, psychiatric assessment is usually needed.*
- *Diogenes syndrome is linked to brain injury, anxiety and depression so assessment needs to be thorough.*
- *Recognition of impact on other people.*



- *Multi-agency response required and appropriate sharing of information.*
- *Multi-agency policy needed.*
- *Hoarding may be included in the ICD (International Classification of Diseases) in 2017.*

Assessment of capacity or non-engagement does not negate duty of care. No case should be closed until a multi-agency meeting has been held to explore options for intervention that will improve outcomes.

Information Sources

Sussex Multi-Agency Procedures to Support People Who Self-Neglect
Conceptualising and Responding to Self-Neglect: The Challenges for Adult Safeguarding (*Suzy Braye, David Orr and Michael Preston-Shoot, 2011*)

Contacts

Scottish Fire & Rescue Service - Home Fire Safety

www.firescotland.gov.uk/your-safety/hfsv-form.aspx

Bridget Barker, Wellbeing Support Team Co-ordinator

Community Mental Health Team

Tel 01738 476263 • Email BBarker@pkc.gov.uk

SAMH (Scottish Association for Mental Health)

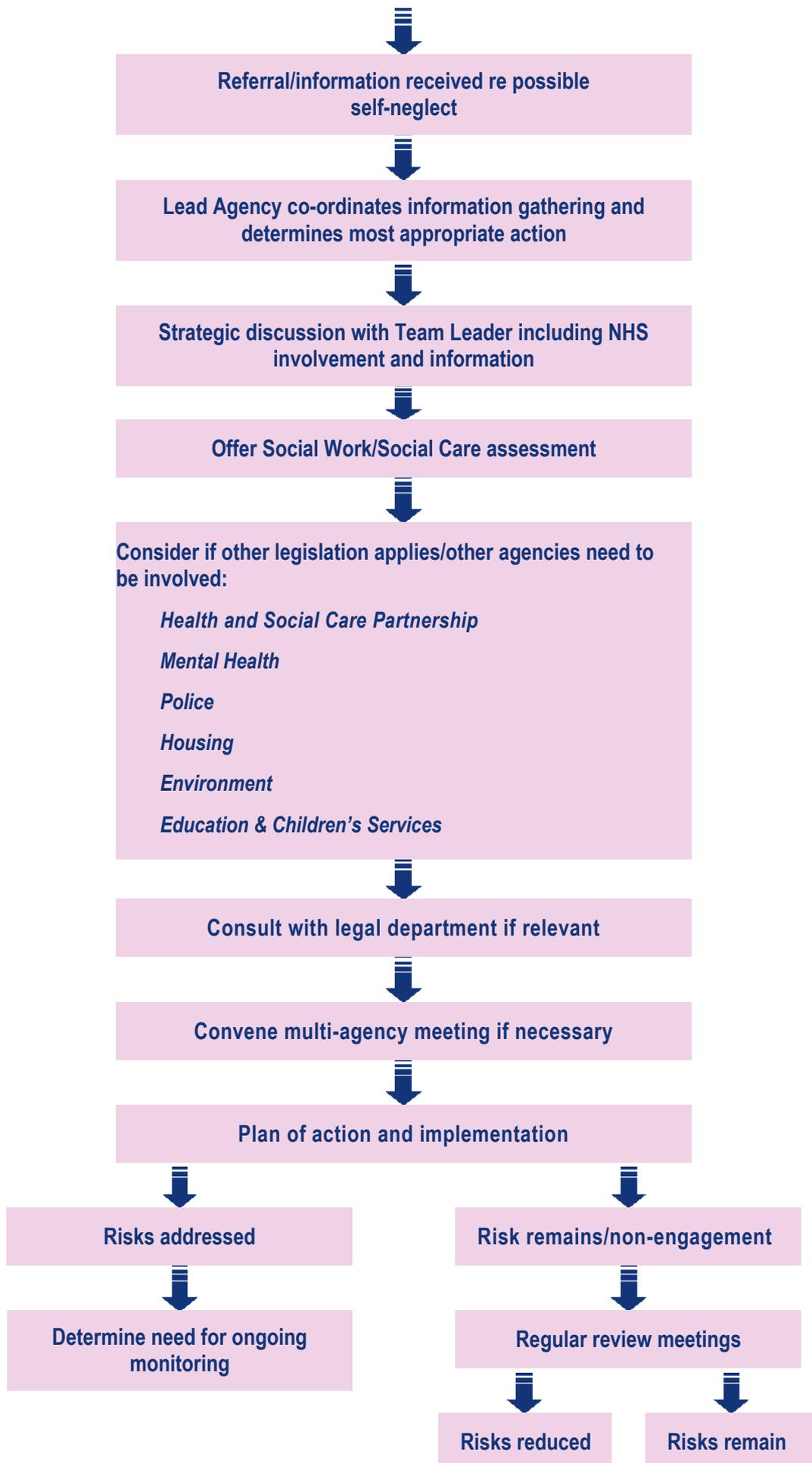
Tel 0141 530 1000 • Email enquire@samh.org.uk

Life - Pod CIC

Tel 07421 329380 • Email linda@life-pod.co.uk • www.life-pod.co.uk



Self-Neglect



Appendix 6

Financial Harm



POLICE
SCOTLAND

Document Version Control

Version Number	Version Information	Date	Approved By
1	Financial Harm	March 2014	APC & Sub-Group
2	Content checked and logos updated New flowchart added for paid carers	June 2018	APC & Sub-Group



Financial Harm

1 Legislative Basis

- *Adult Support and Protection (Scotland) Act 2007*
- *Mental Health (Care and Treatment) (Scotland) Act 2003*
- *Adults with Incapacity (Scotland) Act 2000*
- *The Trading Standards*

2 Background

National consultation exercises undertaken consider how best to develop guidance for financial harm. These consultations have highlighted that financial harm appears to have increased steadily and has given rise to questions about how to respond most effectively to this challenge. Increased awareness and better levels of reporting may explain the perceived increase, but it is still thought that much of this type of crime goes undetected. Welfare reform, unemployment and static wages mean that more people are experiencing financial hardship which may increase targeting of those more vulnerable due to their own situations.

Many types of financial crime can go unnoticed and factors, such as the economy, technology and social change, are diversifying the threat. In an increasingly connected world, it can no longer be assumed that adults at risk are safe in their own homes.

The diversity of financial crime against vulnerable adults makes it difficult to provide a single, all-embracing solution to the problem. Prevention and responses need to take into account the nature of the alleged perpetrator, the detail of the crime and the level of vulnerability of the adult.

Harm can range from not acting in the person's best interests, to persuasion or coercion in respect of gifts or loans, misappropriation of property or allowances, theft, rogue trading, or mass-marketing fraud.

Regardless of the nature of such harm, or the methods used by perpetrators, the resulting impact on adults at risk can be significant.

2.1 Definition of Financial Harm

Financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits. (DH/Home Office, 2000)

Financial harm includes:

- *feeling under pressure to hand over money or possessions;*
- *misuse of property or welfare benefits;*
- *stopping someone getting their money or possessions;*
- *stealing;*
- *cheating or fraud;*
- *misuse of bankcards;*
- *putting someone under pressure to re-write a will or take out a loan;*
- *withholding information about entitlements;*
- *SCAMS;*
- *computer hacking.*



2.2 Impact of financial crime and harm

Even small losses have the potential for significant impact when considered in context with a person's overall wealth/income and whether or not they have access to the right support.

The impact of financial crime should not be underestimated, and it can be every bit as significant as physical harm:

- *Deem (2000) suggests that victims of financial crimes can suffer as much as those who are victims of violent crime.*
- *Spalek (2007) suggests that anger and outrage, as well as anxiety, stress, fear and depression, were experienced by victims of the Maxwell pension fraud.*
- *Social care practitioners describe the distress and betrayal experienced by adults at risk who are victims of financial crime perpetrated by a person they have trusted. They suggest that it can leave such victims unsettled and without the confidence to live independently.*

The negative impact of financial harm, regardless of the source, can cause an adult who previously coped well to lack confidence and find it difficult to cope with daily living.

3 Indicators of Financial Harm

If you are a family member, carer or someone who works with adults who may be at risk, there are certain things which might trigger you to think about financial harm:

- *a lack of food in the house;*
- *unexplained disappearance of funds or valuable possessions such as art, silverware or jewellery;*
- *unexplained debt;*
- *withdrawing lots of money from the bank or post office;*
- *numerous unpaid bills, or overdue rent, when someone else is supposed to be paying the bills;*
- *another person using the adult's possessions, bank account or property without his or her informed consent;*
- *work getting done on the house or garden which is unusual;*
- *someone taking out extra loans;*
- *always accompanied by people to make withdrawals;*
- *lack of access to own money;*
- *poor accommodation, lack of repairs etc.*

In relation to older people additional indicators may be:

- *signatures on cheques etc that do not resemble the older person's signature, or signed when the older person cannot write;*
- *sudden changes in bank accounts, including unexplained withdrawals of large sums of money by a person accompanying the older person;*
- *the inclusion of additional names on an older person's bank account;*
- *abrupt changes to, or the sudden establishment of, wills;*
- *the sudden appearance of previously uninvolved relatives claiming their rights to an older person's affairs or possessions;*
- *the unexplained sudden transfer of assets to a family member or someone outside the family;*
- *unusual concern by someone that an excessive amount of money is being expended on the care of the older person;*



- *lack of amenities, such as TV, personal grooming items, appropriate clothing, that the older person should be able to afford;*
- *deliberate isolation of an older person from friends and family, resulting in the caregiver alone having total control.*

Many people who are not receiving services, or considered eligible for them, may lack the ability to protect themselves from financial exploitation or harm. Such vulnerabilities or risk factors may include the following:

- *lack of capacity to know what's happening;*
- *dependency on others to manage care or finances;*
- *cognitive impairment having an impact on decision-making;*
- *low levels of financial capability (ability to deal with financial products and services);*
- *bereavement/social isolation/loneliness, which may provide an opportunity for exploitation;*
- *gullibility/over-trusting nature;*
- *for older people in particular, potentially increased assets coupled with low-cost lifestyles and a lack of awareness of the modern world may make them more susceptible;*
- *physical and/or mental disability, illness or impairment;*
- *history of poor family relationships/violence;*
- *family member with alcohol/drug misuse;*
- *particular factors, such as age, social isolation and/or declining/variable mental health, may lead adults at risk to become chronic or repeat victims.*

4 Who does it?

It could be anyone:

- *a relative;*
- *a husband, wife or partner;*
- *a friend;*
- *a professional;*
- *a carer;*

- *a neighbour;*
- *a stranger;*
- *a volunteer;*
- *bogus workmen/companies;*
- *internet hackers.*

Suspected Harm by Paid Carer

If a paid carer is suspected of financial harm, it is important that there is a discussion between Social Work and the manager of the organisation before any action is taken. It may need the involvement of Police to ensure there is an agreed plan to address the issue.

5 Where does financial harm happen?

Financial Harm can happen anywhere:

- *in the family home;*
- *in a hospital ward;*
- *in a care home;*
- *at a social club or day centre;*

- *at work;*
- *on the internet;*
- *in a public place.*



6 Protective Factors

Identification of risk factors can be balanced by the existence of protective factors that can ensure that adults at risk have the right support to make informed decisions and help empower them to make own choices and live as independently as possible.

Protective factors may be:

- *trusted person with legal powers - financial attorney/guardianship;*
- *supportive, wide family network;*

- *good social network*
- *ability to recognise risks;*
- *technology (CCTV, Community Alarm).*

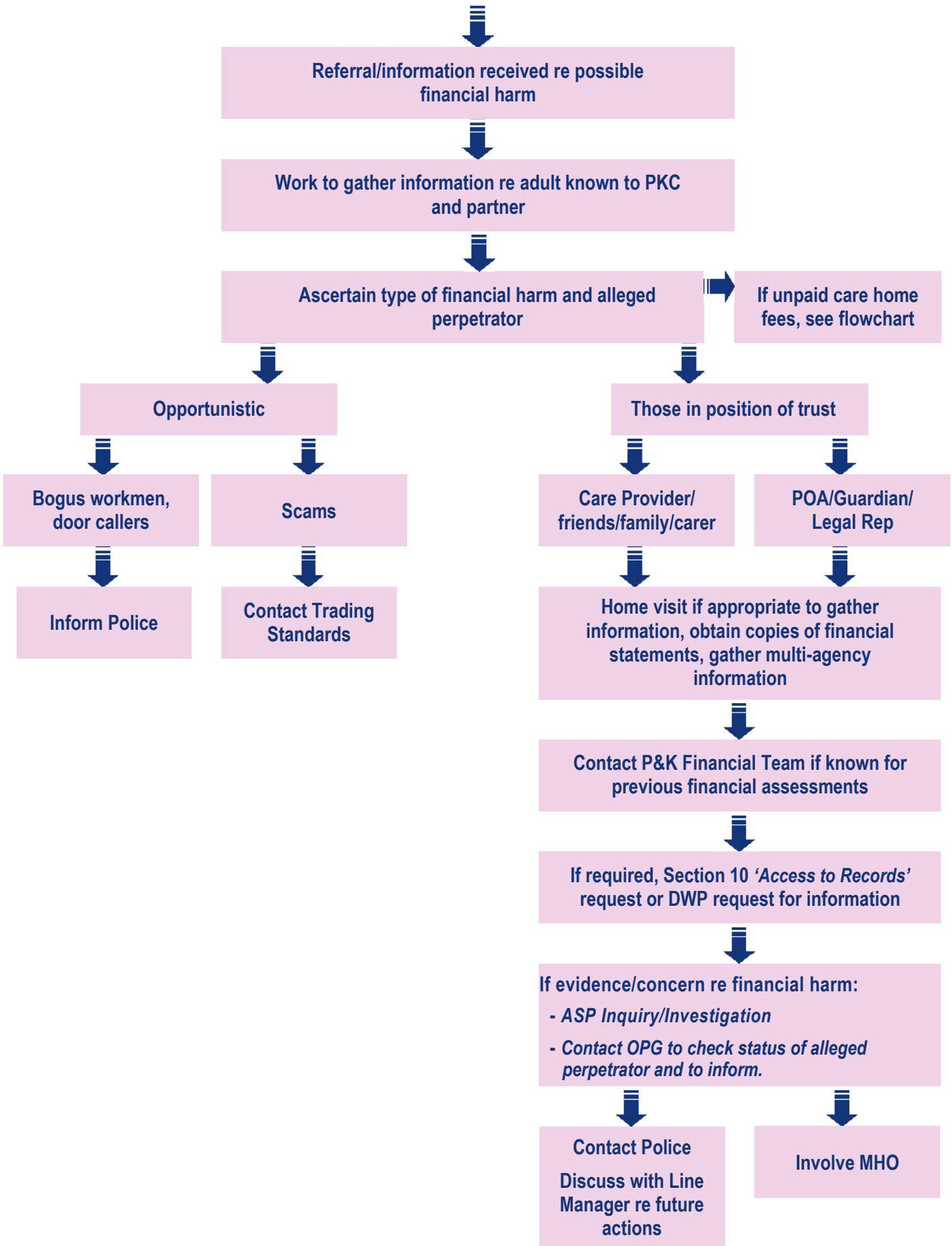
7 Who do I tell?

Organisations that can help:

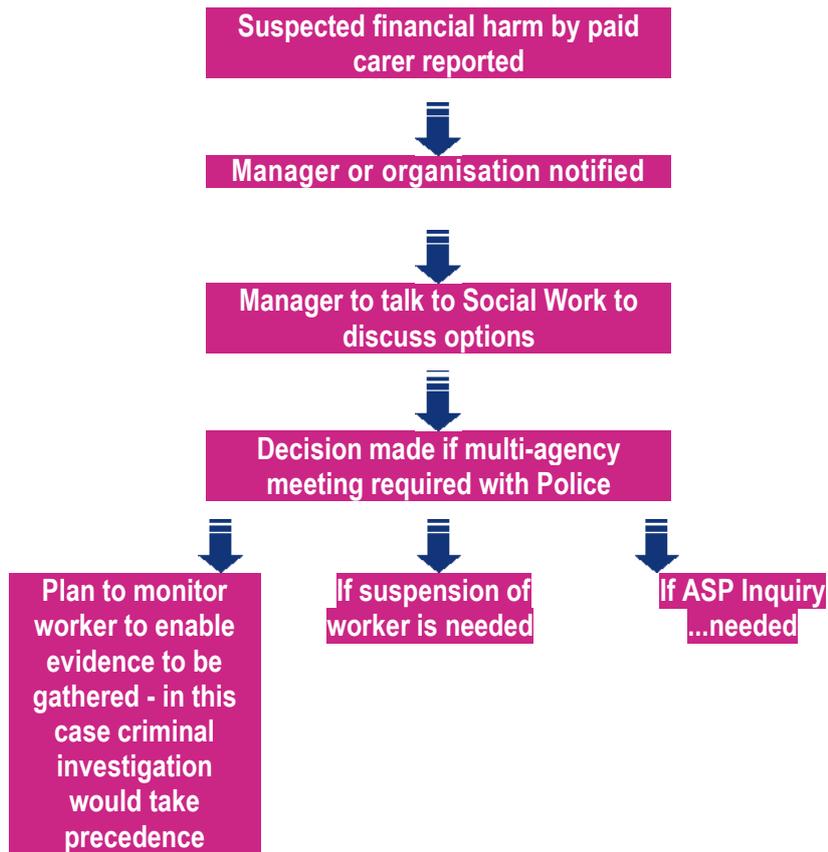
- **Police** **Tel 101**
- **Access Team** **Tel 0345 3011120**
*Housing & Environment
Perth & Kinross Council
Pullar House
35 Kinnoull Street
PERTH
PH1 5GD*
- **Citizens Advice Bureau** **Tel 01738 450580**
*7 Atholl Crescent
PERTH
PH1 5NG*
- **Trading Standards (SCAMS)** **Tel 01738 476476**
*Housing & Environment
Perth & Kinross Council
Pullar House
35 Kinnoull Street
PERTH
PH1 5GD*



Financial Harm



Suspected Financial Harm by a Paid Carer



Appendix 7

Notes on Referral Discussion with the Police

1 Person Responsible Team Leader

2 Action to be Taken

- Where a criminal offence may have or believed to have been committed, referral must be made to the Police. Consideration should be given to whether an urgent response is required in order to protect the adult and formulate an interim safety plan. This is likely to take the form of a telephone discussion.
- Where the adult at risk does not wish to make a complaint to the Police, this telephone discussion with the Police will assist in deciding on the most appropriate action, balancing the interests of the adult at risk against those of public safety.
- If attendance of Police is required urgently contact should be made to 999 to ensure a prompt response from the first available unit. If the matter is non-urgent the referrer should contact one of the following:
 - Force Control Centre Tel 101
 - Risk/Concern Hub Tel 01382 596004
 - Public Protection Unit (Perth) Tel 01738 892912
(As there is no dedicated response line, where no response is obtained the referrer should send a brief email to taysideppu@scotland.pnn.police.uk requesting a call back)
- Duty CID Detective Sergeant can be contacted for serious matter any time Tel 01382 591916

3 The referral discussion will:

- require the sharing of all available information between agencies to assist in the planning of an investigation;
- address the possible need to use the Appropriate Adult Scheme for interviewing adult at risk, witnesses or suspected persons;
- examine the current available evidence, how best to obtain further evidence and the possible need for any medical/forensic examinations;
- determine the manner of the investigation, the process and the agencies that need to be involved;
- agree on personnel to be involved from the appropriate agencies and the level of communication to monitor the progress of the inquiry;
- assess risk of further harm, mistreatment or neglect to the adult at risk and community safety issues;
- agree a media strategy if deemed necessary;
- the consultation and information sharing process should be ongoing and will involve agencies sharing, reviewing and evaluating information as it comes to light;
- details of initial referral discussions should be recorded and attributed.



Appendix 8

Notes on Interviewing

1 The Reasons for and Objectives of Joint Investigative Interviews

Interviewing a person who is suspected of having been harmed is an important task which may have far reaching consequences for a number of people. Such an interview must be carefully planned in all aspects and must be conducted in a manner that will stand scrutiny. The interview may prove to be an extremely important part of an investigation and can often determine the outcome of an inquiry.

Consequently, it is crucial that the processes adopted when planning, preparing and conducting a joint investigative interview are transparent, accountable and sensitive to the needs of the adult at risk.

To this end, interviewers must be clear why they are conducting an interview jointly with a Police Officer or a Social Worker.

The reasons for and the objectives of the interview are outlined below.

1.1 Reasons

- *To reduce as far as possible the number of interviews that the adult at risk is subjected to.*
- *To reduce as far as possible the trauma caused to both the adult at risk and his or her family.*
- *To ensure that any necessary support is provided for the adult at risk.*

1.2 Objectives

- *To establish what, if anything, has happened.*
- *To gather best evidence regarding the matter under investigation for both criminal and civil proceedings.*
- *To allow a joint assessment of risk and needs to be undertaken.*
- *To inform any decision to be taken in relation to the best way to proceed with an investigation.*

At all times when planning, preparing and conducting a joint investigative interview the needs and wellbeing of the adult at risk are of paramount consideration, e.g. consider the presence of a support person, an advocate or a carer.

All considerations and decisions taken with regard to the planning, preparation and conduct of an interview must be clearly and accurately recorded by both agencies.

2 Recording the Interview Checklist

It is imperative that when recording the details of a joint investigative interview that the recording is an accurate and true reflection of the interview. The recording must include the actual words of significant statements made by the interviewee in relation to the event of harm. It must also be recorded in chronological order as it takes place in the interview.

It is best practice to record the following details.

2.1 Prior to commencing the interview:

- *a full description of the interview environment;*
- *details of who has given consent if applicable, e.g. Welfare Guardian;*

(continued)



(continued)

- *details of those present during the interview;*
- *the demeanour of the person;*
- *the start time of the interview.*

2.2 During the interview:

- *any changes in the interviewers' roles;*
- *any changes in the adult at risk's demeanour;*
- *description of any props used;*
- *details of any drawings made by the person;*
- *time and length of, and reason for, any breaks during the interview;*
- *attribution of statements;*
- *body language;*
- *finish time.*

2.3 After the conclusion of the interview:

- *interviewers must review the written record of the interview to ensure that it is an accurate account of the interview;*
- *any omissions should be discussed and, if appropriate, entries made to reflect the omission - any such entries must be highlighted;*
- *the record should be signed and dated by the interviewers;*
- *any drawings or other items written by the person should also be signed and dated by the interviewers;*
- *all records and drawings, etc will be retained by the Police and copies made available for Social Work and Social Care services.*

Please remember that the above list is not exhaustive and any other information that the interviewers feel is relevant should be recorded.

2.4 Points to consider when preparing the person for interview

During an investigative interview, interviewers must remember that the adult at risk may perceive the interviewers as 'figures of authority' and may, therefore, answer questions in a way that he or she may think will please the interviewers. The adult at risk may also be under the misapprehension that the interviewers are aware of what may have happened to them and may therefore assume that they do not need to tell them everything. The adult at risk must also be made aware that when they are unable to provide an answer to a question, then they should tell the interviewer that they 'don't know' or do not understand the question. So the interviewers should explain that:

- *if he or she does not know the answer to any question, it is okay for him or her to say so;*
- *if he or she does not understand any question that is asked, he or she should tell the interviewers;*
- *in situations where something has happened to the person, he or she must be reminded that the interviewers were not there at the time and he or she should try to tell the interviewers everything that happened;*
- *if the interviewers misunderstand something that the person has said, then he or she should not be afraid to tell them.*



3 Interviewing People with Special Needs

Planning for an interview with a person with dementia, learning disabilities, sensory impairment or communication difficulties should be carried out with particular attention to their individual needs. In all cases they should be offered the opportunity to have someone present to support them, possibly a family member, Key Worker or advocacy worker, unless they are the alleged perpetrator. If the person at risk of harm has capacity and refuses this, his or her choice must be respected.

If the person is under a Guardianship Order, the Guardian must be notified and be present, unless they are the alleged perpetrator.

Attention should be given to:

- *individual communication needs;*
- *environmental factors to minimise the likelihood of triggering upset or challenging behaviour;*
- *particular routines that must be maintained to aid their management of the situation.*



Appendix 9

Medical Examinations (Section 9)

1 Introduction

Section 9 of the Adult Support and Protection (Scotland) Act 2007 allows health professionals (i.e. doctors or nurses) to carry out private medical examinations on adults who are known or are believed to be at risk. A medical examination can take place either at a place being visited under Section 7 of the Act or at the premises where an adult has been taken under an assessment order granted under Section 11. A medical examination includes any physical or psychological assessment or examination.

A medical assessment may be a necessary component of an Adult Protection Investigation for the following reasons:

- *in order to gather evidence of harm to inform a criminal prosecution or action to safeguard the adult;*
- *for health reasons only, physical and/or mental;*
- *to establish mental capacity.*

Subjecting an adult to a medical examination requires serious consideration especially if they lack capacity to make informed decisions about their future care. The guiding principles governing intervention should be the current safety and wellbeing of the adult and their future safety and development.

2 Consent

Consent must be obtained from the adult prior to a medical assessment by the GP/Medical Practitioner. If the adult lacks capacity to make informed decisions about consenting to an assessment, consent should be obtained from their Welfare Guardian or Welfare Power of Attorney. If there are no details of Welfare Guardian or Power of Attorney, the Office of the Public Guardian should be contacted to confirm whether or not one exists. If there is no Guardian or Power of Attorney, an MHO should be consulted, and consideration should be given to using provisions in the Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Care and Treatment) (Scotland) Act 2003.

If there is no Welfare Guardian or Welfare Power of Attorney, or they are not available or they are alleged perpetrators or are suspected of colluding with alleged perpetrators, an Assessment Order may be applied for (see Appendix 17). An Assessment Order may also be applied for if there is a Welfare Guardian or Power of Attorney, and they are refusing permission for a medical examination to take place or if it is suspected that the adult has made the decision not to participate in a medical examination due to undue pressure (see Appendix 13).

A person is not obliged to answer any questions put to him or her in an interview and must be informed of his or her right to refuse prior to a medical examination being carried out. If there are concerns that an adult has not understood the question, inquiries should be made to ensure whether there is a Welfare Guardian or Power of Attorney who should be contacted for consent. In a forensic medical examination, Police may consider the use of an Appropriate Adult who could inform regarding consent. Regardless of whether the medical examination is carried out by a Police Doctor/GP/Medical Practitioner it is the responsibility of the Medical Practitioner to be satisfied that the adult at risk has consented or at least has no resistance to the examination.

3 Procedure

If an adult at risk requires immediate medical treatment, this must be sought without delay. The medical staff should be informed of any known history and that their findings may have forensic significance.

Council Officers and other non-medical staff must not carry out medical examinations. However it is acceptable, when injuries and/or bruises are obvious, to assess whether these are consistent with any explanation provided. Absence of physical signs should not be taken as conclusive evidence that no harm has taken place.



If an adult at risk has an injury that does not require immediate treatment, he or she should be subject to an interview prior to any medical examination. This will enable the investigating officers to assess whether or not a medical is necessary.

A joint decision will be made regarding the necessity for a medical examination except where a crime has been committed. Decisions will be made in relation to:

- *the need for the medical examination;*
- *the purpose of the medical examination;*
- *the type of medical examination;*
- *who should conduct the medical examination;*
- *where it should take place;*
- *when it should take place.*

If, after a joint investigation, the Police decide not to commission a specialist medical examination, but the Council Officer believes one is necessary, the Council Officer (SW) should discuss this with the designated Team Leader immediately.

3.1 Forensic medical examinations usually take place under the following circumstances if:

- *it is believed that an adult has sustained a non-accidental injury;*
- *there is concern regarding sexual harm and there is the likelihood that physical evidence may be present;*
- *the adult has injuries where the explanation (from the adult or other person) is inconsistent with the injuries and an examination may provide a medical opinion as to whether or not harm has been perpetrated;*
- *the adult appears to have been subject to neglect or self-neglect;*
- *the adult is ill or injured and no treatment has previously been sought.*

Sexual harm medical assessments will only be conducted by registered medical practitioners who are appropriately qualified and skilled. They will be forensic medical examiners contracted by the Police.

It is appropriate for the investigating Council Officer to accompany the adult for both sexual harm and physical harm medical examinations. This is in order to provide support and assessment and management of risk. The Council Officer will not be present when the adult is being examined. The adult may have someone else accompany them during a forensic medical examination as long as that person is not an alleged perpetrator.

It is the responsibility of the Police to co-ordinate forensic medical examinations. In cases of serious sexual offences Police officers should follow the 'Scottish Investigators Guide to Serious Sexual Offences.'

Following a forensic medical examination, the forensic medical examiner should provide a handwritten interim report of their findings.

Some medical examinations can be arranged by the Council Officer with the adult's GP. This would be appropriate if, for example, an adult has been injured and there is no evidence at that stage that the injury is non-accidental. The consent requirements remain. If, after examination, the GP believes that injuries are non-accidental, the Police should be contacted immediately for further discussion.



Appendix 10

Access to Records Request Form/DWP Form (Section 10)

Existing procedures relating to the sharing of information should be followed wherever possible. Where appropriate, 'Consent to Share Information' forms should be signed by the adult. If the adult lacks capacity to make informed decisions about their future, their Welfare Guardian or Welfare Power of Attorney should sign the form. If the adult lacks capacity and there are no details of a Welfare Guardian or Power of Attorney, the Office of the Public Guardian should be contacted to check whether or not one exists. Where there is no Welfare Guardian or Power of Attorney, consideration should be given to using the provisions in the Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Care and Treatment) (Scotland) Act 2003, or to sharing without consent if required to protect the adult or others.

If there is reasonable concern that an adult at risk is being harmed or is at risk of harm, this will always override a professional or agency requirement to keep information confidential. If it is not possible to obtain consent from the adult, for example, if the situation is so urgent that obtaining consent would cause an unacceptable delay or where the adult cannot consent, the adult should be informed about the information sharing wherever possible. If the adult lacks capacity, their Welfare Guardian or Welfare Power of Attorney should be informed about the information sharing unless it is felt that this may be detrimental to the adult. The Council has discretion regarding whether or not a Welfare Guardian or Power of Attorney is informed.

Section 10(1) of the Adult Support and Protection Act (Scotland) 2007 states that "a Council Officer may require any person holding health, financial or other records on an individual the officer knows or believes to be an adult at risk to give the records, or copies of them, to the officer."

Any decision to access records under the 2007 Act should be made by the relevant Social Work & Social Care Team Leader. The Council Officer (SW) should complete form. This form should be signed by the Team Leader and the Council Officer (SW) and given to the holder of the records. A copy of the form should be placed in the client's file. When a Council Officer (SW) requests access to records he or she should explain:

- what information they need;
- why they need it;
- what they will do with the information;
- who the information will be shared with;
- how long the records will be kept and whether or not they will be returned or destroyed.

Information should only be shared with those who need to know and only if it is relevant to the particular concern identified. The amount of information shared should be proportionate to addressing that concern.

Records can be requested in person during a visit. The Council Officer (SW) must have appropriate identification with him or her and a completed form. Records can be requested in writing at any other time. Written requests can also be made electronically. Examples of records that may be useful in an investigation include bank statements, employers' records, records held by Department of Work and Pensions or records held by voluntary agencies. This is not an exhaustive list. All formats of records such as computer, audio and visual are covered by the legislation.

If it appears an offence may have been committed, the Police should be contacted, and a joint investigation carried out. Only original documents or certified copies can be used in court. If computer records are to be submitted as evidence, they must be printed off and signed by the holder to confirm they are a certified copy. It is the responsibility of the Police to gather evidence in a criminal investigation. The Council Officer (SW) should request copies of the records and ensure that original documents remain with the source of the information.

Section 49 of the Act states it is an offence of obstruction for a person to fail to comply with a requirement to provide information under Section 10. Reasonable efforts should be made to resolve disagreements through informal means, initially, before considering any legal action.



1 Accessing Health Records

If the Council Officer (SW) knows or believes an adult is at risk under the 2007 Act, he or she has the right to request any person holding health records to give access to the records or copies of them. Health records are any record made by or on behalf of a health professional relating to an individual's physical or mental health. Records include notes written by GPs, occupational therapists, physiotherapists and nurse, either written or electronic.

Health records may only be inspected by a registered health professional for example doctor, nurse or midwife.

If possible, an appointment should be made in advance to allow the author of the record time to gather the relevant information. It is best practice for the Council Officer (SW), with the assistance of the health professional reading the records if appropriate, to interview the author. However, it may not always be possible to interview the author especially if records contain entries made by a large number of different health professionals. During the interview, the Council Officer (SW) should record any statements made by the health professional inspecting the records. In certain circumstances, it may be appropriate to request the records or copies of them, e.g. for inspection by another health professional for a second opinion.

In some cases it may be sufficient for a health professional to provide a written summary of his or her involvement and of the adult's physical and mental health along with any relevant documents or reports. However, it should be noted that Section 10 of the Act refers to existing records held by a professional or an organisation rather than information created specifically to meet a request.



**Adult Support and
Form (AR1) Request to Access Records**

Protection (Scotland) Act 2007

Section 10(1) of the Adult Support and Protection Act (Scotland) 2007 states that “a Council Officer may require any person holding health, financial or other records on an individual the Officer knows or believes to be an adult at risk to give the records, or copies of them, to the Officer”.

Name of Organisation/Individual request is being made to	Name Address
Name of Adult	Name Address Date of Birth Consent given (<i>please circle</i>) Yes / No If yes, signature of Adult/Power of Attorney/Guardian
Information Required	
Reason for Request	
Who the information will be shared with	
How long the information will be kept	
Once the investigation is complete the records will be (<i>please circle one</i>): Returned Destroyed Retained on File	

Signature of Requesting Officer

Tel No _____ Date _____

Signature of Team Leader

Tel No _____ Date _____



Adult Support and Protection - Local Authority Application for Disclosure of Information from Department of Works and Pensions Under the Adult Support and Protection (Scotland) Act 2007

Overview

DWP's policy for disclosure of personal information for 'vulnerable adults' is that as long as a requester can provide sufficient informative detail as to the indicators of the person's vulnerability and risk to DWP, we can disclose factual and relevant information in order to ensure the safety of the person. DWP is able to share data on a case-by-case basis when disclosure is deemed to be in the public interest.

In Scotland, the Adult Support and Protection (ASP) (Scotland) Act 2007 gives Councils and other public bodies working with them various powers to support and protect adults at risk (as defined by the Act).

Section 10 of the Act requires any person holding health, financial or other records relating to a particular individual to give the records, or copies of them, to a Council Officer. Information requested under Section 10 of the Act is used to allow the Council to decide whether the individual is an adult at risk of harm and whether it needs to do anything to protect them from harm. An adult protection investigation may also lead to criminal action, depending on what the information reveals. Under Section 49(2) of the Act it is an offence to fail to comply with a requirement made under Section 10, without reasonable excuse.

While the ASP Act is not recognised as an enactment by the Social Security Administration Act 1992, it is a key tool for safeguarding adults at risk in Scotland. Co-operation between organisations which hold information about people who may be adults at risk is central to the ethos of the Act, and is necessary to ensure that steps can be taken to support and protect adults from harm.

Request for Information Under Section 10 of the ASP Act

I would like to request disclosure of information under Section 10 of the Adult Support and Protection (Scotland) Act 2007 as follows:

Name of Person	
National Insurance Number* and/or Date of Birth & Address <i>(* National Insurance Number preferred identifier)</i>	
Brief reason why the information is requested and the use that will be made of it	
Information that is requested	
Requestor's name, position, organisation, address and telephone number	



Request for Information from Financial Institution

To be used with the Local Authority or delegated body's logo or logos for such requests at the top of each page

Dear

Re: Request for Information from Financial Institution Section 10 Adult Support and Protection (Scotland) Act 2007 (ASPA)

Following contact with your **[name, title, phone number and location of financial institution staff]** by telephone and having confirmed the correct legal entity to make this request to, I, **[name]**, in my role as Council Officer for **[insert relevant organisation name and where the power is delegated from the local authority state]** with delegated authority and powers in relation to this request from **[enter Local Authority name]** formally request disclosure of information from **[company name and address]**. The request is made under Sections 4 (Inquiry) and 10 (Examination of Records) of the Adult Support and Protection (Scotland) Act 2007 (the Act) on the basis that we know or believe the below named to be at risk as defined by the Act.

Please contact the Council Officer named above upon receipt of this request to discuss the provision of the information requested. A copy of their ID or other formal proof of identity is attached as confirmation of their authority to act on behalf of **[insert agency]**. The professional title of the Council Officer may vary as per the definition of Council Officer in the attached information sheet. The ID provided therefore indicates their Council Officer status either directly or by way of professional or agency title and as such is considered proof of their legal authority to make this request. This is confirmed by the countersignature of their line manager *confirming the applicant's status as a Council Officer and that the request is required by the named agency in the performance of its duties under the Act. If for any reason, you are unable to comply with this request, please contact the Council Officer immediately as a person commits an offence by, without reasonable excuse, refusing or otherwise failing to comply with a requirement made under Section 10.*

All information provided will be managed within the terms of the Adult Support and Protection (Scotland) Act 2007 and the Data Protection Act 1998.

Please see the *Information Sheet* attached regarding the legal context of this request and provide the information below:

Name of Customer	
Date of Birth (if available)	
Address (if available)	
Account Names, Numbers and Sort Codes (if available)	
Brief Description of the ASPA Inquiry	
Financial Information that is Required (please include any third party mandates relating to the accounts located)	
Information Format Required	<input type="checkbox"/> Hard copy
	<input type="checkbox"/> Electronic copy to the stated email addresses above (where available)
Information Required by	(Date Month Year)
Council Officer's Name, Contact Details and Signature	
Line Manager's Name, Contact Details and Signature	

Yours faithfully



Information Sheet

Designated Agency Application for Disclosure of Information Under Sections 4 and 10 of the Adult Support and Protection (Scotland) Act 2007

The Adult Support and Protection (Scotland) Act 2007 (the Act) gives Councils and other public bodies working with them various powers to support and protect adults at risk (as defined by the Act).

The Adult Support and Protection (Scotland) Act 2007, (the Act) confers on 'Council Officers' a duty to investigate cases of suspected harm to an 'adult at risk'. As part of this investigation, financial records pertaining to the adult at risk can be requested. Bodies holding these records have a legal duty to co-operate with the investigation. Failure to do so can amount to the commission of an offence under the Act making the individual liable on summary conviction to a fine or imprisonment.

'Council Officer' means an individual appointed by a Council (local authority) under Section 64 of the Local Government (Scotland) Act 1973 to properly discharge the Council's functions. The Council Officer submitting this request is registered with the appropriate professional body as a Social Worker, Social Service Worker, Occupational Therapist or Nurse. In addition they will have at least 12 months' post qualifying experience of identifying, assessing and managing adults at risk as per article 3 of the Act (Restriction on the Authorisation of Council Officers) Order 2008. In addition we expect such officers to have undertaken additional specialist training in Adult Support and Protection. Based upon these factors they have been delegated the statutory responsibility of Council Officer by the Chief Social Work Officer of *[insert agency]*.

Section 4 of the Act states that a Council (or delegated agency as per Section 1(7) of and Schedule 1 to the Public Bodies (Joint Working) (Scotland) Act 2014) and associated relevant regulations, i.e. SSI 2014/345 and SSI 2014/282, must make inquiries about a person's wellbeing, property or financial affairs if it knows or believes that the person is an adult at risk, and that it might need to intervene to protect their wellbeing, property or financial affairs. As part of this process, **Section 10** of the Act stipulates: *A Council Officer may require any person holding health, financial or other records relating to an individual whom the officer knows or believes to be an adult at risk to give the records, or copies of them, to the officer.* This requirement can be made during a visit to the record holder or thereafter in writing. Where there is any dubiety about the identification of the Council Officer the financial institution will verify this.

Section 3 of the Act defines an 'adult at risk' as someone who is unable to safeguard their own wellbeing, property, rights or other interests and is at risk of harm. In such instances and where the person is more vulnerable because of a disability, disorder, illness or infirmity, the Act can be used to protect them.

The request does not require the consent of the individual, any financial power of attorney or financial guardian before the requested information is provided, as in some circumstances the adult in question may be placed at greater risk of harm. *Under Section 49(2) of the Act it is an offence for a person or an organisation to fail to comply with a requirement made under Section 10, without reasonable excuse.*

Whilst you will be concerned about customer confidentiality, it is important to note that NOT sharing this information may place the adult at further risk of harm. Please refer to your internal guidance.

Any information received in the course of an investigation is treated with the utmost confidence and will not be disclosed to any third parties other than in accordance with the provisions of the above Act. For the avoidance of doubt, Section 35 (1) of the Data Protection Act 1998, concerning disclosures required by law or made in connection with legal proceedings, states that personal data are exempt from non-disclosure provisions where it is required under enactment or to protect legal rights. Section 29 of the Data Protection Act may also be relevant in any case where the disclosure is for the prevention or detection of crime, the apprehension or prosecution of offenders.

The attached request is countersigned by the Council Officer's line manager to ensure probity, assuring the record holder that the request is being made in accordance with the requesting agencies procedures and powers. Should you be unfamiliar with the Adult Support and Protection (Scotland) Act 2007, you can view a copy of it at www.legislation.gov.uk/asp/2007/10/contents



Council Officer Guidance Notes

The wording and ordering of this document has been approved by national agreement between Social Work Scotland and the National Banking Support Group under the auspices of the Financial Sector Resilience Group (Scottish Business Resilience Centre/Police Scotland). If issues arise with the structure of the form please contact: napc@stir.ac.uk in order that any amendments can be considered at national level.

Please use this template in conjunction with the **Adult Support and Protection (Scotland) Act 2007 Code of Practice (April 2014)** especially noting chapter ten.

Prior to making a written request a telephone call should be placed with a staff member whose name, title and contract details are noted on the request. ***It is essential at this point that you identify the correct legal entity to address your request to.*** The name of the legal entity may be different to that of the company you are contacting and may also change over time. Some financial institutions may provide a central point and others local or regional contacts. However, obtaining the correct person, title and address will save time and allow the financial institution to provide you with the fullest level of detail in relation to your request.

The request should use the locally agreed logo or logos for such requests and be accompanied by the Information Sheet. Where the functions of a local authority have been delegated to your agency under Section 1(5) of the Public Bodies (Joint Working) (Scotland) Act 2014 please indicate in your request which local authority has delegated that power to your agency.

Requests may be made electronically where they can be sent and received securely.

Name of Customer	Full name and any known pseudonyms listed separately, e.g. Mary McTavish May McTavish
Date of Birth (if available)	Please state in full, e.g. 22 July 1952
Address (if available)	
Account Names, Numbers and Sort Codes (if available)	
Brief Description of the ASPA Inquiry	Basic information only to demonstrate that there is a risk or potential risk which has triggered an ASPA inquiry. This may assist the financial institution in locating the type of information required.
Financial Information that is required (please include any third party mandates relating to the accounts located):	<p>The information requested must be specific as opposed to generic. Ensure you emphasise the need to provide any information about third party mandates. Requests for 'all statements' will not be accepted. Consider the issues the service user is facing and what material over what period may support your inquiry. Where you are unclear about the types of information the financial institution may hold use the 'verbal' option to seek advice as to what may be available to support your inquiry. Examples include:</p> <p><i>The balance of Ms XXXX's account(s).</i></p> <p><i>Any current Standing Orders or Direct Debits (including to whom payable, regularity and amounts).</i></p> <p><i>Statements covering the period</i></p> <p><i>We should also wish to request similar information for any other account in her name of which we are unaware.</i></p> <p><i>Whether.... holds a Bank or Building Society account with your bank?</i></p> <p><i>If so, whether any other persons are signatories to his/her account(s)?</i></p> <p><i>(continued)</i></p>



<p>Financial Information that is required (please include any third party mandates relating to the accounts located):</p>	<p><i>(continued)</i></p> <p><i>Please provide copy statements in relation to any accounts held by, either jointly or solely for the last months.</i></p> <p><i>Similar information regarding any other account held in this name.</i></p> <p><i>Any known liabilities/debts/mortgages etc.</i></p> <p><i>Any relevant financial information held in wills.</i></p> <p><i>Any accounts in other name, e.g. joint accounts.</i></p>
<p>Information Format required</p>	<p>It is likely that most institutions will only provide information in hard copy due to potential security issues with electronic transmission of personal information.</p>
<p>Information required by</p>	<p>In some circumstances this will be urgent, and it may be useful to state the reasons the information is required quickly and facilitate a verbal information exchange.</p> <p>In other circumstances please indicate in your request the required time frame, e.g. 7, 14 or 21 calendar days.</p>
<p>Council Officer's Details and Signature</p>	<p>Name, position, organisation, address, email address, telephone number and signature. Please DO NOT provide a direct dial contact in the first instance.</p> <p>All applications should be accompanied by a copy of both sides of the Council Officer's ID badge or other form of authorisation which either directly states or intimates through professional title that the person making the request is a Council Officer in terms of ASPA.</p>
<p>Counter Signatory's Details and Signature</p>	<p>This should be your line manager or the delegated counter signatory for your agency. Please provide name, position, organisation, address, email address, telephone number and signature. Please Do NOT provide direct dial contact in the first instance. The counter signatory is confirming the applicant's status as a Council Officer and that the request is required by the named agency in the performance of its duties under the Act.</p>



Appendix 11

Adult Protection Forms

Protection of Adults at Risk Inquiry Form

Details of Subject

Client Information			
Name		Date concern notified to Community Care	
IT System No			
Age		Date screened	
Gender		Date Inquiry completed	
Address		Any previous allegations of harm?	
Team		If 'Yes', date(s) if known	
Referred by			
Lives alone?		What needs to be assessed?	
Is capacity assessment required?		Type of alleged harm	
Client group		If location of harm 'Other', please state	
Location of alleged harm		Name of Guardian or Attorney	
Legal status (e.g. Adults with Incapacity Act Guardianship, Mental Health Act Compulsory Order)			

Alleged Perpetrator			
Name		Does the alleged perpetrator need to be informed? (see Guidance)	
Address			If 'Yes', date informed
Age		If 'No', list reasons	
Gender			
Relationship to client		Does he/she have access to vulnerable people?	
Is the person known to H&CC?		Date Police contacted if applicable	
Date of Entry on IT System			



If alleged perpetrator is under 16 years or is a vulnerable adult, to which service has he/she been referred?	
Multiple perpetrators? (If 'Yes' check IT System for further information)	

Legal Status (e.g., Adults with Incapacity Act Guardianship, Mental Health Act Compulsory Order)					
Care Programme approach?	Yes/No	Hazard activated?	Yes/No	Date	

Referral to Other Agencies	
Police	
Op Mental Health Team	
Community Mental Health	
Community Health	
Advocacy	
Central Health Care - Homeless	
Housing Association	
Victim Support	
Other Agency (please state)	
Other Local Authorities	

Referral to Other Teams	
CJS	
Housing	
Drug & Alcohol Team	
Mental Health Team	
Community Wardens	
Community Safety	
Supporting People	
Child Care Team	
Locality Team	
Learning Disabilities	



Client IT System ID

1 Presenting Concern *(Details of referral)*

2 Background *(Relevant information)*

3 Chronology *(A list in date order of all the major changes and events in a person's life - what is important to the person is key here - an event which may affect one person may be insignificant to another)*

4 Involvements

Section (5 and 6) of The Adult Support and Protection (Scotland) Act 2007 should be taken into account when looking at co-operation from other agencies and when considering advocacy.

Household composition

Related Person's Name	Relationship

Name	Role

5 Risk Assessment

- ❖ *Include risks to other adults, children and from others.*
- ❖ *Consider what disadvantages, or reductions to the adult's quality of life, or freedom, or independence might result from these actions (e.g. if increased supervision, change of home, statutory intervention).*
- ❖ *Consider need to complete a positive risk taking form.*

Identification and discussion of risks

Risk Identified	Triggers	Protective Factors	Consequences



Client view of risk

(Does the client feel at risk and give reasons)

6 Have communication and capacity needs been assessed? Are any supports needed, e.g. Appropriate adult, talking mats?

Yes/No If 'Yes' please specify _____

7 Has advocacy been offered?

Yes/No/Offered but refused

8 Is this person an adult at risk/meet the 3 point test?

** are unable to safeguard their own wellbeing, property, rights or other interests;*

** are at risk of harm; and*

** because they are affected by disability, mental disorder, or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.*

Please explain reasons for the decision.

9 Record of Inquiry

Consider capacity issues.

Consider environmental and protective factors.

Current Situation:

Client Views:

Family Views:

Disagreements/Challenges:

10 Support Needed/Risk Management Plan

What support is required for adult at risk and for the wider family in order to reduce risks?

Any risk identified must be recorded with an action relating to reduce risk.

Detail any immediate or planned actions taken in order to protect, or reduce the risk.

Identified Risks	Action Taken or Needed	Date to be Completed	Person Responsible



Have risks been reduced?

Yes/No If 'No' consider if Positive Risk Taking Form needs to be completed

11 Analysis and Recommendation

Provide overview of inquiry.

12 Does the adult feel the intervention has been helpful?

Give details

Signature _____ (*Adult at risk*) Date _____

Signature _____ (*Council Officer*) Date _____

Signature _____ (*Team Leader*) Date _____

Signature _____ (*Service Manager*) Date _____



This page should contain a brief concise description of concern raised, information gathered in course of inquiry, analysis and recommendation. It must contain the salient points that clearly show why this action is proposed to allow Line Managers and Service Managers to make informed decisions. The incident of harm and involvement tabs need to be completed before opening the Adult Protection Form as this information will populate the form.

- 1 The description of concern raised in referral should clearly and concisely state the concern raised in the referral.*
- 2 Background should include any relevant details that is pertinent to the concern raised or environmental/family factors that impact on the issue.*
- 3 History/Chronologies - The key purpose of a single agency chronology is to provide an easily accessible record of significant events and/or changes that have impacted (immediate or cumulative) either negatively or positively on the person. This is to assist in the collation and analysis of key information for the identification and patterns of risk. There may be a need to collect and collate chronology from a variety of sources.*
- 4 Involvements - All professional and relevant personal involvements, especially if reside in same household should be recorded. This area will populate with information if the involvements tab has been updated.*
- 5 Risk assessment should include risks to other adults, children and risk of harm from others. Consider intrinsic risks like wandering and effect of memory and cognitive impairment.*
Consider what disadvantages, or reductions to the adult's quality of life, or freedom, or independence might result from these actions (e.g. if increased supervision, change of home, statutory intervention).
- 6 Ability to communicate effectively is essential to obtain accurate information. This includes capacity to understand and articulate views.*
- 7 Independent advocacy should be offered to all service users who progress to ASP investigation regardless of whether there are legal powers in place and should be considered for all other appropriate cases.*
- 8 It should state if the person is an adult at risk and the reason for this decision, e.g. how they meet or don't meet the criteria of the 3 point test. It should be documented that consideration has been given to using the appropriate legislation, e.g. ASP if meet the 3 point test, or other relevant legislation is more appropriate AWI, MH Act. If unsure if person meets the criteria for "adult at risk" a network meeting should be convened.*
- 9 Record of Inquiry should consider all aspects of the current situation and information obtained and observations made during visit and information gathering.*
- 10 Support needed/risk management plan - What support is required for adult at risk and for the wider family in order to reduce risks? Any risk identified must be recorded with an action relating to reduce risk. Detail any immediate or planned actions taken in order to protect, or reduce the risk. If risk remains, consider completing the positive risk taking form. If there is still concern regarding risks, discuss with team leader if referral to CCIG would be appropriate.*
- 11 The information gathered should provide an overview of investigation and must be analysed to give a balanced view of risks, protective factors and client choice. Recommend action to be taken in the longer term to reduce the risk, or protect the adult. If no further action under ASP, identify any transfer to other team or organisations.*
- 12 The outcome of any intervention should be recorded to allow for evaluation of effectiveness of inquiry.*

Worker signs the form and forwards to Team Leader. After the Team Leader has agreed the proposed action, the form is signed and forwarded to the Service Manager for authorisation.

A copy is sent to the Adult Support and Protection Co-ordinator.



Protection of Adults at Risk Inquiry Form

Details of Subject

Client Information			
Name		Date concern notified to Community Care	
IT System No			
Age		Date screened	
Gender		Date Inquiry completed	
Address		Any previous allegations of harm?	
Team		If 'Yes', date(s) if known	
Referred by			
Lives alone?		What needs to be assessed?	
Is capacity assessment required?		Type of alleged harm	
Client group		If location of harm 'Other', please state	
Location of alleged harm		Name of Guardian or Attorney	
Legal status (e.g. Adults with Incapacity Act Guardianship, Mental Health Act Compulsory Order)			

Alleged Perpetrator			
Name		Does the alleged perpetrator need to be informed? (see Guidance)	
Address			If 'Yes', date informed
Age		If 'No', list reasons	
Gender			
Relationship to client		Does he/she have access to vulnerable people?	
Is the person known to H&CC?		Date Police contacted if applicable	
Date of Entry on IT System			
If alleged perpetrator is under 16 years or is a vulnerable adult, to which service has he/she been referred?			
Multiple perpetrators? (If 'Yes' check IT System for further information)			



Legal Status (e.g., Adults with Incapacity Act Guardianship, Mental Health Act Compulsory Order)					
Care Programme approach?	Yes/No	Hazard activated?	Yes/No	Date	

Referral to Other Agencies	
Police	
Op Mental Health Team	
Community Mental Health	
Community Health	
Advocacy	
Central Health Care - Homeless	
Housing Association	
Victim Support	
Other Agency (<i>please state</i>)	
Other Local Authorities	

Referral to Other Teams	
CJS	
Housing	
Drug & Alcohol Team	
Mental Health Team	
Community Wardens	
Community Safety	
Supporting People	
Child Care Team	
Locality Team	
Learning Disabilities	



Client IT System ID

1 **Presenting Concern** (*Details of referral*)

2 **Background** (*Relevant information*)

3 **Chronology** (*A list in date order of all the major changes and events in a person's life - what is important to the person is key here - an event which may affect one person may be insignificant to another*)

4 Involvements

Section (5 and 6) of The Adult Support and Protection (Scotland) Act 2007 should be taken into account when looking at co-operation from other agencies and when considering advocacy.

Household composition

Related Person's Name	Relationship

Name	Role

5 Risk Assessment

- ❖ *Include risks to other adults, children and from others.*
- ❖ *Consider what disadvantages, or reductions to the adult's quality of life, or freedom, or independence might result from these actions (e.g. if increased supervision, change of home, statutory intervention).*
- ❖ *Consider need to complete a positive risk taking form.*

Identification and discussion of risks

Risk Identified	Triggers	Protective Factors	Consequences



Client view of risk

(Does the client feel at risk and give reasons)

6 Have communication and capacity needs been assessed? Are

any supports needed, e.g. Appropriate adult, talking mats?

Yes/No If 'Yes' please specify

7 Has advocacy been offered?

Should be offered to all adults who progress to ASP Investigation regardless of capacity or if legal powers in place. Carer can also be offered advocacy if applicable.

Yes/No/Offered but refused

8 Is this person an adult at risk/meet the 3 point test?

** are unable to safeguard their own wellbeing, property, rights or other interests;*

** are at risk of harm; and*

** because they are affected by disability, mental disorder, or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.*

Please explain reasons for the decision.

If 'Yes', ASP Investigation (complete headings 9-14)

9 Is this part of a Large-Scale Inquiry?

If 'Yes', use Large-Scale Inquiry for under Care Setting IT System record.

10 Record of Investigation

Consider capacity issues.

Consider environmental and protective factors.

Current Situation:

Client Views:

Family Views:

Disagreements/Challenges:

11 Support Needed/Risk Management Plan

What support is required for adult at risk and for the wider family in order to reduce risks?

Any risk identified must be recorded with an action relating to reduce risk.

Detail any immediate or planned actions taken in order to protect, or reduce the risk.



Identified Risks	Action Taken or Needed	Date to be Completed	Person Responsible

Have risks been reduced?

Yes/No If 'No' consider if Positive Risk Taking Form needs to be completed

12 Analysis and Recommendation

Provide overview of investigation and what action you recommend is taken in the longer term to reduce the risk or protect the adult.

13 Has the hazard been activated?

Yes (enter date in text field)/No

Date

14 Progressing to Adult Protection Case Conference?

Yes (enter date in text field)/No

Date

If 'No' - Outcomes: Has the intervention been helpful?

Yes (give details)

Signature _____ (Adult at risk) Date _____

Signature _____ (Council Officer) Date _____

Signature _____ (Team Leader) Date _____

Signature _____ (Service Manager) Date _____



This page should contain a brief concise description of concern raised, information gathered in course of investigation, analysis and recommendation. It must contain the salient points that clearly show why this action is proposed to allow Line Mangers and Service Managers to make informed decisions. The incident of harm and involvement tabs need to be completed before opening the Adult Protection Form as this information will populate the form.

- 1 The description of concern raised in referral should clearly and concisely state the concern raised in the referral.*
- 2 Background should include any relevant details that is pertinent to the concern raised or environmental/family factors that impact on the issue.*
- 3 History/Chronologies - The key purpose of a single agency chronology is to provide an easily accessible record of significant events and/or changes that have impacted (immediate or cumulative) either negatively or positively on the person. This is to assist in the collation and analysis of key information for the identification and patterns of risk. There may be a need to collect and collate chronology from a variety of sources.*
- 4 Involvements - All professional and relevant personal involvements, especially if reside in same household should be recorded. This area will populate with information if the involvements tab has been updated.*
- 5 Risk assessment should include risks to other adults, children and risk of harm from others. Consider intrinsic risks like wandering and effect of memory and cognitive impairment. Consider what disadvantages, or reductions to the adult's quality of life, or freedom, or independence might result from these actions (e.g. if increased supervision, change of home, statutory intervention).*
- 6 Ability to communicate effectively is essential to obtain accurate information. This includes capacity to understand and articulate views.*
- 7 Independent advocacy should be offered to all service users who progress to ASP investigation regardless of whether there are legal powers in place and should be considered for all other appropriate cases.*
- 8 It should state if the person is an adult at risk and the reason for this decision, e.g. how they meet or don't meet the criteria of the 3 point test. It should be documented that consideration has been given to using the appropriate legislation, e.g. ASP if meet the 3 point test, or other relevant legislation is more appropriate AWI, MH Act. If unsure if person meets the criteria for 'adult at risk', a network meeting should be convened.*
- 9 If this incident forms part of a Large-Scale Inquiry, use the Large-Scale Inquiry form under the Care Setting record on IT System.*
- 10 Record of investigation should consider all aspects of the current situation including client and family/ carer views and any disagreements and challenges.*
- 11 What support is required for adult at risk and for the wider family in order to reduce risks? Any risk identified must be recorded with an action relating to reduce risk. Detail any immediate or planned actions taken in order to protect, or reduce the risk. If risk remains, consider completing the positive risk taking form.*
- 12 The information gathered should provide an overview of investigation and must be analysed to give a balanced view of risks, protective factors and client choice. Recommend action to be taken in the longer term to reduce the risk, or protect the adult.*
- 13 Hazard activated - All clients who proceed to Adult Protection Case Conference should have a hazard lodged with IT System.*
- 14 Please state if progressing to Adult Protection Case Conference (APCC). If 'Yes', record date of APCC. If 'No', state reason why not and complete outcomes of intervention to allow for evaluation of effectiveness of investigation.*

Worker signs the form and forwards to Team Leader. After the Team Leader has agreed the proposed action, the form is signed and forwarded to the Service Manager for authorisation. A copy is sent to the Adult Support and Protection Co-ordinator.



Appendix 12

Guidance on GP Involvement in Multi-Agency Protection Arrangements/Capacity Assessment Letter Proforma

Guidance on the Involvement of GPs in Multi-Agency Protection Arrangements

This is a summary of the guidance and contains only part of the information contained in the document. The full version can be accessed at:

www2.gov.scot/Topics/Health/Support-Social-Care/Adult-Support-Protection/Resources/GPGuidance

Introduction

1 This guidance has been produced by the Scottish Government to help support the involvement of GPs in adult protection. It is designed to ensure that GPs are part of local multi-agency arrangements for adult protection and are thereby enabled to:

- fulfil their statutory responsibilities under the Adult Support and Protection (Scotland) Act 2007 ('the 2007 Act');
- make a broader contribution to adult protection beyond that required by statute.

- 2 Section 1 provides an overview of the framework for the multi-agency arrangements enshrined in the 2007 Act and offers advice on how GPs might be included within the management structures of these networks. A collaborative approach is vital and GP involvement invaluable when developing and/or refining local adult protection policy, procedure and strategy to ensure statutory obligations can be met and adult protection delivered effectively. However, this guidance is not intended to be a substitute or replacement for locally agreed arrangements already in place. Its aim is to guide thinking and encourage consistency in the overall approach to GP involvement in multi-agency arrangements for adult protection across Scotland.
- 3 Section 2 sets out the main ways GPs may come into contact with the 2007 Act and considers the issues this raises, such as the benefit of having local adult protection policies which cover the range of interested professionals and the duty GPs have in regard to patient confidentiality.
- 4 The guidance is for GPs primarily and for those involved in the management of adult protection. It is also for their colleagues in primary care teams and others involved in GP activity, such as practice managers, Local Medical Committees and the BMA. For these people, it will aid understanding of the wider context for adult protection, including the network of interests involved, and provide guidance on the key issues adult protection raises for them.

Section 1: Multi-Agency Adult Protection Arrangements Integrating GPs into Local Multi-Agency Networks

- 8 GPs have a key role to play in adult protection. They may be the first professional to see signs of potential harm, and are crucial not only in helping to protect adults, but also in helping to develop effective multi-agency responses.

Duty to Co-operate

- 8 Multi-agency partnership is at the heart of the 2007 Act. This approach is underpinned by a statutory duty placed on a range of public bodies and office holders to co-operate with Councils and with each other where harm is known or suspected. The duty to co-operate applies to:

- all Councils;
- Health Boards;



- *the Mental Welfare Commission for Scotland;*
- *contractors (including GP independent contractors - university staff with honorary contracts);*
- *the Care Inspectorate - Healthcare Improvement Scotland;*
- *the Public Guardian - Chief Constables of Police forces;*
- *any other public body or office holder that Scottish Ministers specify.*

Involving GPs in multi-agency arrangements for adult protection will help develop a strong understanding of the considerations and pressures that apply in adult protection cases. It will help to raise awareness of adult protection generally among GPs, so that they know how to respond when they encounter a possible adult protection case. Their involvement will allow their views to be taken into account in the development, revision and implementation of adult protection policies and procedures, as well as when agreeing strategic directions. It will also help foster a greater collaborative approach.

- 11 This type of collaborative approach will help to develop a shared understanding of the issues GPs must consider when interacting with the 2007 Act and carrying out adult protection activity, including respecting patient confidentiality. It should also help GPs to better understand the various processes and considerations that all professionals involved in adult protection are required to make. Involving GPs in this way will help to build mutual confidence in the processes to be followed and provide clarity on where roles and responsibilities lie.
- 12 This will help to address any practical difficulties in sharing information appropriately and developing strong, positive relationships between GPs and Social Workers. For example, local arrangements might be developed so that on referring a concern to the Council, GPs are sent details of the allocated Social Worker and an outline of the action that will be taken within a certain timeframe.

Section 2: GP Roles and Responsibilities in Adult Protection Overview of GP Responsibilities

- 17 GPs can become involved in the adult protection process in a number of ways. This section sets out the various responsibilities GPs have under the 2007 Act and the type of activities they may be asked to undertake as part of multi-agency adult protection arrangements. It also offers advice to APCs and others involved in the management of adult protection on the issues that local policy, procedure and strategy might cover to ensure appropriate and effective GP involvement in the delivery of adult protection.

- 18 There are four main ways in which GPs are most likely to be involved in adult protection:

- *taking appropriate steps when they identify possible adult protection case;*
- *carrying out medical examinations when requested to do so by a Council undertaking action under the 2007 Act;*
- *providing relevant information from healthcare records to a Council Officer who is carrying out certain functions under the 2007 Act;*
- *participating in other activity subsequent to action being taken under the 2007 Act, such as attending case conferences, providing reports and, on some occasions, providing evidence during court proceedings.*

- 19 In order to be able to respond promptly where there is cause for concern that an adult is at risk of harm, GPs should be familiar with:

- *the guiding principles of the 2007 Act and the duties they may be required to perform;*
- *local multi-agency adult protection arrangements, including key contacts in the network, particularly in the Council Social Work department;*
- *how to make an adult protection referral and how the Council is obliged to respond;*



- *the Code of Practice 3 to the 2007 Act (which offers useful practical advice on carrying out functions);*
- *the multi-agency adult protection arrangements set out in Section 1 of this guidance note;*
- *the Data Protection Act 4 and the ICO Data Sharing Code of Practice 5 Identifying and responding to harm.*

20 Where a GP knows or believes that a patient is or may be an adult at risk of harm they must make a referral to the Council in line with local Adult Protection Procedures. The circumstances may be so serious that it may be necessary to alert the Police straight away. However in the majority of cases contact with the duty Social Work service would clarify when and who would involve the Police. For example, a suspected case of neglect might be referred to the Council only, but where it is suspected that a crime is being committed, such as physical or financial harm, the GP should alert the Police as well. When a Council is made aware of a possible case of adult harm it has a duty under Section 4 of the 2007 Act to make the necessary inquiries to decide if action is required to stop or prevent harm from occurring. This will include considering whether the adult meets the ‘adult at risk’ definition as per the three-point criteria at Section 3. Where the criteria are not satisfied the 2007 Act will not apply; however, this decision will not prevent the Council from working to identify alternative and appropriate means of support and/or protection for the individual using means other than the 2007 Act. Local protocols can be important to ensure that all appropriate actions are taken.

21 The dynamics of harm can be complex and a number of factors may need to be considered. Some types of harm are subtle and have no obvious physical trace, such as psychological harm or financial harm. It should also be borne in mind that harm may occur through acts of omission. Some harm may be the result of lifestyle choices made by the adult. As such, care should be taken to avoid implying that deliberate or malicious abuse has occurred.

22 Councils have a legal obligation to instigate an adult protection inquiry if they know or believe that an individual is or may be an adult at risk of harm. A Council will be able to provide general advice on adult protection, including the kind of steps that will be taken when a referral is received and the sorts of services an adult may be offered. It should be noted that if guidance is sought on an actual case this may trigger the duty to inquire by the Council. GPs should familiarise themselves and regularly update their knowledge of local adult protection procedures and guidelines so that they understand what processes will be set in motion by a referral. This will be made easier by involving GPs in multi-agency adult protection procedures.

24 Where a GP has made a referral the Council should keep the GP informed about what action is being taken as result. Social Workers carrying out adult protection activity should be mindful that GPs are likely to have ongoing relationships with any patient who they have referred to the Council. Being kept up-to-date with progress will be important in informing any future interactions between the GP and their patient. More generally, this will help to build strong links between adult protection leads in Councils and GPs. Local multi-agency adult protection arrangements should therefore ensure that where a GP has made a referral that he or she is subsequently provided with information on:

- *any intervention made to support and protect the adult;*
- *whether the adult is safer as a result of any intervention;*
- *whether the adult has an improved quality of life as a result of any intervention.*

Information about outcomes could also be gained through GP engagement in adult protection processes such as initial referral discussions and Case Conferences.

25 GPs should ensure that all actions carried out by them, including records of any conversations and meetings with public bodies, and decisions made by them are documented fully in the patient’s healthcare records.

Patient Consent in the Referral Process

26 When responding to a suspected case of harm, the duty of confidentiality will be a key consideration for GPs, as it is for all public bodies involved in adult protection. GPs must consider the need to balance his or her duty of care to the patient and towards public protection with the need to protect patient confidentiality and



autonomy. Where the adult has the capacity to consent (to a particular decision), GPs will always seek to gain his or her consent before taking action on their behalf and this includes when making a referral under the 2007 Act. There are a number of sources of advice on patient confidentiality including:

- *the NHS Code of Practice on Protecting Confidentiality;*
- *the General Medical Council's guidance document Confidentiality;*
- *the BMA's Confidentiality and Disclosure of Information Toolkit;*
- *the BMA's Handbook of Ethics and Law 10.*

- 27 It should be assumed that an adult has capacity to consent to a particular action until proven otherwise. It is not the case that an adult who has a mental disorder automatically lacks capacity. Similarly, no assumptions should be made about an adult's capacity on the basis of age, appearance, condition or any aspect of their behaviour.
- 28 Capacity is decision-specific and not necessarily static: for example, it may fluctuate from one day to the next, and may apply differently to specific decisions. An adult's capacity should therefore be judged based on specific circumstances at a given time, including consideration of the nature of the decision which requires to be made. Consent might also be granted after initially being refused.
- 29 Where an adult's capacity to consent to an adult protection referral being made is in question, an assessment of his or her capacity should be undertaken. There is no single test of capacity, and any test should not be so high that it undermines an adult's right to autonomy. Efforts should be made to assist the adult in understanding why an assessment of his or her capacity is needed, to assist their consideration of the result of that assessment and to enable them to communicate this to other significant individuals, such as their carer or nearest relative. The adult should also be advised of their right to access independent advocacy and to make a referral for this if they wish.
- 30 Where the patient has a Responsible Medical Officer (RMO), it is expected that the RMO would provide advice on the patient's ability to consent, as well as assisting with an assessment of capacity as necessary. Where there is no RMO, in many cases the GP will be able to carry out the assessment of capacity but where an assessment is complicated (e.g. by mild learning disability or mental illness) then appropriate steps should be taken to seek advice and input from an appropriately skilled medical practitioner.
- 31 Although the decision as to whether or not an adult has capacity will be made by a single medical practitioner, assessments of capacity should be undertaken on a multi-agency basis. Professionals from different backgrounds who have a long-standing or ongoing relationship with an adult may be able to offer a view on whether:

- *the adult's behaviour or ability at the time of the assessment is typical;*
- *whether they have demonstrated capacity in particular regards in the past; or*
- *whether there are certain methods of helping the adult make a decision which have previously proved successful.*

- 32 The GP should consider seeking the views and contribution of relevant professionals with whom the adult is familiar to provide the adult with the support and confidence necessary to make the decision to consent to the proposed action being taken.

Adults with Incapacity

- 33 Adults assessed as being unable to consent to an adult protection referral being made may be particularly at risk. GPs must immediately take action on their behalf and make a referral to the Council, and, if they judge it to be appropriate, also alert the Police. The formal assessment of capacity is more likely to come later, on request from a Council Officer exercising functions under the Act. Any subsequent intervention made under the 2007 Act will be guided by the 'least restrictive' principle.



- 34 GPs may wish to seek reassurance from senior colleagues or professional representative bodies such as the BMA, medical defence unions, Caldicott Guardians, and the GMC, but should not delay taking action. The sources of information on patient confidentiality listed at paragraph 26 may also be of use and Councils will also be a good source of advice on how best to respond in these type of circumstances, bearing in mind that Councils have a duty to make inquiries when they know or believe that a person is an adult at risk of harm and that they might need to intervene.
- 35 When an adult has been assessed as having incapacity, GPs should ordinarily seek to speak to anyone who has guardianship powers or welfare power of attorney in regard of the adult. This engagement may also help the GP and/or Council decide on the most relevant course of action. However, in some cases it may be someone with guardianship or welfare responsibilities who is the source of the harm so GPs must make a careful consideration about discussing the case with such individuals. If there is any doubt the GP should liaise with the Council as necessary.

Adults with Capacity Who Withhold Consent

- 36 The decision on how to respond to a suspected case of harm is made additionally complex where the adult has the capacity to consent to the GP making a referral under the 2007 Act, but chooses not to do so.
- 37 Competent adults have considerable rights about the extent to which their information is used and shared, and these are protected both by law and by professional and ethical standards. Although the 2007 Act requires relevant information to be shared with the Council, or any other public body, for the purposes of protecting an adult at risk of harm, where a competent adult explicitly states that an adult protection referral should not be made, this should ordinarily be respected. Well-established local arrangements will help reassure patients that any information sharing will be handled sensitively.
- 38 Where a competent adult refuses to agree to an adult protection referral that would seem in their best interests and could help to mitigate a potential harm, the GP might consider it appropriate to employ the following strategies when discussing the matter with their patient:

- *advise them of the risks of failing to alert relevant authorities and the benefits of doing so;*
- *sensitively explore the reasons for their refusal to grant consent;*
- *encourage them to speak to the Council directly, emphasising that it is in their best interest to allow the Council to carry out an inquiry under the 2007 Act;*
- *explain the 'least restrictive' principle that guides any intervention made;*
- *assist or empower them to take steps to safeguard themselves, including providing advice on independent advocacy services and other services which could offer support and protection. This may include the GP, with the adult's consent, contacting independent advocacy services in the local multi-agency adult protection network on their behalf;*
- *seek further advice, perhaps consulting the Mental Welfare Commission.*

- 39 It is reasonable to ensure that the adult is informed about and understands the consequences of his or her decision, but an adult with capacity has the right to make his or her own decisions without interference or coercion.
- 40 Pressure should not be exerted on an adult to consent, nor should another professional exert pressure on a GP to take action, including sharing information, where an adult with capacity has refused to consent to action being taken. In order to best comply with the Data Protection Act, approaches outlined above should be adopted prior to seeking consent, to ensure that the patient is properly informed at the outset, removing any suggestion of coercion if consent was not initially forthcoming.
- 41 While adults with capacity have the right to consent or otherwise to the GP making a referral, this right is not absolute and may be overridden. The multi-agency approach to adult support and protection means that, where it is lawful and ethical to do so, appropriate information should be shared between relevant agencies to ensure that support that is right for the individual can be provided. GPs should take a proportionate approach to make balanced decisions about whether to share information without consent.



- 42 Where it appears to the GP that a crime is being, or has been, committed, the GP must report it to the Police. In such circumstances, a GP should keep the patient informed as much as possible, even though the report may have been made against the patient's wishes. In addition to informing the Police, the GP may also choose to notify the Council if it appears necessary or appropriate to safeguard the adult or his or her interests. Failure to report a crime may lead to a GP being held accountable for a serious failing of his or her duty to protect the adult or other people.
- 43 GPs should also be alert to the possibility that consent may be withheld because the adult in question is being unduly pressurised to refuse. Undue pressure could include, for example, threats, blackmail, manipulation, dependency on the harmer, or a sense of responsibility or loyalty to the harmer. If a GP suspects that consent is being withheld because of undue pressure from another party, it is reasonable to take action in the patient's best interests and make a referral to the Council. Similarly, if the GP considers it appropriate in the circumstances, for example if the adult is at risk of ongoing harm if no intervention is made, they must refer the case to the Council, even though consent has not been given. In such circumstances, the GP must consider the need to balance his or her duty of care to the patient and towards public protection with the need to protect the patient's confidentiality and autonomy.

Requests to Undertake Medical Examinations

- 49 The 2007 Act creates powers for Councils to ask a nominated health professional to undertake a medical examination for the purposes of establishing whether an adult is at risk and to inform the Council's decision on whether any further action is required.
- 50 In the context of the 2007 Act, *'health professional'* means a doctor, nurse, midwife or any other type of individual described (by reference to skills, qualifications, experience or otherwise) by order made by the Scottish Ministers (to date, no such order has been made).
- 51 In most cases covered by Sections 9 and 11, the adult's GP may be the most appropriate health professional to carry out a medical examination. GPs are an important part of multi-agency adult protection arrangements and must consider favourably requests to carry out examinations and other activity under the 2007 Act.
- 52 Two sections of the 2007 Act relate specifically to medical examinations. Section 9 allows a medical examination in private to be carried out where a Council Officer is carrying out a visit under Section 7 of the 2007 Act and finds a person who is, or may be, an adult at risk of harm. The Council Officer must be accompanied by a health professional for this purpose and before any examination is carried out the adult must be informed of his or her right to refuse.

Providing Relevant Information From Healthcare Records

- 62 In carrying out inquiries and investigations under the 2007 Act, a Council Officer may request health records (as well as financial and other records) relating to an individual who the officer knows, or believes, to be an adult at risk of harm. This is an important part of a Council carrying out its functions under the 2007 Act, as it will help to ascertain whether the individual is an adult at risk, as well as potentially indicating the nature and extent of any harm which has been experienced. This will not only allow appropriate support and protection to be offered to the adult, but it may lead to action being taken against the person who caused the harm. Records should be handled securely in accordance with DPA principle 7 with local protocols developed in line with the Information Commissioner's Office Code of Practice.
- 63 Section 10 requires any person holding health records to disclose them to a Council Officer carrying out an adult protection inquiry or investigation for the purpose of enabling the Council to decide whether it needs to do anything further to protect an adult at risk. Under Section 49(2), it is an offence for a person to refuse or otherwise fail to comply with a request made under Section 10, without reasonable excuse.
- 64 Only a health professional may physically inspect health records. The Adult Support and Protection (Scotland) Act 2007 (Restriction on the Authorisation of Council Officers) Order 200816 allows a Council to authorise a person to carry out the Council Officer functions under the 2007 Act if they are a nurse and have at least 12 months' post qualifying experience of identifying, assessing and managing adults at risk. If the Council Officer requesting health records under Section 10 does not meet this definition, he or she must pass the records to a health professional for examination and the GP should be informed of this.



65 In carrying out this function, the Council Officer must speak to the GP to provide context as to why the records are being requested, in particular emphasising that only information relevant to the assessment of risk and to allow the Council Officer to assess whether any further action is required to safeguard the adult is needed. There is not necessarily a need for entire healthcare records to be provided; only such information as is relevant to the case, and this may not need to be in writing if that is sufficient for the Council Officer to carry out his or her duties under the 2007 Act. However if a Council Officer receives information verbally a note of any relevant information might be prepared and agreed with the healthcare professional for accuracy and to provide an audit trail of actions. The Council Officer must discuss the nature of the case with the GP to decide jointly what medical information is required for this purpose.



Dear Dr

Re: Request for Capacity Assessment

Name of Adult: _____

Address:

Date of Birth: _____

As the Social Worker/Council Officer/Social Work Assistant involved with _____ I am writing to request an assessment of capacity.

I am requesting a specific assessment of capacity relating to _____
(e.g. ability to manage money. Describe the behaviour causing concern that is affecting their decision-making process and any relevant information about current circumstances)

I am requesting a capacity assessment at this time as the outcome will allow us to _____

(explain how the capacity assessment will alter current situation, e.g. intervene under legislation if they lack capacity in this area)

The Adults with Incapacity Act 2000 makes use of a 'functional' test of capacity which focuses on the decision-making process itself and identifies certain areas in the decision-making process.

The area of main concern in relation to decision making is:

- () to understand the information relevant to the decision;
- () to retain the information relevant to the decision;
- () to use or weigh the information; or
- () to communicate the decision (by any means);
- () the ability to act on decisions made.

As there are adult protection concerns there is a degree of urgency for this request and I would appreciate if this could be given priority.

Yours sincerely

Social Worker/Council Officer/Social Work Assistant

Team Leader



Appendix 13

Undue Pressure (Section 35)

(The provisions relating to undue pressure do not apply where the adult at risk does not have capacity or if it has not been possible to ascertain the view of the adult at risk, e.g. access has been denied)

No Protection Order can be granted where the court knows that the adult at risk has refused consent to this unless the Sheriff reasonably believes that:

- (a) the adult at risk has been unduly pressurised to refuse consent to the action; and*
- (b) there are no steps which could reasonably be taken with the adult's consent which would protect the adult from harm which the Order or action is intended to prevent.*

'Undue Pressure' applies in situations where the harm is carried out by a person in whom the adult has confidence and trust and where the adult at risk would consent to the inquiry investigation of harm if the adult did not have confidence and trust in that person. A relationship founded on trust and confidence may be with a family member, neighbour, or other person who may provide support in order to exploit or harm, or a person upon whom the adult at risk is very dependent.

There may be other situations where it could be shown that there has been undue pressure. There may be grounds which evidence undue pressure where the adult may not wish to upset the person by giving consent because of:

- *anticipation of threats or intimidation;*
- *belief that the consequences of giving consent will result in the adult at risk experiencing negative consequences;*
- *fear of abandonment and/or loneliness;*
- *fear of withdrawal of practical and emotional support;*
- *being worried about talking when certain people are present;*
- *not being allowed time alone with the worker;*
- *lack of eye contact;*
- *personal presentation.*

The Act says that if there has been undue pressure, a refusal to consent can be ignored:

- (a) by the Sheriff in determining whether to grant a Protection Order; or*
- (b) by any person taking action to carry out or enforce a Protection Order. However, in this case, a refusal of consent cannot be ignored where it relates to the interview or medical examination of the adult. Therefore an interview or medical examination cannot take place where the adult refuses consent, even if the Council Officer thinks there has been undue pressure. In these circumstances much will depend on the evidence which has been gathered for the application from sources other than the adult themselves.*

The burden of proof of establishing that there has been undue pressure on an adult at risk rests with the Council in court applications.

Where the Council considers that, after making inquiries under Section 4, it needs to intervene, it has a duty to ensure that the adult's past and present wishes are represented and that the adult is assisted to participate as fully as possible in proceedings.



Appendix 14

Organising and Chairing an Adult Protection Case Conference

1 Organising and Chairing

Adult Social Work and Social Care will take responsibility for the organising and chairing of Case Conferences. The Chairperson should be the Locality Manager involved. He or she will ensure that time and venues are arranged and that all relevant people are invited.

Whenever possible, and where appropriate, the adult at risk should be invited to attend. He or she will have the right to be accompanied by an independent advocate, appropriate adult or support worker of their choice, including family member(s). Before attending a Conference, the adult at risk and, where appropriate, his or her relative(s) or carer(s) should be briefed about the purpose and format of the meeting. The person who will take the minutes of the meeting should be identified in advance and should not be the Chairperson.

1.1 Guidance to Chairpersons

- *Where there is dissent or concern, the Chairperson will consider and rule on requests for a family member and/or a carer to be included or excluded from the Case Conference or requests that the adult involved should or should not attend the Case Conference. Decisions about who should or should not attend should be recorded in writing with reasons.*
- *Provision should be made for the Chairperson to ascertain if any professional needs to share information without the family being present. If so, this should be done prior to the family joining the Case Conference. It is expected that this will be exceptional and that the adult at risk and family or carer, will be able to attend for all of most meetings.*
- *The Chairperson will introduce him or herself to the adult involved and his or her family and/or carer immediately prior to the Case Conference and confirm their understanding of the purpose and process of the Case Conference.*
- *Where the adult at risk (and/or his or her family or carer) has chosen not to attend or has been excluded from the Case Conference, the Chairperson must ensure that the decisions of the Case Conference are fed back to them as soon as practicable after the Case Conference. Where appropriate, the adult at risk should be consulted before details are passed to family or carer(s).*
- *The Chairperson will ensure that the minutes of the Case Conference are accurate and that they are distributed to the appropriate agencies and, where appropriate, the adult at risk and his or her family and/or carer within ten working days of the Case Conference.*
- *The Chairperson should ensure that any necessary communication aids (e.g. loop system) are made available.*

1.2 Involvement of the Adult at Risk

The wishes and needs of the adult at risk are at the heart of the Case Conference process. It should be normal practice for the adult to be involved in discussions about them and their circumstances.

In making decisions about the adult at risk's involvement, the Chairperson should be guided by:

- *the capacity of the person;*
- *the information likely to be shared at the Case Conference;*
- *the likely effect on the adult, particularly when the person suspected of harm may also require having some involvement;*
- *the views of the family and carers.*



1.3 Involvement of Family and Carers

If the adult at risk does not wish the attendance of a family member or carer and it is felt crucial to any protection plan that the family member or carer attend, the Social Worker should discuss the issue with the Chairperson who will make a final decision on attendance. Decisions will be recorded in writing.

1.4 Exclusion of Family and Carers

This will only occur where there are substantive grounds to believe that the involvement of family and carers would undermine the process and purpose of the Case Conference and they may need to be excluded throughout.

Grounds for exclusion would be:

- when a significant level of conflict or tension exists within the family and carers or;
- when there is substantive evidence to believe that there is a likelihood of violent or serious disruption of the process of the Case Conference;
- if frank discussion would be curtailed by the presence of a particular person.

Family and carers may also be excluded when third party or sub-judice information is being presented to the Case Conference.

Being an alleged perpetrator is not sufficient reason in itself to exclude a family member or carer. This may be judged necessary by the Chairperson if it is considered that their presence would seriously affect the consideration of the risk to the adult concerned.

1.5 Involvement of a Friend or Advocate

There may be occasions when the adult concerned, or a carer or family member may wish to be supported by the attendance at the Case Conference of a friend, other relative, professional person or member of an independent advocacy service. The attendance of such a person who may be able to assist the adult in clarifying the content of the discussion should be encouraged. The use of an independent advocate should be considered.

1.6 Attendance of Professionals

Conferences should be attended by individual professionals from partner agencies that have a direct contribution to make and a role to play. These may include:

- Social Work professionals carrying out the investigation or who already know the individual and/or their carer or family and their supervising Senior Social Worker or Team Leader;
- medical professionals who are involved in the investigation or who know the carers and family concerned (e.g. Health Visitor, GP, District Nurse, Community Mental Health Nurse etc);
- Police officers who are involved in the investigation;
- voluntary or private sector staff who are directly involved with the carer/family;
- residential or day care staff involved with the adult;
- members of the interpretation services;
- Power of Attorney or Welfare Guardian;
- the Office of the Public Guardian.

Consideration needs to be given to the number of people attending the Case Conference as the purpose is to enable the adult at risk to be fully involved in the discussion and the decision-making process.



1.7 Information Sharing

Confidentiality is required from each participant in a Case Conference, and this should be made explicit at the beginning of the meeting by the Chairperson. Information will be shared in line with the legislation on Data Protection.

Exceptionally, it may be considered that the disclosure of certain information in this kind of meeting could cause serious damage to the person it concerns, and care needs to be taken on how this information is shared.

2 Conduct of Case Conference

2.1 Introduction

The Chairperson introduces the Case Conference by confirming:

- the function of the Case Conference and the context of the adult protection guidelines;
- the right to information of those present; clarifying that certain information may have to be restricted, giving the reason for that restriction;
- the Chairperson then asks participants to introduce themselves.

2.2 Fact Gathering

The professionals are asked by the Chairperson to share information:

- beginning with the circumstances of the referral and conduct of enquiries;
- moving on to any relevant background information only once all the information relating to the current inquiry has been shared;
- the Chairperson briefly summarises each contribution at the time it is made to ensure that the contribution has been properly understood. This process should also facilitate the taking of the minute of the meeting;
- it is particularly important that the carers and family understand the information being shared and that they have an opportunity to make their own contribution. If there are disagreements about the information, then there should be an attempt to resolve these at the time. However, it may be that some disagreements can only be acknowledged;
- the unrestricted information shared at the Case Conference is summarised by the Chairperson.

2.3 Interpretation and Assessment

The Chairperson should lead the discussion which focuses on:

- What are the strengths of the family and carers and what are the threats to the adult at risk's wellbeing?
- What are the specific dangers to the adult at risk and/or the carers and family members?
- What extended family, professional and community supports could be offered?
- How can the harm be stopped?

2.4 Decisions

The Case Conference needs to decide whether the adult and/or any other person is believed to be at risk of being harmed, mistreated or neglected and if so:

- consideration must be given as to whether or not a referral should be made to the Police if it is believed that a crime may have been committed if this has not already been done;

(continued)



- an Adult Protection Plan must be agreed with a list of action points and timescales and details of who will be responsible and for what;
- a Communication Strategy should be included in the Protection Plan to ensure appropriate liaison between agencies;
- a Case Co-ordinator must be appointed who should be a Social Worker and regular contact to ensure Protection Plan is implemented;
- a Review date must be agreed which must take place within three months;
- any supplementary actions that may be required as a contingency in the event of a breakdown in care arrangements or other changes in circumstances;
- consideration of whether a Criminal Injuries Claim may be appropriate, along with the need for a referral to the Victim Support Agency.

2.5 Conclusion

The Chairperson will summarise the decisions made by the Case Conference and confirm with participants the roles that they will play in the Adult Protection Plan. The outcome questionnaire will be completed by the Social Worker at the conclusion of every Case Conference and checked by the Service Manager.

2.6 Minutes of the Case Conference

The minutes of the Case Conference should be completed and circulated to those attending and, where appropriate, with the consent of the adult at risk, to family and carers not present. The Chairperson is responsible for making any alterations to inaccuracies noted by those in attendance and for ensuring that the minutes are circulated to all the relevant people as soon as possible but within ten working days.

The minutes should include as a minimum:

- essential facts;
- details of the Adult Protection Plan (if applicable);
- whether the Case Conference decided to refer the matter to the Police;
- recommendations for further action;
- an account of the process of the discussion and the reasons for the recommendations;
- a note of any dissent;
- date of the Review Conference.

Where an adult at risk (and/or his or her family/carer) has chosen not to attend, lacks capacity or has been excluded from the Case Conference, the Chairperson must ensure that the decisions of the Case Conference are fed back as soon as practicable after the Case Conference to the appropriate person. Minutes must be distributed to all people who have attended the Case Conference and they must have the chance to voice concerns about the accuracy of the minutes.

Copies of the Adult Protection Case Conference minutes and Review Case Conference minutes are sent to the Head of Adult Social Work & Social Care and to the Adult Support & Protection Co-ordinator. Distribution of the minutes can be by email internally in Perth & Kinross Council and to other agencies with secure email. Otherwise registered post should be used.



ASP Protection Plan

Name	ID number
Gender	Age

Main address	
Incident type of harm	
Alleged perpetrator	
Location of harm	

Action 1

Description of action to be taken	How will this be done	Who will do it	How will we know that this is achieved	Was action achieved	Date

Action 2

Description of action to be taken	How will this be done	Who will do it	How will we know that this is achieved	Was action achieved	Date

Action 3

Description of action to be taken	How will this be done	Who will do it	How will we know that this is achieved	Was action achieved	Date



Adult Protection Initial Case Conference Questionnaire

- 1 Date adult protection hazard was activated _____
- 2 Date investigation completed _____
- 3 What are the factors present for the adult at risk?

Impairment of capacity	Yes/No/Not known/Not applicable
Social isolation	Yes/No/Not known/Not applicable
Unemployment	Yes/No/Not known/Not applicable
Marital problems	Yes/No/Not known/Not applicable
Debts/financial problems	Yes/No/Not known/Not applicable
Inadequate housing	Yes/No/Not known/Not applicable
Frequent address changes	Yes/No/Not known/Not applicable
Homelessness	Yes/No/Not known/Not applicable
Currently funding own services	Yes/No/Not known/Not applicable
People whose behaviour and visual presentation may suggest they are at risk	Yes/No/Not known/Not applicable
Owns their house	Yes/No/Not known/Not applicable
Communication difficulties	Yes/No/Not known/Not applicable
Inappropriate behaviour	Yes/No/Not known/Not applicable
History of family violence	Yes/No/Not known/Not applicable
History of unstable relationships	Yes/No/Not known/Not applicable
In receipt of services	Yes/No/Not known/Not applicable
Drug use	Yes/No/Not known/Not applicable
Alcohol use	Yes/No/Not known/Not applicable

- 4 What are the factors present for the alleged perpetrator?

Is there an identified alleged perpetrator?	Yes/No/Not known/Not applicable
Social isolation	Yes/No/Not known/Not applicable
Share accommodation with person harmed	Yes/No/Not known/Not applicable
Previous history of aggression	Yes/No/Not known/Not applicable
Drug use	Yes/No/Not known/Not applicable
Alcohol use	Yes/No/Not known/Not applicable
Financially dependent on person harmed	Yes/No/Not known/Not applicable
Financial problems	Yes/No/Not known/Not applicable
Schedule 1/sexual offender	Yes/No/Not known/Not applicable
Mental illness	Yes/No/Not known/Not applicable
Learning disability	Yes/No/Not known/Not applicable
Homelessness	Yes/No/Not known/Not applicable
Past history of offending	Yes/No/Not known/Not applicable



Unemployed	Yes/No/Not known/Not applicable
Caring role in relation to adult at risk	Yes/No/Not known/Not applicable

5 What has been the impact of harm on the adult at risk?

Level of Risk	Low	Medium	High
---------------	-----	--------	------

Does the adult at risk lack the capacity to be aware of impact?	Yes/No
Has the adult at risk been affected by the harm?	Yes/No
Feel safe	Yes/No
Deterioration in quality of life	Yes/No
Deterioration in health	Yes/No
Deterioration in wellbeing	Yes/No
Deterioration in responsibility and independence	Yes/No
Deterioration in self-confidence/control	Yes/No
Deterioration in family relationships	Yes/No
Notes field for comments	

6 What has been the impact of intervention on the adult at risk?

Does the adult at risk lack the capacity to be aware of impact?	Yes/No
Has the adult at risk been affected by the harm?	Yes/No
Feel safe	Yes/No
Deterioration in quality of life	Yes/No
Deterioration in health	Yes/No
Deterioration in wellbeing	Yes/No
Deterioration in responsibility and independence	Yes/No
Deterioration in self-confidence/control	Yes/No
Deterioration in family relationships	Yes/No
Notes field for comments	

7 Impact on the carer

Is there a carer involved?	Yes/No
Is the carer the alleged perpetrator?	Yes/No
Feel able to continue caring	Yes/No
Feels more supported	Yes/No
Feels anger/resentment at local authority	Yes/No
Other - please state	Yes/No



Relationship with adult at risk	Yes/No
Notes field for comments	

Adult Protection Review Case Conference Questionnaire

Codes: BI *big improvement*

SI *small improvement*

NC *no change*

W *worse*

ND *not discussed*

1 What has been the ongoing impact of intervention on the adult at risk?

Does the adult at risk lack the capacity to be aware of impact?	Yes/No				
	BI	SI	NC	W	ND
Feeling safe					
Quality of life					
Health status					
Wellbeing					
Responsibility and independence					
Self-confidence/control					
Level of financial independence					
Family relationships					
If the impact of intervention has been no change or worse, give reasons - <i>notes field for comments</i>					

2 Impact of intervention on the carer

Is there a carer involved?	Yes/No				
Is the carer the alleged perpetrator?	Yes/No				
	BI	SI	NC	W	ND
Feel able to continue caring					
Feels more supported					
Feels anger/resentment at LA					
Other - please state					
Relationship with adult at risk					
Notes field for comments					



3 Has there been any further occurrence of harm?

No

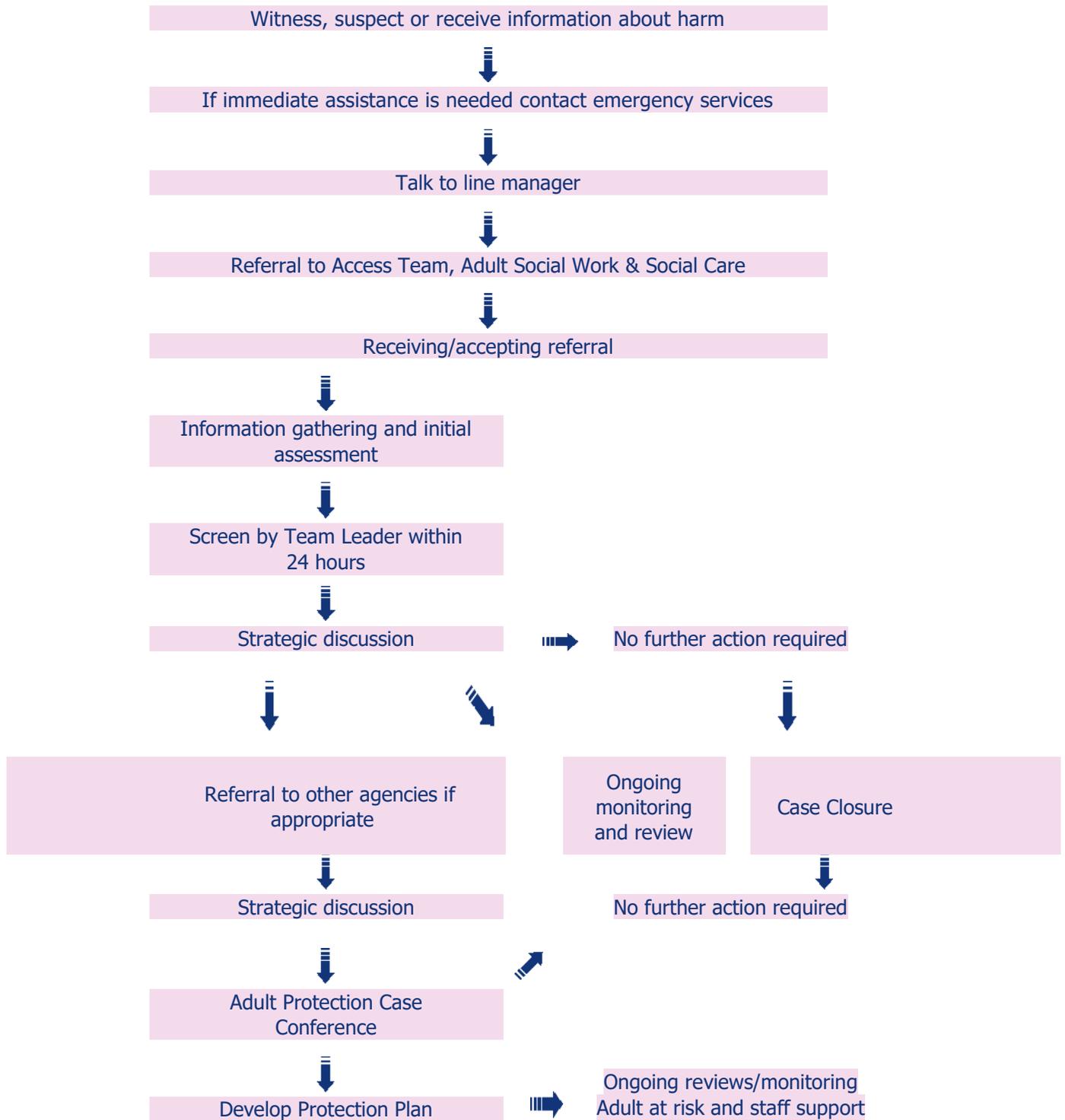
Yes - *what was the reason?*

Non-compliance with protection plan	
Different alleged perpetrator	
Further incident of harm by same perpetrator	
Other - please state	



Appendix 15

Adult Protection Process Flowchart and Responsibilities



1 Adult Protection - Responsibilities

1.1 Team Leader

- *Receive information about an adult protection concern.*
- *Screen information - record contact evidencing action to be taken or reason why none being taken.*
- *Gather further information.*
- *Allocate Social Worker.*
- *Contact Police if required.*
- *Notify Service Manager.*

The above actions are to be done on the same day the concern is reported.

- *Ongoing case discussion with the Council Officer (SW) throughout the inquiry investigation.*
- *Discuss the case with the Service Manager regarding further action as required throughout the inquiry investigation stage.*
- *Discuss with Legal Services if Protection Order being considered.*
- *Ensure completion of Adult Protection form. Sign and send to Service Manager who will add relevant comments, sign off and forward it to the appropriate person for statistical purposes.*
- *Carry out delegated tasks in relation to arranging a Case Conference.*
- *Attend Case Conference.*
- *Attend reviews as required.*

1.2 Social Worker/Council Officer

- *Commence inquiry investigation within 48 hours unless otherwise agreed with the Service Manager.*
- *Contact other agencies to gather appropriate information.*
- *Complete the inquiry investigation report immediately after the visit.*
- *Discuss with Team Leader.*
- *Carry out delegated duties in relation to arranging a Case Conference.*
- *Ensure that the investigation report and risk assessment is available to the Service Manager prior to the Case Conference.*
- *Attend the Case Conference and complete questionnaire.*
- *Inform the adult at risk of the outcome of the Case Conference as soon as possible if he or she was not in attendance.*
- *Ensure the Adult Protection Plan is recorded on IT system, shared with appropriate people and implemented.*
- *Attend Reviews as required.*
- *Visit on a regular basis unless otherwise agreed on the Action Plan and maintain case records.*



1.3 Locality Manager

- Be available for consultation.
- Be involved in discussion about future action including the need for Police involvement and a Case Conference.
- Ensure that the adult protection form is completed with evidence to justify decisions taken. Forward it to the appropriate person for statistical purposes and return a signed copy to case holder.
- In high-profile cases and where the media may be involved, the Service Manager must contact Head of Adult Social Work & Social Care to discuss and agree action to be taken.
- If proceeding to Case Conference, ensure appropriate arrangements are made within the timescale - ten working days from completion of investigation.
- Chair Case Conference and ensure questionnaire is completed.
- Agree protection plan and identify responsible person.
- If the adult at risk did not attend, delegate responsibility to notify the outcome within the agreed timescale.
- Ensure the accuracy of the minutes and sign them. Ensure that they are signed by the minute taker prior to circulation.
- Ensure circulation of minutes within ten working days of the Case Conference. These can be sent by email internally in Perth & Kinross Council and to the Police and other agencies which have secure email. Otherwise registered post should be used.
- Copies of minutes are to be sent to the Head of Adult Social Work & Social Care and to the ASP Co-ordinator for statistical analysis.

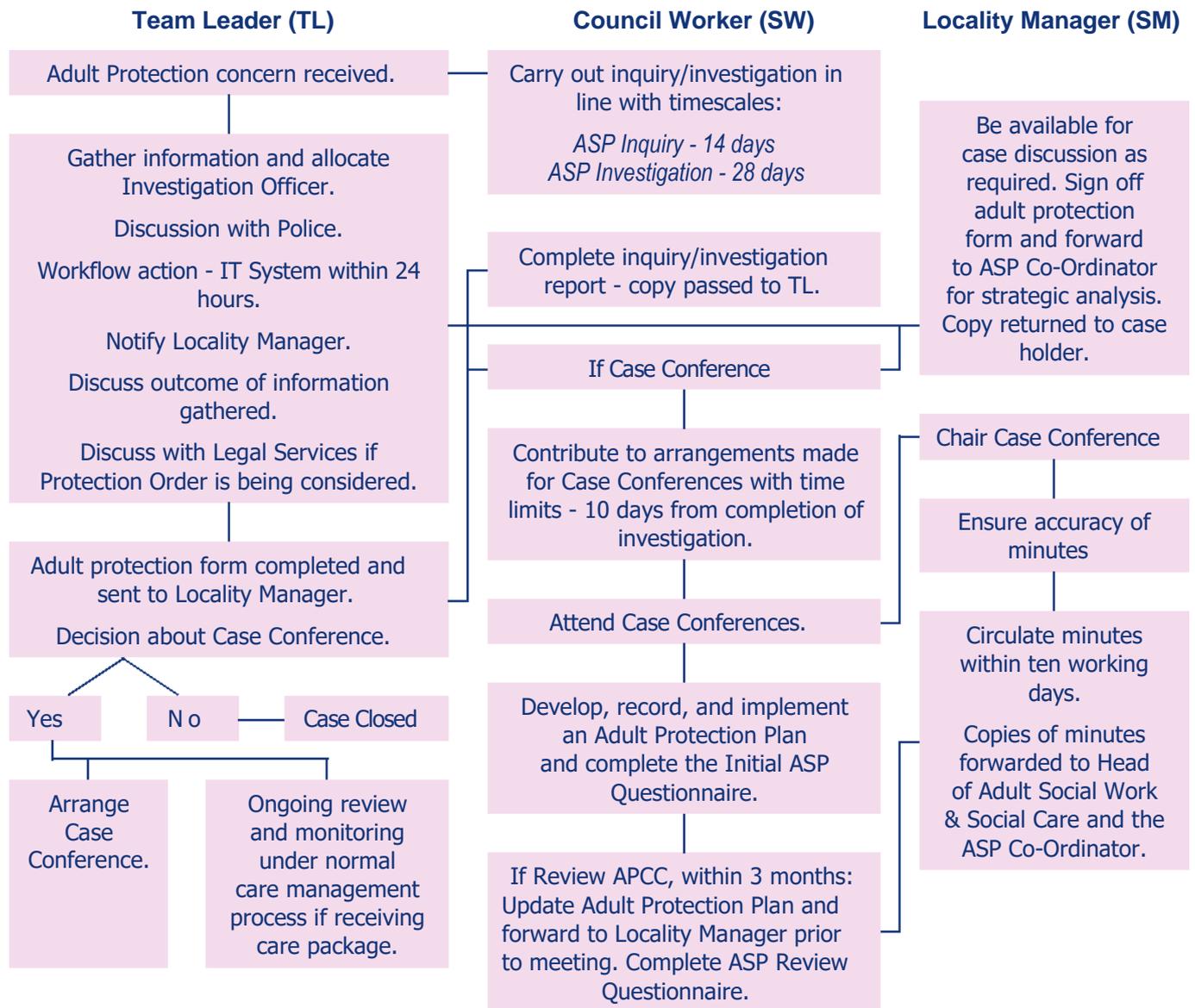
1.4 Admin Support

- Arrange Case Conference date ensuring this is within ten working days of the completion of investigation, book the venue and send out invitation letters.
- If Review Case Conference it must be held within 3 months.
- Attend the Case Conference to take minutes.
- Process the minutes on the Adult Protection Case Conference template.
- Following Locality Manager scrutiny, distribute minutes within ten working days of Case Conference, including the Head of Social Work & Social Care, Out of Hours Service and the Adult Support & Protection Co-ordinator. Minutes to be distributed by secure email or registered post. Minutes must be distributed to all people who have attended the Case Conference and they must have the chance to voice concerns about the accuracy of minutes.
- Details of minutes to be recorded in Adult Protection module on IT system as follows:
 - date, time and location of Case Conference recorded in Conference tab;
 - those invited who attended and apologies given should be entered in Conference Tab, Further Details;
 - conclusion of minute entered in notes on Plans Tab.



Appendix 16

Adult Protection Paperwork and Timescales



Appendix 17

Protection Orders and Safeguarding of Property (Sections 11-28)

1 Procedures for Applying for a Protection Order

There are three kinds of Protection Order that can be applied for to protect adults from harm. These are:

- *Assessment Order*
- *Removal Order*
- *Banning Order*

The decision to apply for a Protection Order will be taken after discussion with the Team Leader, Legal Services and the relevant Locality Manager. Legal Services are responsible for preparing and presenting all applications to court.

It is envisaged that in most cases investigations will have taken place.

2 Definition of Serious Harm

Protection Orders will only be granted where there is reasonable cause to suspect that the affected adult is at risk of serious harm.

What constitutes serious harm will be different for different persons and is not defined in the Act. When assessing harm, areas that need to be taken into consideration are:

- *impact of harm on adult at risk and the outcome on his or her physical and mental health;*
- *personal perception;*
- *level of risk;*
- *injuries which are severe and/or life threatening;*
- *the need for urgent action;*
- *the frequency, consistency and severity of harm;*
- *the intent by the perpetrator;*
- *history of harm;*
- *the probable consequences of non-intervention.*

3 Assessment Order (Sections 11-13)

An Assessment Order can be used in situations where there is concern that an adult may be at risk of serious harm, and it has not been possible to undertake an assessment through informal means. An Assessment Order allows a Council Officer (SW) to interview the adult at risk in private and if necessary, arrange a medical examination. However the adult at risk must give their consent before the Order can be implemented. They must be advised that they are not obliged to answer any questions.

If it is likely that there will be a lack of privacy, the adult at risk can be taken elsewhere for the interview and the examination to be completed. The Sheriff can authorise a Council Officer (SW) to take an adult at risk from a place being visited under Section 7 to allow for an assessment. It may be necessary to consider an alternative place to undertake the assessment if someone is not allowing the interview to proceed or the adult is unwilling to talk freely and/or requires specialised equipment to facilitate the interview.



Before an Order is granted, the Sheriff must be satisfied that an assessment is necessary and meets the criteria (Section 12, Adult Support and Protection (Scotland) Act 2007) as follows:

- (a) where the Council has reasonable cause to suspect that an adult at risk is being or is likely to be seriously harmed;*
- (b) that an Assessment Order is required to establish whether the person is an adult at risk who is being or is likely to be seriously harmed; and*
- (c) the availability and suitability of the place at which the person is to be interviewed.*

When an Assessment Order is granted the Sheriff also grants a warrant for entry. This is necessary where the Council Officer has been, or reasonably expects to be, refused entry or be unable to enter the place where the adult at risk is.

The visit to implement the Assessment Order will be carried out in conjunction with the Police. A Police Constable will be in attendance and if necessary can use reasonable force to fulfil the object of the order. It is only the Constable who can use reasonable force.

The warrant expires 72 hours after it is granted, and the Assessment Order will expire after a seven day period. The following factors should be considered before applying for an Assessment Order:

- *Has a risk assessment been completed?*
- *What type of harm might the adult be suffering or be likely to suffer?*
- *Is it of a serious nature?*
- *What steps have been taken to establish the extent of the harm or the likelihood of it?*
- *Why have these not been successful?*
- *Has there been non co-operation from the adult and/or their carer or relative or significant other?*
- *What steps have you taken to overcome this?*
- *What kind of assessment is needed?*
 - *Consider any communication difficulties.*
 - *Consider any known health issues.*
- *Where will the assessment take place?*
 - *At home or at an appropriate other place if it is not possible to interview the person in private.*
 - *Need to establish the course of action if the adult at risk cannot be assessed at home.*
- *Has the adult's capacity been assessed/established?*
- *If the adult at risk has a known mental disorder, has an MHO been consulted?*
- *Have you considered any other legislation in order to intervene effectively? If so, why is it not appropriate?*
- *Have you contacted and liaised with the Police?*
- *Has a referral to the Advocacy Service been considered?*
- *Have you applied the principles of the Act throughout your decision-making process when considering the proposed action?*

The Council should re-consider the merit of the application if it considers that the adult will refuse consent to the granting of an Assessment Order, or compliance with any interview or medical examination.



3.1 Consent of Adult at Risk

It is also necessary to consider whether the adult has given consent or not to the action being considered. You must evidence this to the Sheriff. Therefore it may be helpful to consider the following steps:

Step 1 *Is the adult able to give consent?*

Step 2 *If not, demonstrate how you have tried to gain consent and the reasons why this has not been achieved.*

Step 3 *If the adult specifically refuses to give consent, you must consider whether they have been unduly pressurised, unless the adult at risk does not have capacity.*

3.2 Urgent Cases

A Warrant for Entry under Section 37 may be applied for in an emergency. Therefore, there may not be sufficient time to arrange a Network Meeting or Case Conference. In such instances, the application will be determined through discussions with relevant professionals and appropriate management. Discussion and decision-making should be recorded and attributed as Strategic Discussion.

Where someone has been hurt and sustained a physical injury, it may be necessary to contact the emergency services.

4 Removal Order (Sections 14-18)

A Removal Order can be used in situations where there is concern that an adult may be at risk of serious harm, and it is necessary to move the person to a specified place and take reasonable steps to protect that person from harm.

Before a Removal Order is granted, the Sheriff must be satisfied that it is necessary and meets the criteria (Section 15):

- (a)** *that the adult at risk is likely to be seriously harmed if not moved to another place;*
- (b)** *that there is an available suitable place where the adult at risk can be moved to.*

When a Removal Order is granted, the Sheriff also grants a warrant for entry.

A Police Constable will be in attendance and, if necessary, can use reasonable force to fulfil the object of the Order. It is only the Constable who can use reasonable force.

The warrant expires 72 hours after it is granted.

The Order expires seven days from when the adult at risk is moved, or after any shorter period that the Sheriff has decided upon when granting the Order.

4.1 Consent of Adult at Risk

When considering applying for a Removal Order, it is necessary to establish whether the adult at risk is able to consent to the action. The following steps should be considered:

Step 1 *Is the adult able to give consent?*

Step 2 *If not, demonstrate how you have tried to gain consent and the reasons why this has not been achieved.*

Step 3 *If the adult specifically refuses to give consent you must consider whether they have been unduly pressurised, unless the adult at risk does not have capacity.*



The following factors should be considered before applying for a Removal Order:

- Have you completed a risk assessment?
- Has a Network Meeting or Case Conference taken place or is one necessary? (The situation may not allow for this due to the immediacy of circumstances)
- What type of harm might the adult be suffering or be likely to suffer?
- Is it of a serious nature?
- What steps have been taken to establish the extent of the harm or the likelihood of it?
- What attempts have been made to minimise harm?
- Why have these not been successful?
- Has there been non co-operation from the adult and/or the carer/relative or significant other?
- What steps have you taken to overcome this?
- Have you tried to establish whether the adult at risk has capacity?
- If the adult at risk has a known mental disorder, has an MHO been consulted?
- Have you considered any other legislation in order to intervene effectively? If so, why is it not appropriate?
- Have you contacted and liaised with the Police?
- Has a referral to the Advocacy Service been considered?
- Have you applied the principles of the Act throughout your decision-making process when considering the proposed action?
- Social Work or Out of Hours Service must be informed if the adult at risk chooses to leave prior to expiry date.

The Council should re-consider the merit of the application, if it considers that the adult will refuse consent to the granting of a Removal Order, or it is not likely to remain in the place to which he or she has been taken. This is because a Removal Order only permits the removal of the adult. It does not authorise the keeping of the adult in the place for the duration of the Order.

4.2 Planning

A Removal Order will expire after seven days, or such shorter period as may be specified in the order from when the person is removed. This is a short period of time to complete an assessment and establish a plan. It is therefore necessary to formulate a plan at the earliest point. This should be when considering your application.

The following factors will assist the planning stages when invoking a Removal Order:

- Why does the adult at risk need to be removed?
- How will the adult at risk be removed?
 - Have you considered means of accessing an adult at risk through attendance at day care?
 - Consider transport.
 - Consider safety of Council Officers.
 - Consider any immediate health needs.
 - Liaise with Police regarding execution of warrant for entry.
 - Who will secure the property? See Section 5.



- *Where will the adult at risk be removed to?*
 - *Consider availability of specified place.*
 - *Consider suitability of place of safety.*
 - *Consider specialised equipment.*
 - *Consider cultural needs.*
 - *What conditions should be considered?*
 - *Who should have contact?*
 - *Have you identified any other relevant parties - guardian, relatives, etc?*
 - *Do you require to consider a plan for those who should have access?*
 - *Have you applied the principles of the Act throughout your decision-making process when considering the proposed action?*

4.3 Case Conference Procedures

A Case Conference should be arranged within 24 hours of the adult being removed.

The following factors should be considered at the Case Conference:

- *how the Removal Order was enforced, and any issues addressed;*
- *review the outcome of the Removal Order;*
- *determine possible alternatives to returning home, if applicable;*
- *determine what action is necessary to facilitate the person's return home;*
- *a Risk Assessment must be completed or reviewed;*
- *a Protection Plan must be established or reviewed;*
- *the Core Group and a Communication Plan must be established;*
- *clear roles and responsibilities for the period that the adult is removed should be established;*
- *consider other measures within the Act (e.g. Banning Order) or any other relevant legislation?*

4.4 Variation or Recall

Whilst there is no right of appeal, it is possible for the Order to be varied or recalled. The adult who is subject to the Order, the Council or any other person who has an interest can apply for the Order to be varied or recalled.

4.5 Representation

Council Officers should consider supporting the adult to seek representation through advocacy and a solicitor.

4.6 Financial Implications

It is envisaged that where an adult at risk is removed to a care home for the period of the Order, he or she will not be charged. The Council has an overriding responsibility to protect the adult at risk. The costs of securing the property of the adult at risk during the period of the Order will also be the responsibility of the Council.

4.7 Warrant for Entry

A Police Constable will be in attendance and if necessary can use reasonable force to fulfil the object of the Order. It is only the Constable who can use reasonable force.



4.8 Safeguarding of Property

Section 18 obliges the Council to take reasonable steps to prevent loss or damage to any property owned by someone removed under a Removal Order.

The Act authorises entry to any place where the property that is owned or controlled by the adult at risk is known or believed to be for the purposes of preventing loss or damage.

Where a person is removed, the Council must ensure that the property is locked fast, and that water and heating are safe in terms of the maintenance of the property. The Council should also make provision for animal welfare and ensure any valuables and monies are securely stored.

There may be storage issues for the Council and there is no entitlement to recover any costs as long as the Order is in force (seven days).

This duty would allow Council Officers (SW) to remove any personal papers or bank books and adequate storage should be identified for these. The adult should be informed of their location if unable to take care of them.

The Police should be advised that a property is vacant, particularly where the adult has been targeted.

5 Banning Orders (Sections 19-28)

A Banning Order or a Temporary Banning Order can be considered where the adult at risk is in danger of being seriously harmed, and where it would be better for the adult to remain where they are than be removed.

Before a Banning Order can be granted, the Sheriff must be satisfied that it is necessary and meets the criteria under Section 20 as follows:

- *that the adult at risk is being or is likely to be seriously harmed by another person;*
- *that the adult at risk's wellbeing or property would be better safeguarded by banning the other person from a place occupied by the adult than it would be by moving the adult from that place;*
- *that the adult at risk is entitled or permitted to occupy the place the subject is being banned from (or that neither the person to be banned or the adult is entitled to occupy the place from which the subject is to be banned). The most important effect of this is that if the adult does not have a right to occupy the property then the subject cannot be banned.*

Any decision to grant or refuse to grant a Banning Order can be appealed to the Sheriff.

The subject may be banned from being in a specified place and in a specified area in the vicinity of the specified place.

A Banning Order can be made:

- *by or on behalf of the adult whose wellbeing and property would be better safeguarded by the Order;*
- *by any other person who is entitled to occupy the place concerned;*
- *by the Council if there is no-one else to make the application and the grounds are met.*

A Banning or Temporary Banning Order which bans the subject of the Order from a specified place may have conditions attached to it, and may last up to six months.



5.1 What can a Banning Order or Temporary Banning Order do?

- Ban the subject from being in a specified place.
- Authorise the summary ejection of the subject from the specified place and specified area.
- Prohibit the subject from moving any specified thing from the specified place.
- Direct any specified person to take specified measures to preserve any moveable property owned or controlled by the subject which remains in the specified place while the Order has effect.
- Be made subject to specific conditions.
- Require or authorise any person to do, or refrain from doing, anything else that the Sheriff thinks necessary for the proper enforcement of the Order.

A condition specified in an Order may authorise the subject of the Order to be in a place from which they are banned for a specific reason, e.g. supervised contact.

5.2 Consent of the affected adult (adult at risk)

Step 1 Is the adult able to give consent?

Step 2 If yes - have they refused?

Step 3 If they have refused - have they been unduly pressured?

Step 4 Have you considered alternatives where the adult may agree to work with you under different terms?

5.3 Representation

Section 19 (4)

- The Council Officer (SW) should consider organising a representative for the adult at risk. The Council has a responsibility to support the adult to access advocacy.
- It is the responsibility of Legal Services to advise the subject and any other relevant person of the application.

5.4 Intimation

It is the responsibility of Legal Services to formally notify the subject and any other relevant person that the application has been made.

5.5 Factors to consider before making an application

- Does the adult meet the criteria for 'adult at risk'?
- Have the principles of the Act been applied?
- The type and severity of harm.
- Have any other legislation or options been considered?
- Risk assessment completed.
- Does the adult at risk have capacity?
- Is an MHO required?
- Is there anyone else applying for a Banning Order?
- Who will be the subject of this Order, what length of time is required and what area does it cover?

(continued)



- Consider any other places where the subject may gain access to the adult at risk.
- What conditions should be considered, e.g. power of arrest, no contact by telephone, internet, third party, etc.
- Will the banned person have supervised contact with the adult? Develop an Access Plan.
- Discuss if the subject of the Order makes contact, what action needs to be taken.
- How will the Order be implemented? Consider safety issues to the adult and to staff.
- Where a child may be the subject of a Banning Order, Education & Children's Services must be contacted to discuss appropriate action. It may be necessary to consider an application to the Children's Panel Reporter.
- Consider how the subject will remove their own property from the specified place.
- Consider any removable items of the subject's, which remain in the property - i.e. take an inventory and check with the subject to verify.
- Does the banned person reside in the same place? Does banned person have a key to the property they are banned from?
- Will the banned person need to be re-housed? How will their property be secured?

Consultation with all relevant agencies will be ongoing and documented and attributed as Strategic Discussion.

5.6 Notifications

If the application is granted, Legal Services will be responsible for notifying the subject of the Order, and the affected adult.

There may be occasions when it is in the best interests of the adult for the intimation of the application or Order to be dispensed with. The Sheriff needs to be satisfied that by doing so this will protect the adult from serious harm or will not prejudice any other person.

5.7 Serving the Order

This should be co-ordinated between the Social Worker, Legal Services and the Police. Where necessary, Sheriff Officers can be involved in implementing an Order or serving court papers. Legal Services will make initial contact with them and organise the service of papers. If the person subject to the Order needs to be ejected, Sheriff Officers will need to be present. It may be appropriate for the Police to be present too.

5.8 A Case Conference should be arranged within 48 hours with regular meetings arranged to review the situation.

- If the adult at risk is dependent on the subject of the Order for his or her care needs, this will need to be considered and appropriate support provided.
- Safety issues.
- Clear protection plan.

5.9 Occupancy Rights

The banning order does not affect the adult at risk's rights, as a non-entitled spouse whose name is not on the occupancy agreement, to occupy a home within the place from where the subject of the Order is banned, under the Matrimonial Homes (FP) (Sc) Act 1981.

Where the adult at risk is entitled to occupy a place, their rights are not affected if their husband, wife, partner, etc is banned from the place.



Where the adult at risk has no occupancy rights and the proposed subject of the Order does have these rights, the subject cannot be banned from the place.

If you are unsure about the position, then this should be discussed with Legal Services prior to making a decision to apply for an Order.

5.10 Variations of the Banning Order (Once Granted)

Section 24 of the Act makes provision for an application to be made to the Sheriff to recall or vary an Order. It is possible to vary or recall an Order if there has been a change in circumstances where the Order is not required or it may be necessary to make a change to the Order either to add or delete conditions.

This can be carried out by:

- *the person who applied for the Order;*
- *the subject of the Order;*
- *the adult at risk;*
- *any other person who has an interest in the adult at risk's wellbeing or property.*

5.11 Safeguarding of Property

When a Banning Order has been made, the Council's duties to protect relate only to moveable property belonging to the subject of the Banning Order which remains in the specified place, e.g. the adult at risk's home, while the Banning Order is in place. An inventory of such moveable items must be made and the best practice would be for the subject of the Banning Order to sign that this inventory is correct.

An inventory should be made; and a copy given to the subject of the Order for signature. This will be carried out by the person delegated by the Team Leader. Costs incurred should be authorised by Team Leader (e.g. storage, pet care, locksmiths/joiners).



Appendix 18

Criteria for Passing Information to Police in Relation to Staff Suspected of Harming

Adult protection concerns are referred to Perth & Kinross Council from a variety of sources, both internally and externally. It is important that members of staff who have been or suspected of being involved in harmful behaviour to clients have their details logged in a central system. This will ensure that the next employer who recruits them becomes aware of the circumstances through the Disclosure Scotland Process.

Background

The implementation of the Protection of Vulnerable Groups (Scotland) Act 2007 (PVG) identifies individuals who are barred from working (paid or unpaid) with 'protected adults' (an individual, aged 16 or over, who receives one or more type of care or welfare service). The list will be managed by a single agency that incorporates current disclosure services (Disclosure Scotland). The Act introduces a scheme membership system for people who work with protected adults and children. If a person is considered unsuitable to work with children, protected adults or both, they will not be able to become a member of the scheme in relation to either workforce.

Information in respect of a person who may be deemed unsuitable to work with protected adults requires this to be captured and shared appropriately.

Where a **criminal act** (i.e. assault, theft etc) is committed by a member of health or care staff in respect of a service user then, as per current guidelines, the Police will be advised of the incident for investigation, and it will be recorded on the Police Crime recording system. As there is no guarantee of a conviction which would result in details of the incident and the offender being recorded on the Scottish Criminal Records Database, it is appropriate to enter this information on the Scottish Intelligence Database, commonly referred to as SID. In situations where a member of staff who works at the Council or in private, voluntary or health sectors has conducted himself/herself inappropriately towards a service user during the course of their employment and the conduct is deemed by those investigating the incident not to be criminal, i.e. rough handling, inappropriate verbal language, then it is important that this information is also held for future reference.

At present there is no single database within the local authorities or employing agencies that can hold such incident information on staff. Staff member's employment may be terminated, or they may resign. They may move to another area and apply for another job within the care system. We need to ensure that this information can be referred to by other local authorities/employees through disclosure checks on a person. Currently the only national database available for this purpose would be the Scottish Intelligence Database (SID).

Perth & Kinross Council (Housing & Environment) Process to Ensure the Sharing of Relevant Information with Police Scotland

In cases where the local authority has knowledge of or reasonable grounds to suspect inappropriate behaviour by someone in a caring position, the following procedure should be followed.

1 Criteria

When an adult protection concern is received, an inquiry/investigation is carried out in line with agreed guidelines. This includes contact with the Public Protection Unit.

Relevant information will be passed by the Team Leader/Service Manager to Police Scotland for consideration of entry onto the Scottish Intelligence Database (SID). This may include allegations of behaviour by a member of staff who works at the Council or in private, voluntary or health sectors leading to actual/potential adult harm being identified.

Information received must have a factual basis and detail alleged incidents or behaviours that took place at specific times, places and with specific clients. Details of any witnesses must also be recorded.



2 Accountability

Action around allegations about staff employed by Perth & Kinross Council's Adult Social Work & Social Care will be the responsibility of the appropriate manager within that service. Allegations may also be received through Adult Support and Protection procedures concerning staff employed in the private, voluntary, health and independent sectors. Management who are leading the Adult Support and Protection procedures will have the responsibility to ensure that managers from the private, voluntary and independent sector also follow this process.

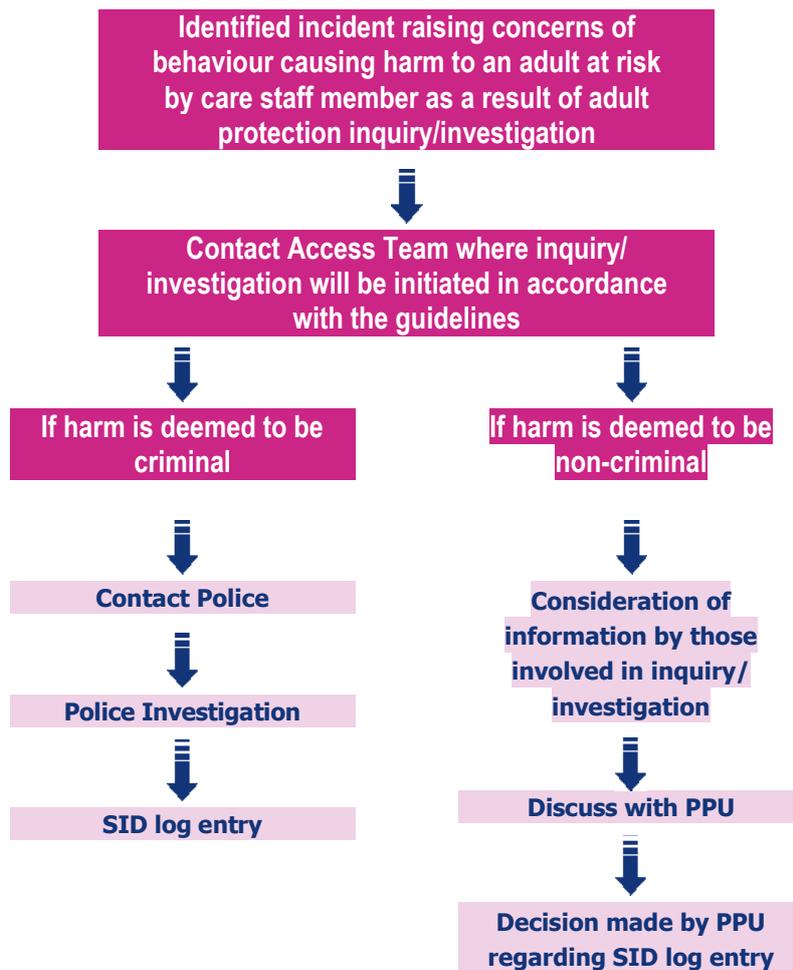
It will be the responsibility of the private, voluntary and independent sector organisations to adhere with this procedure under its obligations to comply with Adult Protection in terms of the National Care Contract or Service Level Agreement.

3 Police Procedures

The Police Service have well established practices and procedures for dealing with this type of intelligence and will make the decision about whether information that has been shared with them fits the criteria for inclusion on SID.

Information (Intelligence) held on SID is subject to review and the review period is set by the SID bureau. All information must be reviewed at least once every 5 years and at that point a decision is made either to keep that piece of intelligence or 'weed' it from the system. For intelligence that is retained a further review date is then set.

Process for Request for Information to be Recorded on Scottish Intelligence Database (SID)



Appendix 19

Perth and Kinross Contacts

The following contacts can provide advice and guidance regarding action to be taken where there is a suspicion of harm.

Social Work & Social Care Service

Perth Office - Central Duty System

Adult Social Work & Social Care

Perth & Kinross Council

Pullar House

35 Kinnoull Street

PERTH

PH1 5PH

Tel 0345 30 111 20

Out of Hours Service

Tel 0345 30 111 20

Police Scotland

Urgent

Tel 999

Non-Urgent - Tayside PPU

Tel 101

Tel 01382 596004

Email taysideppu@scotland.pnn.police.uk

Health

NHS 24

Tel 111

Victim Support

Tel 01738 567171



Appendix 20

Glossary of Terms

Access Plan

Method of approach about how to gain entry to the location where the adult at risk is believed to be.

Adult at Risk

Section 3(1) defines 'adults at risk' as adults who:

- (1) are unable to safeguard their own wellbeing, property, rights or other interests;
- (2) are at risk of harm; and
- (3) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

Adjacent Place

A place near, or next to, any place where an adult at risk may be, such as a garage outbuilding etc.

Adult Protection Committee

A committee established by a Council to safeguard adults at risk in its area.

Adult Protection Plan

A list of actions to be taken by specific individuals in set timescales or frequency in order to minimise the risks of further episodes of harm. It is devised as part of the first Case Conference following the multi-disciplinary discussion. It may be that the adult at risk of harm will have actions designated to them in the plan. It will be reviewed at subsequent case conferences. **NB:** This is in addition to immediate action to protect the adult at risk of harm at point of notification, if required.

Adult Protection Case Conference

A multi-disciplinary meeting of relevant people including the adult at risk and carer, and sometimes the alleged perpetrator at which all information about all aspects of the situation will be shared with a focus on the likelihood of recurrence of incidents of harm and prevention leading to an Adult Protection Plan. The investigation report will be made available to the meeting and will be presented by the Council Officer. An Adult Protection Plan will be devised indicating joint responsibility and accountability. The reporting questionnaire will be completed at the end of the meeting and Council Officers should have relevant data to hand although the discussion of the meeting will have a bearing on what is recorded. Consideration should be given to whether attendees retain a copy of the investigation report. A review date will be set within a period of 3 months.

Adult Protection Case Conference Review

Following the Adult Protection Case Conference, the Review will follow the same format and will take place within 3 months. The meeting will assess the impact and effectiveness of the Adult Protection Plan and decide if further action is required. The updated risk assessment and report will be made available to the meeting and will be presented by the Council Officer. Page 2 of the reporting questionnaire will be completed at the end of every review meeting and Council Officers should have relevant data to hand although the discussion of the meeting will have a bearing on what is recorded.

Advance Statement

A statement made under the provisions of Section 275 of the Mental Health (Care and Treatment) (Scotland) Act 2003 setting how a person would, or would not, wish to be treated should they subsequently require care and treatment under that Act.

Advocacy Services

Services of support and representation made available for the purpose of enabling the person to whom they are available to have as much control of, or capacity to influence, that person's care and welfare as is, in the circumstances, appropriate.

Affected Person

Term for an adult at risk when applying for protection orders.



Alarm

Sudden anxiety and fear, especially that something dangerous or unpleasant might happen.

Allegation

A statement which has not been proven to be true which says that someone has done something wrong or illegal.

Appeal

A request that a legal decision is changed.

Appropriate Adult

The role of the appropriate adult is to facilitate communication between a mentally disordered person and the Police and as far as is possible, ensure understanding by both parties.

Appropriate Services

Suitable or right provision of services for a particular situation or occasion.

Ascertainable Wishes

To discover; to make certain of the person's views.

Assessment Order

Order granted by a Sheriff to help the Council to decide whether the person is an adult at risk and, if so, whether it needs to do anything to protect the person from harm.

At Risk

In a potentially dangerous situation.

Attorney

Means a continuing attorney or welfare attorney (within the meaning of the Adults with Incapacity (Scotland) Act 2000).

Authorisation (in relation to Council Officer)

Producible evidence that the Council Officer has permission from their Council to carry out duties in relation to the Act.

Availability and Suitability

Able to be obtained, used, or reached to be right for a particular person, situation or occasion.

Banning Order

Order granted by a Sheriff to ban a person from being in a specified place or area. The order may have specified conditions attached. The banned person can be any age, including a child.

Benefit

A helpful or good effect, or something intended to help.

Biennial Report

Happening once every two years.

Body Corporate

A group of people relating to a large company.

Breach

An act of breaking a law, promise, agreement or relationship.

Capacity

See mental capacity.

Care Inspectorate

The Scottish Commission for the Regulation of Care.

Children's Reporter

Person who will decide if a child needs to be referred to a Children's Hearing which aims to provide a safety net for vulnerable children, and to work with partner agencies who deliver tailored solutions which meet the needs of the individuals involved.



Civil Law

Law relating to private arguments between people or organisations rather than criminal matters.

Communication

To share information with others by speaking, writing, moving your body or using other signals.

Communication Difficulties

When a person does not have clear verbal skills and needs the support of other aids or a person that knows them well to support them in sharing information, thoughts and feelings.

Confidentiality

Protection of information in an organisational situation within agreed parameters.

Collaboration

Joint working with other agencies for the benefit of the adult at risk.

Comparable Situation

To examine a specific case and circumstances in its own right and to take into consideration how a different person in a similar position would be treated.

Conduct

Includes neglect and other failures to act.

Consent

Permission or agreement.

Convenor

Person who arranges a meeting, or for a group of people to attend a meeting.

Co-operation

To act or work together for a particular purpose, or to help someone willingly when help is requested.

Contingencies

Something that might possibly happen in the future, usually causing problems or requiring further arrangements to be made.

Council Nominee

An individual who is not a Council Officer under Section 52 of the Act, nominated by the Council to either interview the adult under an Assessment Order or to move the adult under a Removal Order.

Council Officer

A professionally qualified Council employee who will lead the inquiry/investigation and completion of the report and risk assessment and have shared responsibility for implementation of the Protection Plan and ongoing monitoring. The Council Officer will be supported by the Team Leader and Service Manager.

Detain/Detention

To force someone officially to stay in a place.

Disability

An illness, injury or condition that makes it difficult for someone to do the things that other people do.

Disapply/Disapplication

To dispense with.

Disclosure

To make something known, or to show something that was hidden.

Distress

A feeling of extreme worry, sadness or pain.

Duty of Candour

An act to ensure that organisations are open, honest and supportive when there is unexpected or unintended consequences resulting in death or harm.



Entitled

To give someone the right to do or have something.

Exhausted

Tried without success.

Fear

An unpleasant emotion or thought that you have when the person is frightened or worried by something dangerous, painful or bad that is happening or might happen.

Harm

Includes all harmful conduct. This includes conduct that causes physical or psychological harm, unlawful conduct that adversely affects property, rights or interests possessions, conduct that causes self-harm.

Health Professional

The person is a Doctor, Nurse, Midwife or other type of individual prescribed by the Scottish Ministers.

Health Records

Records relating to an individual's physical or mental health which have been made by or on behalf of a health professional in connection with the care of the individual.

Hoarding

The excessive collection and retention of any material to the point that it impedes day-to-day functioning.

Impaired Mental Capacity

Reduced ability to effective thought processes.

Independent Advocacy Services

Services are provided by a person who is none of the following:

- (a) a local authority;*
- (b) a Health Board;*
- (c) a National Health Service trust;*
- (d) a member of:*
 - (i) the local authority;*
 - (ii) the Health Board;*
 - (iii) a National Health Service trust;*

in the area of which the person to whom those services are made available is to be provided with them.

Information Sharing

Process of effective exchange of relevant details and specific circumstances of an individual within professional agencies and confidential boundaries.

Inquiry

In general, after notification of an adult protection concern, there is an initial information gathering phase by the Council Officer which may involve a visit and will indicate the likelihood of harm being perpetrated or if there are unexplained/complex issues that need to be further explored. This will either proceed to an investigation, be dealt with using other legislation or not require any further action.

Inventory

A detailed list of all the items in a place.

Intervention

To intentionally become involved in a difficult situation in order to improve it or prevent it from getting worse.

Interview

A meeting in which someone asks you questions to ascertain the facts of which an accurate record is kept.



Investigation

In general, following an adult protection inquiry, the multi-disciplinary process led by the Council Officer in which all aspects of the situation are examined and reported on using appropriate risk assessment. This will usually culminate in an Adult Protection Case Conference.

Occasionally when the adult protection notification clearly indicates that harm has been perpetrated, the investigation will be initiated from the outset.

Where there is a need to use any powers under the Act, this would be regarded as an investigation.

Justification/Justifiable

You give a good reason for what you have done which is documented.

Least Restrictive

To intervene only as much is necessary in order to achieve the desired outcome.

Legal Representative

Person connected by law to speak, act or be present officially for another person or people.

Liability

Having legal responsibility for something.

Medical Examination

Assessment related to the treatment of illness and injuries.

Mental Capacity

Relating to the mind, or involving the process of thinking: condition of thinking process.

Mental Disorder

Person with a mental illness, learning disability or personality disorder.

Mental Infirmity

Relating to the mind, or involving the process of thinking in relation to a person who is ill or needing care, especially for long periods and often because of old age.

Mental Illness

A disease of the mind or involving the process of thinking.

Mental Welfare Commission

The Mental Welfare Commission for Scotland is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder.

Movable Property

An object or objects that belong to someone that can be moved.

Multi-disciplinary Assessment

Gathering of information that is analysed by multi-disciplinary team members application of professional knowledge.

Multi-disciplinary Plan

Inter-agency joint agreement of tasks to be carried out by named individuals within specified timescales.

Neglect

To give insufficient care or attention to vulnerable people to their detriment.

Network Meeting

Inter-agency meeting held when there is uncertainty about whether circumstances require intervention though Adult Support and Protection. The purpose of the meeting is sharing information and developing a joint approach to proceeding with the intervention/support in an appropriate way under relevant legislation. Clients/carers will not be invited to this meeting. If it is agreed that the person is not an adult at risk and does not wish intervention, it may be appropriate to take no further action. This meeting will be chaired by the Service Manager/Team Leader depending on available information, complexities of case and level of risk

The meeting will be minuted with an agreed action plan in most cases indicating joint responsibility and accountability.



Obstruction

To prevent something from happening correctly by putting difficulties in its way.

Occupancy Rights

Legal entitlement to the use of a room or building for the purposes of living or working.

Parental Responsibility

As provided for in Section 1 and 2 of the Children (Scotland) Act 1995. Subject to Section 3(1)(b) and (3) of this Act, a parent has in relation to his child the responsibility:

- (a) to safeguard and promote the child's health, development and welfare;*
- (b) to provide, in a manner appropriate to the stage of development of the child:
 - (i) direction;*
 - (ii) guidance to the child;**
- (c) if the child is not living with the parent, to maintain personal relations and direct contact with the child on a regular basis; and*
- (d) to act as the child's legal representative.*

Power of Arrest

Power attached to a Banning Order (or Temporary Banning Order) granted to the Police by a Sheriff which allows a Police Officer to arrest, without warrant, a person who the Police Officer reasonably suspects to be breaching, or to have breached an Order, and considers arrest necessary to prevent further breaches of the Order. Person may be detained in Police custody and then be brought before a Sheriff on the next court day.

Prejudice

An unfair and unreasonable opinion or feeling, especially when formed without enough thought or knowledge.

Procurator Fiscal

The public prosecutor in Scotland, also carrying out functions broadly equivalent to the coroner in other legal systems.

Proxy

A continuing or welfare attorney, or a guardian under the Adults with Incapacity (Scotland) Act 2000. Can have a combination of powers - welfare, property and/or finance.

Public Body

According to Section 5 of the Act:

- (a) the Mental Welfare Commission for Scotland;*
- (b) the Care Inspectorate;*
- (c) Health Improvement Scotland;*
- (d) the Public Guardian;*
- (e) all Councils;*
- (f) Chief Constables of Police Forces;*
- (g) the relevant Health Board; and*
- (h) any other public body or office-holder as the Scottish Ministers may by order specify.*

Public Guardian

Government department that has legal responsibility to ensure the people who are appointed to take care of someone who cannot take care of themselves fulfil their statutory obligations.

Reasonable Time

To arrange visits at a suitable period of the day taking into account how long it takes for someone to do something.

Recall

An authorisation by the court to cancel a Removal or Banning Order.



Removal Order

An Order granted by a Sheriff authorising a Council Officer or Council nominee to move a named person to a specified place within 72 hours of the Order being made and the Council to take reasonable steps to protect the moved person from harm. The Order can be for any specified period for up to 7 days.

Representations

To articulate views on behalf of another person.

Review

To consider something in order to make changes to it, give an opinion on it or study it.

Risk

The possibility of something happening that has either positive or negative consequences.

Risk Assessment

Judging the relevant impact and likelihood of particular actions.

Risk Management

Making arrangements to minimise the negative impact of particular actions and reduce frequency.

Safeguard

To protect something from harm.

Safeguarder

Person appointed by the Sheriff to safeguard the interests of the person who is the subject of proceedings relating to an application.

Self-Harm

Injuries done to oneself.

Self-Neglect

Not giving enough care or attention to oneself.

Serious Harm

Any action or series of actions that has ongoing consequences for physical or psychological health.

Statutory Interventions

To intentionally become involved in a difficult situation in order to improve it or prevent it from getting worse because there is a legal duty to act.

Strategic Discussion

A sharing of information between key professionals involved in the inquiry or investigation of an adult protection concern which will result in documented decision-making on how to proceed by attributing responsibility for decision-making and actions to named individuals.

The issues that are likely to be considered will be:

adherence to the principles of the act;

if intervention is necessary;

if an MHO is required;

if Police should be consulted;

other relevant legislation;

level of risk;

duty to consider advocacy and other services;

worker's safety;

need for Case Conference;

any undue pressure;



need for medical examination;

need to access records;

protection orders.

This will take place as often as necessary to ensure robust management of case and support of staff.

Subject

The person suspected of harming the adult at risk when applying for a Protection Order.

Subordinate Legislation

Statutory legislation (usually in the form of regulations) which may be made by Ministers under enabling powers within an Act of the Scottish Parliament to clarify and implement the details of an Act.

Temporary Banning Order

An Order granted by a Sheriff pending determination of an application for a Banning Order. The order may specify the same conditions as a Banning Order.

Timeous Investigations

To examine a crime, problem, statement, etc carefully, especially to discover the facts within a suitable time frame.

Undue Pressure

The ability to have an unacceptable or unreasonable influence on how a person behaves or thinks because of their perception of possible consequences.

Variation

A submission to the court to change or cause something to change in relation to a Removal or Banning Order.

Visit

A visit by a Council Officer under Sections 7, 16 or 18 (including warrant entry) unless the contrary intention appears.

Vulnerable

Able to be easily physically, emotionally, or mentally hurt, influenced or attacked.

Vulnerable Witness Scheme

An Act of the Scottish Parliament to make provision for the use of special measures for the purpose of helping vulnerable adults participate more fully in court proceedings.

Warrant for Entry

Authority for a Council Officer to visit any specified place under Section 7 or 16 together with a Constable. The Constable may do anything, including the use of force where necessary, that the Constable considers to be reasonable towards fulfilling the object of the visit.

Wellbeing

State of physical, emotional and mental health relative to one's own personal circumstance.

Wilful Neglect and Ill-treatment

An offence under which there is criminal liability where a person has been placed under the care of health and social care services and is neglected or ill-treated.



Appendix 21

Update on Screening AP Concerns and VPRs

PERTH AND KINROSS COUNCIL ADULT PROTECTION COMMITTEE

29 March 2022

Screening Adult Protection Concerns and Vulnerable Police Reports

BACKGROUND

The report "*Screening Adult Protection Concerns and Vulnerable Police Reports*" dated 23 March 2022 was presented to the Service Manager and Head of Service meeting on 29 March 2022 to discuss and give clarity to Assistant Team Leader's (ATLs) screening Adult Protection concerns and Vulnerable Police Reports (VPRs). This report is attached.

A decision was taken to support that ATLs, and Senior Practitioners are able to screen AP concerns/VPRs with the following conditions:

- That the Assistant Team Leader (ATL) or Senior Practitioner (SP) will only screen VPRs/AP Concerns only where a TL is not available
- It is the responsibility of the Team Leader to determine the competence for the ATL/SP to screen AP concerns
- In the event that an ATL/SP screens an AP Concern/VPR, that ATL/SP will contact another TL if the ATL/SP is not confident about decision making
- Additional audits will be carried out to quality assure decision making
- Social Workers are not to screen VPRs under any circumstances

This formal change to practice will update the existing Adult Support and Protection (Scotland) Act 2007 Perth and Kinross Multi-Agency Guidelines section 6.2

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Telephone: 01738 476735
E-mail address: iwilkie@pkc.gov.uk

