Fife Adult Support & Protection
www.fifedirect.org.uk/adultprotection

Inter-Agency Adult Support and Protection Guidance

Revision 4.4. December 2024

Adult Protection Phone Line
01383 602200

Fife Adult Support and Protection

An Easy Read version, to support communication with the adult can be found at the following link:
Fife Council Adult Protection-Easy Read

Inter-agency learning and development information and booking details are available at the following link:
Staff Information and Training

ADULT PROTECTION REPORTING HARM PROTOCOL

Fife Adult Support & Protection
www.fifedirect.org.uk/adultprotection

INFORMATION RECEIVED

You suspect an adult is being harmed
You have seen an adult being harmed
An adult has told you they are being harmed

What is harm? Who is an adult at risk of harm?
See Fife Inter-agency Adult Protection Guidance, page 18

THE ADULT IS IN **IMMEDIATE** DANGER

CONSIDER CRIMINALITY

THE ADULT NEEDS **IMMEDIATE** MEDICAL ATTENTION

THE ADULT IS **NOT** AT RISK OF IMMEDIATE HARM

CALL POLICE

Remember to preserve evidence
Lock door and restrict access

CALL AN AMBULANCE

Immediately call Social Work Contact Centre on 01383 602200
Or contact allocated social worker (if known)

IN ALL CASES

You have a duty to report harm, even if the adult does not want you to.
It is good practice to inform the adult that you are reporting harm.
Inform your line manager and follow your organisation's Adult Protection procedures
Complete a Report of Harm referral form

Police ONLY— Complete a Vulnerable Person Report - Adult at Risk
Fire Service ONLY - Complete AP1 Form Adult at Risk

Fife Inter-agency Report of Harm Referral Form

Fife Adult Support & Protection
www.fifedirect.org.uk/adultprotection

Copies of this form can be located on the 'Staff Information and Training' page at: www.fife.gov.uk-adult-support-and-protection-staff-information-and-training

Is the adult in immediate danger
or
In need of immediate medical attention?

Call 999 immediately and complete form later

If the adult is NOT in immediate danger:
Call Adult Protection on 01383 602200
AND
Complete and email this form to:

sw.contactctr@fife.gov.uk

This form should be completed by anyone wishing to refer an adult at risk of harm

- Complete as much as you know
- Do not delay reporting harm, even if you do not have access to all information
- The field boxes will expand as required

The Adult Support and Protection (Scotland) Act 2007 defines "adults at risk" as individuals, aged 16 years or over, who:

- **Are unable to safeguard their own wellbeing, property, rights or other interests, and**
- **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 others who are not so affected.

REFERRED BY	
Name and job title: (including any relevant reference no.)	
Agency/Dept:	
Contact details	
Address: **Tel. No:** **E-mail address:** **Where relevant, date line manager notified:** **Date referred to Social Work:**	

Details of Adult at Risk [Complete as much as you know]							
Name & Address	**Tel. No.**	**D.o.B.**	**Gender**	**Ethnicity**	**Known Disability**	**Religion**	**Language**

Do you believe the adult at risk is capable of understanding what has happened to them? (select appropriate answer) [You may need to use your own judgement to answer this]
YES/NO/UNSURE

Have you (or any other person) told the adult at risk that this information will be shared with other relevant agencies? (select appropriate answer) [You should tell the adult that you are making a referral and explain why. If this is not possible, make the referral anyway]
YES/NO

Details of Nearest Relative/Next of Kin [Complete as much as you know]				
Name & Address	**Tel. No.**	**D.o.B.**	**Gender**	**Relationship to adult at risk**

Name and contact details of any other persons involved (where known) [Complete as much as you know]					
GP			**Community Nurse**		

Social Worker			**Housing Support Worker**		
Residential Care Worker			**Police**		
Welfare Attorney/Guardian			**Other**		

Details of why you are making this referral [What are your concerns? Make clear what is first-hand information and what you have been told by others. Identify the source of the information.] **Provide details of the situation where the adult is/was considered to be at risk.** **Include TIME, DATE, LOCATION, plus own observations and information from witnesses. Detail the nature of your report of harm.**

Type of harm you are concerned about [tick relevant box(es)]			
Financial		**Self-injury**	
Neglect		**Self-neglect**	
Physical		**Self-poisoning (including overdose)**	
Psychological/emotional		**Sexual**	
Radicalisation/Extremism			

Details of other adults/children in the setting [There may be others at risk so supply as much information as you can. If you have concerns about others, this will require reporting/action too, e.g. 'Fife Child Concern Notification Form (Multi-Agency)

Full name	**Address**	**D.o.B.**	**Gender**	**Ethnicity**	**Relationship to adult at risk**

Details of person(s) alleged to be causing harm (where known) [Supply as much information as you can]

Name	**Address**	**Tel. No.**	**D.O.B.**	**Gender**	**Ethnicity**	**Nature of relationship to adult**

What action, other than this referral, have you taken to ensure the adult at risk is now safe? [Indicate what you have done to reduce the risk and to safeguard the adult]

Additional information and comments (include any known risks and identified warning markers for information of Partner Agencies etc.) [This is information/intelligence that may be important for Social Work Services to be aware of prior to visit/assessment]

Next steps

You can get further advice about how and when to complete this form from your line manager or on our website at: https://www.fife.gov.uk/kb/docs/articles/health-and-social-care2/help-for-adults-and-older-people/adult-support-and-protection/staff-information-and-training

Acknowledgement will be sent to the referring agency within 5 days of receipt of this form.

An inquiry under the Adult Support and Protection (Scotland) Act 2007 will be undertaken which will establish if further action is required.

Copies of this form can be located at fife.gov.uk website on the 'Staff Information and Training' page using this LINK

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SECTION A: INTRODUCTION

Adult Support and Protection is everyone's business

This guidance outlines the duties and responsibilities of all agencies concerned with the support and protection of adults, however, it is important to recognise that "*Adult support and protection is everyone's business"* as stated in the Adult Support and Protection (Scotland) Act 2007. All individuals and services have a contribution to make in supporting and protecting adults at risk of harm in Fife.

All adults at risk should feel safe, supported and protected from harm

Most adults who are affected by disability, mental disorder, illness, physical or mental infirmity live their lives comfortably and securely, either independently or with the help of caring relatives, friends, neighbours, professionals or volunteers. Some adults affected in this way, however, are unable to safeguard themselves.

Harm of adults at risk may be caused by anyone; relatives or family members, volunteers, paid carers, friends and acquaintances, other service users, neighbours, and more rarely strangers and those who deliberately exploit adults at risk. Harm may also be caused by the adult at risks own actions; support and protection for adults who self-harm, including self–neglect, self-injury and self-poisoning, where linked to an additional vulnerability as described above, may be the focus of support and protective measures.

The support and protection of adults at risk of harm is a high priority for the statutory, voluntary and independent sectors. This inter-agency guidance is designed to ensure that there is common practice across Fife and to provide a framework that can be applied across all agencies to inform and complement individual agency guidance/procedures.

This guidance is an update of "Fife Inter-agency Adult Protection Guidance" (Revision 4.2, 2019) and takes account of inter-agency self-evaluation, national and local case reviews, and the introduction of new national Guidance and relevant legislation changes since that date.

The Guidance cannot be a substitute for professional knowledge and judgement and individuals should utilise their own agency adult support and protection procedures as necessary.

Governance Roles and Responsibilities

Chief Officers' Public Safety Group

The Chief Officers' Public Safety Group (COPS) membership comprises high level Officers (Chief Executive Officers from NHS Fife and Fife Council, the Local Commander, Police Scotland (Fife Division) and Authority Reporter) across all the agencies who are involved in adult protection services. This group provides leadership, direction and accountability and ensures collective responsibility and collaborative working at all levels to ensure improved outcomes for adults at risk.

Adult Support and Protection Committee

The Adult Support and Protection Committee (ASPC) is a statutory body established under section 42 of the Adult Support and Protection (Scotland) Act 2007 (the 2007 Act) within each council area. The committee is chaired by an independent convenor who is neither a member nor an employee of the council.

The ASPC is the primary strategic planning mechanism for inter-agency adult support and protection work in Fife. To operate effectively all office holders and public bodies collaborate on the exercise of functions which relate to the safeguarding of adults at risk in Fife.

The ASPC is made up of senior representatives of key agencies who work together to effectively discharge its obligations in respect of policy and practice in adult support and protection matters. Fife's ASPC reports on its work to the COPS Group.

The key functions of the ASPC as defined in the 2007 Act are:

- To keep under review the procedures and practices of the public bodies and office holders relating to the safeguarding of adults at risk;
- To give information or advice, or make proposals on the exercise of functions which relate to the safeguarding of adults at risk;
- To make, assist in, or encourage the making of, arrangements for improving the skills and knowledge of officers or employees who have responsibilities relating to the safeguarding of adults at risk; and
- Any other function relating to the safeguarding of adults at risk as the Scottish Ministers may specify.

In performing these functions the ASPC must have particular regard to improving co-operation between and across each of the public bodies and office holders.

In 2016 Committee members added "Support" to the name to emphasise that the support element has equal relevance with protection in any intervention.

ASPC Working Groups

Under the 2007 Act, Adult Support and Protection Committees are responsible for monitoring and advising on adult support and protection procedures and practice; for ensuring appropriate co-operation between agencies and for improving the skills and knowledge of those with a responsibility for the protection of adults. The practical application of these functions is delegated to the following working groups:

Self-evaluation and Improvement Working Group

The monitoring tasks are led by the Self Evaluation and Improvement Working Group. The group undertakes a series of self-evaluative activities each year to measure inter-agency adult support and protection performance and outcomes. This is done principally through case file audit, interviews with service users, staff focus groups and data analysis.

In order to complete these evaluative activities, information from any service involved in supporting adults who were at risk from harm is examined to consider the outcomes for the adult. All information gathered is analysed and reported to the Adult Support and Protection Committee, where it is reviewed and decisions made on how any identified issues will be addressed.

While the working group undertakes inter-agency evaluations, there is also an expectation that individual agencies will undertake their own adult support and protection evaluations then report any findings and service improvement actions to the group.

Learning and Development Working Group

The underpinning principle of the learning and development strategy is that delivery of the ASPC vision and aims is dependent on the professionalism of staff and the willingness of all agencies to work together. The support and protection of adults at risk requires effective co-operation between agencies, with staff confident and competent in recognising and responding to situations and events where adults are at risk of harm.

The responsibility for the implementation and delivery of the strategy has been devolved to the Learning and Development Working Group. The Terms of Reference defines its role and responsibilities as the planning, promotion, provision, and quality assurance of all inter-agency training. Membership comprises representatives from statutory, voluntary and independent sectors.

All agencies across Fife in the public, private and not-for-profit sectors remain responsible for the training and continuous development of their own staff with regular refresh or update learning opportunities. Inter-agency training does not replace that requirement, but complements it, and is evaluated to assess its effectiveness and provide evidence of its impact on practice in relation to adult protection. The information obtained is used to inform the planning, content and delivery of future learning and development.

Case Review (CR) Working Group

The CR Working Group considers cases referred from partner agencies when circumstances suggest the case might meet the criteria for a Significant Case Review (SCR). This is where either;

- an adult at risk dies and harm or neglect is known or suspected to be a factor in the adult's death or the death is by suicide, accidental death, or the death is by alleged murder, culpable homicide, reckless conduct, or act of violence AND the incident, or accumulation of incidents, gives rise to concerns about professional and/or service involvement or lack of involvement, or,
- when an adult at risk has not died, but sustains serious harm or risk of serious harm under one or more of the categories of harm and neglect, as set out in the 2007 Act, AND the incident, or accumulation of incidents, gives rise to serious concern about professional and/or service involvement or lack of involvement.

The Working Group undertakes an initial case review based on reports and an inter-agency chronology to determine if SCR criteria are met, and whether there are opportunities for inter-agency learning from further scrutiny.

Cases referred which do not meet the criteria for an SCR may, however, generate single or inter-agency learning points which are progressed, and may impact on practice, policy or procedures.

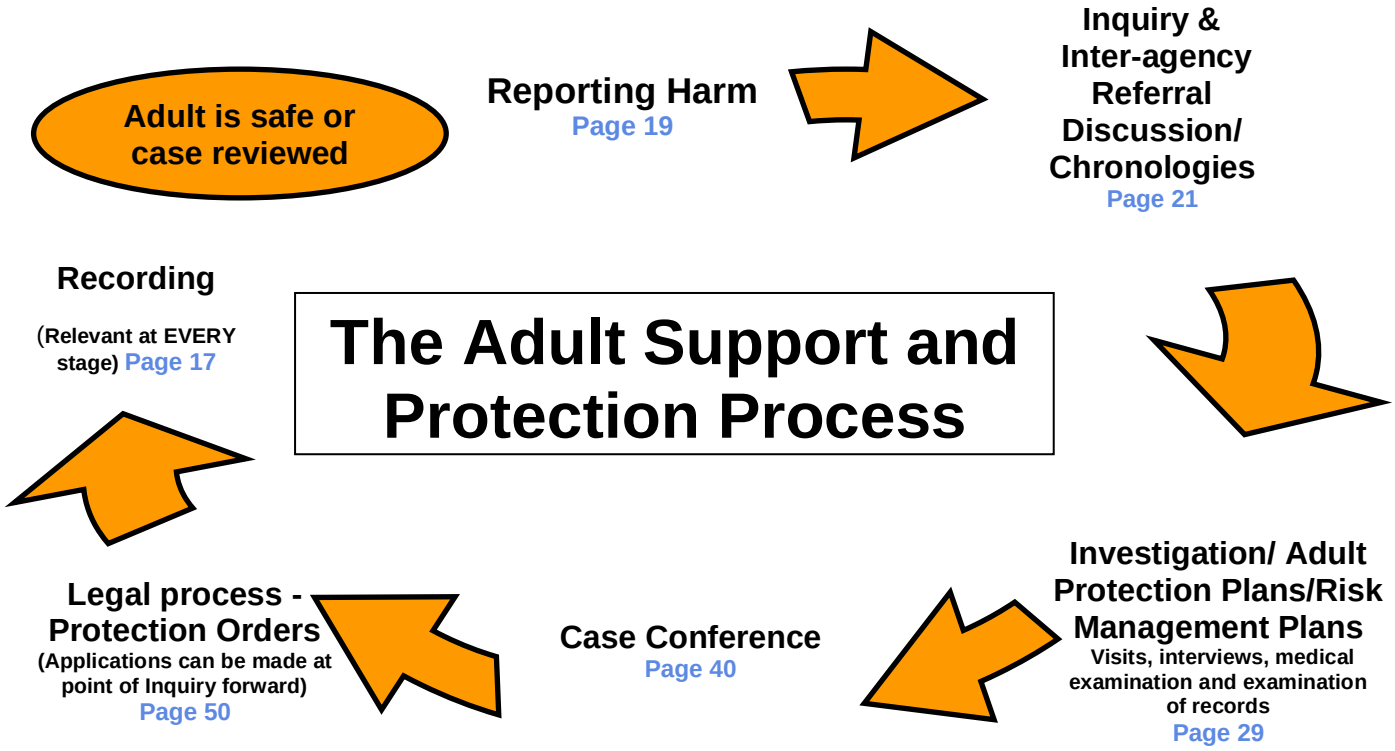
PRINCIPLES: ADULT SUPPORT AND PROTECTION (SCOTLAND) ACT 2007

The principles underpinning the 2007 Act mean that:

- The intervention must benefit the adult;
- All actions should be supportive and the least restrictive; and
- Any 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;

  And
  - Not treat the adult less favourably than any other person in a comparable situation.

SECTION B: ADULT SUPPORT & PROTECTION PROCESS



Timescales in Adult Protection

The Adult Support and Protection process must be undertaken promptly and without delay, to ensure the adult at risk is assessed and responded to appropriately to avoid harm continuing for longer than necessary. Timely intervention may also safeguard others also at risk of harm.

This Guidance includes reference to specific timescales at different stages of the process. Workers are expected to adhere to these timescales. On rare occasions where circumstances create a delay causing timescales to be breached, the worker will inform their manager who will agree a revised timescale, which will be recorded with the reason for the delay clearly stated.

Recording

All adult protection recordings must be accurate, up-to-date, comprehensive and evidence based. Accurate recording assists in understanding why a particular decision was taken and evidences good practice.

The recordings may form the basis of any risk assessment and adult protection plan. Adult support and protection recording provides the means of monitoring, reviewing and evaluating services to protect adults at risk and to identify gaps in service delivery. The records may be needed in court.

Recording must demonstrate that the principles of the 2007 Act have been taken into account. For example, having regard to the views of the adult and relevant others; that the intervention benefits the adult; is the least restrictive option; and that participation of the adult has been central to any decisions.

Adult Protection recording may include:

- Report of Harm Referral
- Chronology
- Confirmation of how the three point criteria is or is not met
- Inter-agency Referral Discussion record
- Investigations undertaken
- Risk assessment and risk management plans
- Case Conferences (including those held under the Adults with Incapacity (Scotland) Act 2000) where the adult is at risk of harm and Reviews
- Adult Support and Protection Plan
- Views of adult about process and outcome
- Core Group Meeting records
- Adult Support and Protection Orders (legal)

Individual agencies should consult their own agencies procedures on what to record and where this information will be stored. All adult support and protection recording may be subject to inter-agency self-evaluation audit.

Investigative interview recording

As soon as possible after an investigative interview both the council officer and the supporting officer should check the written record and agree the contents. The record of the interview, including any drawings, should be signed and dated by both officers and the original should be kept in the adult's social work file. All handwritten notes taken during any part of an adult support and protection inquiry/investigation must be kept in line with agency retention policies. There is no requirement for the investigation interview to be recorded verbatim, however best practice guidance on recording should be followed. [1]

[1] Professional Writing Guidance Booklet for Social Work Practitioners: Aberdeen City Council & Robert Gordon University 2009
Decision making and social work in Scotland: The role of evidence and practice wisdom IRISS 2011
Practice Guide: On the record – getting it right: Effective management of social work recording SWIA 2010

Adult Support and Protection Definitions

Who is an adult at risk of harm? ("3 point criteria")
An adult at risk of harm is any person aged 16 years or over who:

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

All three elements must be met.

What is harm?
An adult is at risk of harm where:

- Another person's conduct is causing (or is likely to cause) the adult to be harmed; or
- The adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.

Harm includes all harmful conduct and in particular includes:

- physical harm
- sexual harm
- psychological/emotional harm
- financial harm
- neglect
- self-harm (including self-neglect, self-poisoning and self-injury)

Harm includes ***all*** harmful conduct, whether deliberate or unintentional.[2] Harmful conduct also includes acts of omission, for example neglect or harm as a consequence of the individual's own behaviour (self-harm). The Code of Practice provides useful guidance when considering self-harm linked to alcohol or substance use (see extract below)

…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 etc., Adult Protection intervention would not normally be appropriate.***[3]

[2] See Section C, page 46, for Signs of Harm
[3] Adult Support and Protection Code of Practice (Revised) 2014, Edinburgh: Scottish Government

Serious Harm
The Adult Support and Protection Act references powers to enact three protection orders, with applications to be made through the Sheriff Court. However, a protection order can only be considered where there is evidence that an adult is at risk of **serious harm.**

Protection orders are covered on page 39 of this guidance which should be followed when such action is being considered, along with any single agency procedures.

Serious harm is not defined in the 2007 Act and there are no absolute criteria on which to rely when assessing what might constitute serious harm.

Consideration of the severity of the harm may include:

- The nature, degree and extent of physical harm
- The duration and frequency of the harm and neglect
- The degree of threat and coercion
- The impact on the person and the risk of repeated or increasingly serious acts involving them or other adults at risk
- The impact on the person concerned. Sometimes a single traumatic event may constitute serious harm.

Serious harm can be an accumulation of events, both acute and longstanding, which cause the impairment of, or an avoidable deterioration in, physical and/or mental health; and the impairment of physical, intellectual, emotional, and social wellbeing.

Reporting Harm

There is a legal duty for all agencies named[4] in the 2007 Act to report to the social work service the circumstances where it is known or believed that an adult is at risk of harm.

It is good practice, wherever possible, to inform the adult of the referral, taking care to emphasis why you are concerned and why you need to seek additional support and/or protection.

If you are unable to inform them of the referral, you should note specific issues such as capacity, third party information, increased risk to the adult or whether the perpetrator is present along with other details on the Inter-agency Report of Harm Referral form or your agencies referral paperwork. Record and retain a copy for your agencies records.

[4] Section 5 of the 2007 Act provides that certain bodies must cooperate with a council making inquiries. These bodies are: the Mental Welfare Commission; the Care Inspectorate; the Public Guardian; all councils; Police Scotland; relevant Health Boards; any other public body specified by the Scottish Ministers.

Emergency response required
Any member of staff who witnesses, suspects or receives information about an adult at risk being subject to harm, mistreatment or neglect, and where the adult is in immediate danger, requires urgent medical attention or crime is suspected, must call the appropriate emergency services (police, ambulance, fire service).

Emergency response *not* required
If the adult does not require urgent medical attention but you suspect or have witnessed harm, mistreatment or neglect, speak to the person about the harm you are concerned about. Record your conversation carefully and try to write down the person's actual words in relation to their description of the event(s) and their feelings about the outcome. Include the time and date that the record was made. Tell the person that you are going to report the details to your line manager[5] and the social work service. The report of harm should be passed without delay to both your manager and the social work service.

Whistle blowing/raising concerns
Organisations should have policies and procedures in place to deal with employee concerns about unprofessional, dangerous or illegal activities which they become aware of through their work. This is often known as "whistle blowing". An essential element of such policies is the underpinning principle that staff who raise concerns reasonably, responsibly and in good faith will not be penalised or victimised in any way. Any agency receiving a whistleblowing report of harm must act on it.

For further information staff should refer to the relevant "Whistle blowing" policy for their own particular organisation.

Inquiry
Inquiry is the first stage of the adult support and protection process undertaken by the local authority social work service, following receipt of information about an adult. Section 4 of the 2007 Act places a duty on the social work service to make inquiries about an adult at risk's wellbeing, property or financial affairs where it is known or believed that intervention may be necessary to protect the adult.

The Report of Harm referral
This information may be received through a report of harm form or a phone call to the Adult Protection Phone Line (01383 602200), but may also be received through information from other sources including elsewhere within the social work service. All information reported about an adult at risk, regardless of source, will be recorded on the social work system.

[5] Exceptions to this would occur where your immediate line manager is not available or where the line manager is implicated. In these cases refer to local guidance.

The social work service will make inquiries to establish whether the three point criteria are met, and to take any immediate actions to support and protect the adult. The inquiry process includes an inter-agency referral discussion (IRD). All cases must be considered with an open mind and without assuming that harm has, or has not, occurred. Such referrals should be acted upon as a source of information that may be presented as evidence at a later stage.

Initial Inquiry
The inquiry has the overall function of establishing whether the three-point-criteria have been met and to ensure the adult is safe.

Initially social work services scrutinise all their own records, to determine whether the adult is known to them, or information is held. Other relevant services will be alerted to the report of harm to establish whether they have relevant information to share. This will facilitate information gathering about the adult, which will assist the Inquiry.

Inter-agency Referral Discussion
An Inter-agency Referral Discussion (IRD) is a professional discussion held with relevant representatives from social work, health, police and any other agency with knowledge of the adult at risk of harm. The sharing of information and planning of approaches can be conducted by phone or in person. There can be frequent IRDs throughout the adult protection process and all will be formally recorded. The social work service will manage the IRD process and will be responsible for recording and sharing the agreed decisions and actions.

The purpose of an IRD is to:

- Share relevant information and jointly analyse the risk, including whether the harm is “serious” (page 20)
- Consider whether a crime has been committed (page 55)
- Consider and agree any immediate protective measures
- Establish whether there is a need for an investigation and agree plans for doing so
- Consider whether a Large Scale Investigation is required (page 37)
- Consider access to advocacy and other supportive measures (a duty once three-point criteria confirmed)
- Consider if, when and how a Section 7 Visit and Interview with the adult may be required
- Consider whether a medical examination may be necessary

Fife Council legal services should be part of the IRD where protective legislation requires clarification. Fife Council Contracts service may also be invited to contribute where the adult is in receipt of contracted services. Consideration should be given to involving regulatory bodies, e.g. the Care

Inspectorate or Office of the Public Guardian. Trading Standards can assist where financial harm is identified related to bogus callers or doorstep crime.

The outcome of the Inquiry/IRD is a joint agreement on whether/how to progress the report of harm based on all the information gathered. Social work services will complete and circulate a form detailing the agreed decisions. On receipt of the form, practitioners who were involved in the IRD have a responsibility to notify social work services if they believe it does not reflect the IRD decisions agreed. See page 24 for IRD template.

An IRD is convened by the council officer or social worker if a council officer has not been appointed, but may be requested by any of the statutory partners. As the IRD is a dynamic part of the information sharing and planning process, it is important this is arranged as quickly as possible by phone or email.

The inquiry/IRD may provide enough information to confirm the adult is at risk of harm as defined by the 2007 Act and whether adult support and protection action is required. It may also provide sufficient information to confirm that the adult does not meet the three point criteria and that there is no need for further adult protection action. In these cases there may be other support or advice which can be offered to the adult. It is also possible that there is insufficient information to establish whether the criteria are, or are not met.

It is essential to record not only whether the criteria is, or is not, met but also on what basis each criterion is or is not met, or not established. The table below indicates some points to consider when applying the criteria.

Adult Support and Protection (Scotland) Act 2007 criteria	Points to consider
Any person aged 16 years or over	An adult aged 16 and 17 years may nevertheless be legally defined as a child. It is essential that these young adults receive appropriate support from both Children's Services and relevant Adult Services.
Is unable to safeguard their own wellbeing, property, rights or other interests	What evidence is there that the adult can or cannot safeguard his/her own wellbeing, property or financial affairs? This is more than "having or not having capacity".
Is at risk of harm	Has harm occurred or is likely to occur? What type/s of harm is the adult at risk from? Is the harm serious?

Because they are affected by disability, mental disorder, illness, physical or mental infirmity[6], are more vulnerable to being harmed than adults who are not so affected.	Is there an additional area of vulnerability that makes the adult more at risk from the harm identified than others who do not have that additional vulnerability? **Remember:** It is not necessary for the adult to have a medical diagnosis to be considered at risk of harm under adult support and protection legislation.

Where there is agreement that the adult is at risk and in need of further support and protection, consideration should be given to wider support needs for the adult, such as advocacy and communication support. All considerations and uptake must be recorded.

A Visit to the adult may be required if it has not been possible to establish if the criteria are met. This should also be undertaken if the information suggests the circumstances are serious and/or complex. This will provide an opportunity to assess the circumstances, including an interview with the adult and others present. This is undertaken under sections 7 and 8 of the 2007 Act. (See Investigations at page 35)

Involvement of families etc. (Added electronically on 21 Feb 2019 at request of social work service)

In line with the principles of the Adult Support and Protection (Scotland) Act 2007, regard for the views of the adult's nearest relative, any primary carer, guardian or attorney and any other person who has an interest in the adult's wellbeing or property will be included in any inquiry, investigation and subsequent intervention.

In practice, and taking account of the views of the adult and any other legal barriers to sharing information, consideration will be given from the outset to how the family etc. will be made aware of and involved in the adult protection process and outcome. Providing the family etc. with a single point of contact and agreeing in advance when updates will be provided (even if there is no progress to report) will reduce anxiety and build trust in the process as it proceeds to outcome. It may be necessary to make the family aware that while they will be kept informed and involved, there may be limitations on what can be shared. This may be because the adult has requested that information is not shared with the family etc., because the information relates to third parties or where it is considered that sharing with the family etc. may impede the investigation (particularly where there is/may be criminality considerations) or outcome.

[6] Some of these terms are not defined in the 2007 Act.

It may be that in some circumstances the family etc. will actively contribute to the inquiry, investigation and subsequent protection plan. This is entirely appropriate and will follow standard investigation procedures, the principles and relevant legislative drivers. Where the family etc. are, or are believed to be perpetrating the harm reported, then sharing information about the investigation with them is likely to be curtailed.

Where the Large Scale Investigation process has been triggered there will require to be consideration to how the family etc. of all involved adults will be kept abreast of the process and outcome early in the process.

Also see ASP 2007 Code of Practice (April 2014), section 19 Carers, page 29.

ADULT PROTECTION: INTER-AGENCY REFERRAL DISCUSSION (IRD)

Section 1

Date of Incident:	**Date of Referral:**	**Referred by: Name and Agency**
Full Name of Adult:		**Date of Birth:**
Address:		
SWIFT ID Number		**CHI Number**

Section 2

Assessment of Risk:	**Met/Not Met/Not established**	**Reason/Evidence** **Identify info received and source**
1 Unable to safeguard own wellbeing, property, rights or other interests		
2 Are at risk of harm (is harm considered serious? - see p17 of ASP Guidance) Indicate harm type/s: • Physical • Sexual • Psychological/Emotional • Financial • Neglect • Self-Harm Indicate sub-category e.g. • self-injury • self-poisoning or • self-neglect Other (please state)		
3 Because they are affected by: • Disability • Mental disorder (mental illness, learning disability, acquired brain injury, personality disorder, autistic spectrum disorder) • Illness • Physical infirmity • Mental Infirmity		

Section 3

IRD Participants: Name	 Agency

Section 4

IRD Decision: Risk Assessment and Decision-making Rationale

Box will expand as necessary

Section 5

Agreed Actions including Risk Management Plan:		
What	**By Who**	**By When**

Rows can be added as necessary

CHECK: Confirm all relevant reasons for holding IRD have been considered:

- Share relevant information and jointly analyse the risk, including if the harm is "serious"
- Consider whether a crime has been committed
- Consider and agree any immediate protective measures
- Establish whether there is a need for an investigation and agree plans for doing so
- Consider if a Large Scale Investigation is required
- Consider access to advocacy and other supportive measure

Section 6

This is an accurate and complete record of the IRD.

Signature	Position	Date
	Team Manager	

Send copy to *all* participants for their records:

Police Scotland: Fifeconcernhub@scotland.police.uk

NHS Fife: Fife.AdultProtection@nhs.scot

Fire Service: e.fifecse@firescotland.gov.uk

For other agencies send direct to involved staff member

Participants should follow their organisations' processes for data management on receipt, ensuring any actions are acted on as detailed.

Chronology (amended electronically on 19 Oct 2021)

Chronologies provide a key link in the chain of understanding needs and risks; including the need for protection from harm. Setting out key events in sequential date order, chronologies give a summary timeline of an individual's circumstances, patterns of behaviour and trends in lifestyle, that may greatly assist any assessment, analysis and planning. They are a logical, methodical and systematic means of organising, merging and helping make sense of information. They also help to highlight gaps and omitted details that require further exploration.

Chronologies can and should also be used to promote engagement with the service/agency users. The content of chronologies is however determined by professional judgement as to what is in fact significant in an individual's life. They should not replicate, or attempt to substitute for case recording, but should provide a clear outline of the most important elements of individual or family circumstances.

Chronologies can be single-agency or multi-agency and can be used for a variety of purposes. A good chronology is a critical tool in helping make sense of the complexity of an individual's life and circumstances. It also establishes a sound foundation for future understandings and analysis
where professional staff change, or new staff / services / agencies come on board. Chronologies are, however, not an end in themselves; they constitute one key element of the suite of tools that we use to inform the analysis of needs and risks in assessments and interventions. Chronologies also inform planning. As dynamic tools, chronologies should be accurate, informative and up-to-date.

Using the information below, staff must, in consultation with their manager, complete a mandatory chronology at the IRD stage when an Adult Protection concern is submitted. The essential purpose of this chronology is to draw together important information and assist understanding, highlighting early indications of emerging patterns of concern. This should be completed as a stand-alone document, on the agreed template (please see the end of this section for this).

The use of the chronology is further underpinned by Fife Council's Adult Protection Engagement and Escalation protocol. Guidance states that the "inter-agency chronology triggered by multiple reports of harm will be key to the first engagement escalation meeting". Therefore, by having a chronology at IRD stage onwards, allocated workers/Council Officers are ensuring more information is available and available earlier in the AP process as a whole.

Prior to any Adult Protection related case closure being authorised, the chronology should be completed by the allocated worker/Council Officer.

The chronology must be:

- Accurate and evidence-based
- A record of facts, events, action taken or a note that no action was taken and if known the outcome (e.g. Support services provided).
- Succinct – a very brief note of an event e.g. bruising discovered, attended A&E., change in adult's presentation/behaviour.
- Concise, avoiding acronyms or professional jargon.

Single/Multi-Agency Adult's Chronology

Appendix A

Name		**AIS No.**	
Date of Birth		**CHI No.**	
		SCN No.	

Date of Event	**Significant Event**	**Action Taken & Outcome if Known**	**Agency/ Individual**

Multiple Referrals (amended electronically on 30 Sept 2019)

Multiple Report of Harm Referral Protocol: Please follow link to access
Some adults will have repeat report of harm referrals, either in a cluster or over a more extended period of time. These repeat reports may be from the same agency or from several agencies and or individuals. Each instance will be subject to inquiry:

- To ensure account is taken of the cumulative nature of some harmful circumstances, or
- To assess any increasing risk, or reduction in ability to safeguard self
- To check if an adult, who has previously refused support and/or protection intervention, may now wish to engage

Where there have been **two or more report of harm referrals within a 6 month period or three or more raised within a 12 month period; regardless** of the previous outcome/s, the current report of harm must be considered in the context of the earlier reports of harm, and not treated in isolation. **Note: this protocol relates only to report of harm referrals.**

All reports of harm will be subject to Inquiry and Inter-agency Discussion (IRD), regardless of whether the Multiple Report of Harm Protocol has been triggered or previously been initiated. Recording should confirm that the current IRD is being undertaken under the Multiple Report of Harm protocol

Practice Guidance:
Where the Multiple Report of Harm Protocol has been triggered, the Contact Centre will automatically send the most recent report of harm to the relevant Assessment and Care Management locality team to assess and inquire further, *whether or not* the case is currently open to a locality team. The locality team social worker/duty worker will require to analyse the pattern of reports of harm through the Inquiry/IRD process.

Chronology Guidance[7] indicates that chronologies must be undertaken for individuals who are at risk of harm or abuse, including self-harm, particularly where the multiple referral protocol is triggered (2 report of harm referrals in six months or 3 in 12 months regardless of outcome of previous inquiry.

The locality team social worker/duty worker will begin to develop or update a chronology and pass this to the locality team manager. This chronology will be part of the agenda for the Multiple Report of Harm IRD and the basis for an inter-agency chronology.
The team manager will then convene and chair a multiple report of harm IRD meeting. The locality team social worker/duty worker will also attend this meeting. The team manager will determine other agency representatives to attend; likely to be Police, appropriate health representative/s as a minimum, plus housing and criminal justice as relevant.

[7] Chronology guidance is also available in Fife Interagency Adult Support and Protection Guidance

The IRD will:

- analyse the most recent report of harm in the context of previous IRD's
- discuss the chronology
- agree the outcome, (see outcome options below).

If outcome 3 is being initiated, the minute will record that the first meeting will be convened within 4 weeks. The adult must be made aware of the outcome and an explanation of what this may entail. The locality social worker will circulate the chronology to all appropriate parties to enable agency updates as the chronology will be required throughout the period the adult is part of the Engagement Escalation Protocol (outcome 3).

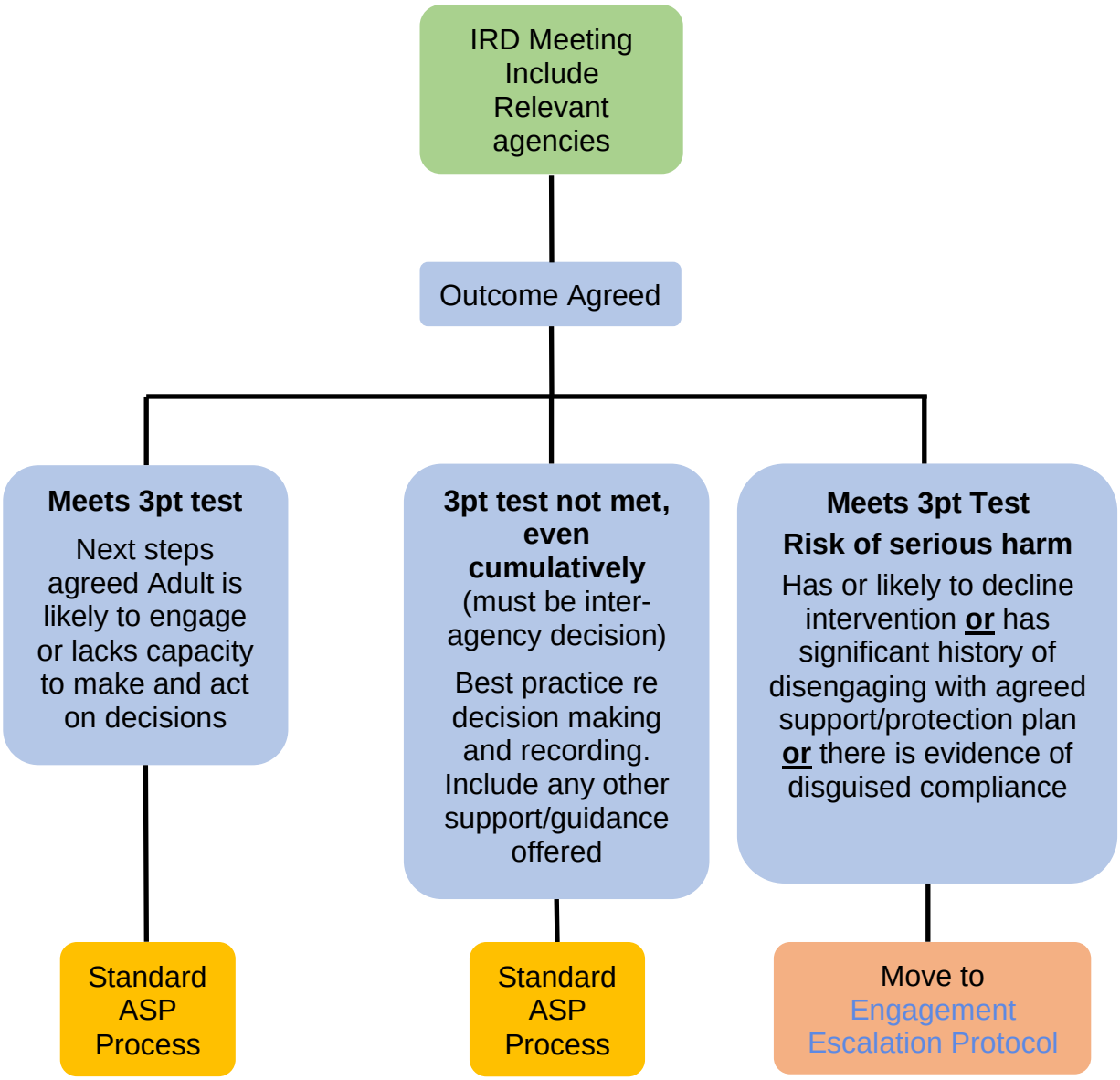
The potential outcomes of the Multiple Report of Harm IRD are:

1. **The three point test not met (even cumulatively).** The three point test is a gateway for support and protection, not a barrier. It should be noted that even where an IRD concludes that action is not appropriate under adult protection legislation, there is a requirement to record evidence of consideration given to other intervention (e.g. Social Work (Scotland) Act 1968) appropriate to the adult's individual needs and increasing number of report of harm referrals being made. Therefore if the MRH IRD meeting concludes or agrees that the 3 point criteria is not met, adult services are responsible for recording the outcome, evidencing defensible decision-making, including evidencing that appropriate support and guidance has been offered by health and social care services, or signposting to relevant agencies.
2. **Meets the three point criteria**. If the MRH IRD meeting concludes the person meets the 3 point criteria and it is agreed the adult is likely to engage OR it is already established the adult lacks capacity to make and act on decisions and has a power of attorney or Guardian with appropriate powers who will agree to safeguarding measures, then the usual ASP process should be followed e.g. investigation or case conference with consideration of protection orders. Consideration of advocacy.
3. **Meets the three point criteria.** If the MRH IRD meeting concludes the adult meets the 3 point criteria and that there is risk of **serious** harm including a public safety interest and the adult is unlikely to or has refused to engage with previously offered safeguarding measures (including consideration of protection orders), or there is a history of disguised compliance with previous proposed support or protective interventions, and the adult has capacity to refuse support, then the Engagement Escalation Protocol must be initiated. Advocacy consideration must be evidenced at this stage, as best practice.

If the outcome is 3, see Engagement and Escalation Protocol and note Engagement Escalation Protocol flow chart on next page.

Multiple Referral Protocol & link to Engagement Escalation Protocol

2 reports of harm in 6 months or 3 in a year require an IRD with relevant agencies. This should be a more structured IRD than held on other occasions and should take account of previous information regardless of outcome. Advise meeting.



Adult Support and Protection Cross Boundary Cases (summary)

Best Practice Principles

Local procedures are largely designed to ensure practitioners apply local processes to support and protect adults at risk of harm. A number of unpublished reviews have identified that local procedures may require augmentation to support an adult at risk of harm when moving between local authority areas. This would clarify the transition arrangements when an adult at risk of harm is moving between areas in either a planned or spontaneous way. The full document therefore articulates the principles which should be considered by both local authority areas when an adult at risk of harm transfers between them.

These principles have been prepared to support permanent changes of residence though they may be useful in guiding the exchange of information in relation to temporary changes in residence. Where an adult moves on a temporary basis and is already known to be at risk of harm, arrangements for managing their care should be in accordance with Section 53 of the Adult Support and Protection (Scotland) Act 2007 in relation to the definition of 'council'. However where the original council retains the supportive and protective role this should be clarified and agreed between the agencies involved based upon the principles outlined in this document.

The strategic principles document is not of itself a procedure. It has been prepared to promote parity between all areas across Scotland in relation to the exchange of information regarding adults at risk of harm when they relocate to another local authority area. It is hoped that consideration of these principles within local procedures will assist in achieving this aim.

Statutory Requirements

The Adult Support and Protection (Scotland) Act 2007 lays out how individual local authority areas must share information about adults at risk and Section 5(2) (b) makes explicit a duty to cooperate with each other. Section 5 of the Scottish Government Guidance for Adult Protection Committees (2008) states that Committees have a significant role in ensuring cooperation and communication within and between agencies to promote appropriate support and protection for adults. Sections 22 to 25 further state they should have regard to the need for communication and cooperation with other Committees. The guidance further states that all staff in all sectors need to understand and accept the absolute necessity of sharing information about adults at risk, and be clear about their roles and responsibilities in supporting those adults. It states that there should be clear guidance about information sharing in procedures for:

- Inter-agency referral discussions
- Inquiry and investigation
- Assessment

Cross Boundary Information Sharing

All Adult Protection Committees (APCs) must articulate within their procedures their model for these circumstances including how information about an Adult

at Risk of Harm will be communicated and shared. An example of the types of information that may be required are detailed within the “Best Principles” document, which can be obtained by clicking the link at the top of this section.

Where the local authority (or delegated agency) is aware that an Adult at Risk of Harm has moved to another local authority area, they will notify them immediately and confirm the details in writing or via secure email/fax etc. Where the receiving authority becomes aware of any move they will notify and request relevant information from the originating authority.
Each local authority (or delegated agency) must include in their procedure how any reduction or increase in risk the move may present will be considered. This will include consideration of the need for a transfer case conference (or equivalent) and/or the essential information which should be shared.

Practitioners are advised to read and familiarise themselves with the full document which can be accessed at the link above.

Other Local Authority Placements
Social work services will undertake inquiries into any report of harm allegations regarding an adult at risk placed by another authority in Fife, whatever the source of the allegation. Appropriate information sharing and cooperation should be extended to the placing authority.

Feedback on Report of Harm
The social work service will acknowledge all reports of harm within 5 days of receipt of the information.

Where the report of harm has come from an agency with responsibility to report harm under the 2007 Act, feedback will be via the inter-agency referral (IRD) report process. (See page 21).

Investigation

The Purpose of an Investigation
The purpose of an adult support and protection investigation is to:

- Establish matters of fact: what has actually happened and the nature and extent of the actual harm or risk of harm to the adult;
- Ascertain the adult’s views about his or her situation; the 2007 Act places a duty on council officers to consider advocacy and other services;
- Determine whether actions are necessary to protect the adult; and
- Complete the council officer report, the basis of which is an assessment of risk.

Other investigations may be conducted in parallel to the adult support and protection investigation. For example, employee conduct disciplinary proceedings, criminal investigations, NHS or Care Inspectorate inquiries may also be ongoing. These processes do not negate the need for the social work service to investigate and fulfil its duties under the 2007 Act, and the Council remains the lead agency throughout the adult support and protection

investigation process.[8] The outcome from any parallel investigation reported to the council officer may impact on and influence any protection plan for the adult/s at risk of harm. Due regard to the duty to cooperate under section 5 of the 2007 Act and data protection considerations will be necessary.

Visits

Visits to an adult may be necessary to

- enable or assist in conducting inquiries under section 4 to decide if the adult is an adult at risk of harm; and
- establish whether any action is required in order to protect the adult at risk from harm

A suitably qualified council officer, with a supporting officer, will carry out visits under the 2007 Act. Identification must be presented indicating the authority to carry out the duties as defined by sections 4-10 of the 2007 Act. An investigative interview will be conducted by two people, led by the council officer, with, for example, another social worker or colleague from a relevant partner agency, for example Health services, Housing or third sector.

If entry is refused and no other reasonable steps can be taken to conduct the visit, further statutory measures may be necessary (See Protection Orders, page 48).

Interviews

Interview of the adult

The Code of Practice (April 2014) provides that the adult is not required to answer any questions, and must be informed of that fact before the interview starts. They can choose to answer any question, but it is important they do not feel compelled to answer any question they prefer not to.

The adult must be assisted to participate as fully as possible. This may require planning on behalf of the council officer (communication aids, location of interview, and personnel involved). The purpose of this support is to aid the adult to contribute while protecting the adult's rights.

The adult may wish another person to be present at the interview, for example, a family member, paid carer, or independent advocate. Section 8 of the 2007 Act allows a council officer, and any person accompanying the officer to interview the adult in private. A decision about whether the interview will be undertaken in private will based on how best to achieve the objectives of the investigation.

A private interview may be requested by the council officer and supporting officer where:

[8] There may be occasions when a criminal investigation takes precedence however the requirement to safeguard the adult at risk takes primacy; close liaison between Council Officer and Police is crucial.

- Someone present is thought to have caused harm or poses a risk of harm to the adult
- The adult says they don't want the individual present
- It is believed the adult will communicate more freely if interviewed alone, or
- There is concern of undue pressure from others

Interviews with others present, besides the adult at risk, are allowed under section 8 of the 2007 Act. This can include someone who shares their home with the adult, or in a regulated care setting, a care worker, for example. These individuals are also not required to answer questions, and they must be informed of this before the interview starts.

During the IRD process consideration will have been given to involvement of the police. The police will lead any interview where there is a possibility of a crime having been committed. The police *may* do so jointly with the council officer if this would assist the investigation and avoid repeated interviewing. It is important to recognise that the objectives of a police investigation and a council officer Visit and Interview may be different.

Other Investigations:

Medical examinations
These may determine if immediate treatment is necessary; provide evidence to inform criminal prosecutions (conducted under police direction) or assess the adult's mental capacity. Any medical examination must be carried out by a health professional (see Section 8 of the 2007 Act).

Examination of records
The 2007 Act gives council officers the right to seek and obtain records including medical and financial records from any source (NHS, public, voluntary, commercial) where this would assist the investigation. The council officer should provide evidence that they are authorised to access records to the record holder.

The council officer can inspect the records or arrange for someone suitably qualified and experienced to inspect the records, for example, financial records may require assistance from colleagues within the council's finance section. Medical records must **only** be examined by a suitably qualified healthcare professional; this will require the council officer to consider a suitable health representative to undertake this aspect of record examination.

Large Scale Investigations (amended electronically on 30 Sept 2019)
A Large Scale Investigation is an inter-agency response to circumstances where there is the potential that more than one adult is at risk of harm within a registered service or health setting (this includes residential care, day services, care at home services or hospital wards).

This procedure has been created to:

- Provide a standardised approach to carrying out a Large Scale Investigation consistent with current best practice.
- Offer a framework for an alternative to holding large numbers of individual Adult Support and Protection Investigations linked to a specific regulated service or health setting and ensure that there is adequate overview / co-ordination where a number of agencies have key roles to play.
- Clarify partner agencies' responsibilities during Large Scale Investigations.

The procedure can be found at the following link: Large Scale Investigations

Outcomes following an investigation (updated 26 Nov 2021)
Within 10 working days of the start of the investigation the council officer will present a report of the findings using the council officer's report paperwork to his/her team manager. Timings may be extended in exceptional circumstances where agreed by the overseeing team manager, with reasons for delay recorded.

The following risk assessment will be completed at part of the investigation, as previously. This same risk assessment will also be used within social work assessments, meaning a consistent risk assessment template is used throughout our processes as per Care Inspectorate feedback at the 2021 ASP Inspection.

Risk Assessment

	Details
What behaviour, allegation, complaint, circumstances, or event has prompted this assessment? (Detail the nature of the behaviour or incidents which put/or is likely to put the person at risk, e.g. the nature and extent of sexual/physical/financial harm; the specific areas of self-neglect (eating, medication, wandering) Do you consider the harm identified as serious?	
Who is the source of concern, and who is involved in the risk events?	
When does this/do these circumstances occur - and **how often**? (Evenings/weekends/every day/mealtimes etc; rarely, frequently, occasionally, etc)	
Where does this/do these circumstances occur? (Day centre, at home, on the streets, travelling)	
Particular triggers or risky circumstances that heighten the risks? (e.g. when person is alone; if carer/support person is late; if relative	

makes contact/does not make contact; arrival of benefit; contact with specific person/staff member etc)	
Protective factors, or circumstances, that have protected the subject, or reduced the risk in the past? (include here any change in subject's ability to manage these risks)	

Agreed Actions including Risk Management Plan if necessary

What	By Who (If on system)	By Who (If not on system)	By When	Progress

Furthermore, at the point of completion of the investigation, a Protection Plan should also be completed by the council officer in partnership with the other services involved. This would ensure that, whether or not further adult protection related measures will be taken, there is a clear plan in place for the adult at risk either for the council officer or other services to take forward. This would also ensure that, if it the case was to proceed to case conference, an initial plan for managing risk is in place prior to the case conference, creating more defensible decision making. Please see below for the Protection Plan template, which is included within the Council Officer Report.

Please see below for the Protection Plan template, which is included within the Council Officer Report.

Needs and Risks	Desired Outcomes	Action	Person Responsible	Timescales	Progress against Plan (reviews only)

Examples of outcomes from an investigation are detailed below.

The adult at risk criteria are met and harm is established

Where the criteria are met certain options may be appropriate:

- Proceed to a case conference;
- Where the adult is already receiving services, assessment may identify that continuation with care management arrangements following a review of an existing care plan is appropriate. **It is important for records to reflect that the criteria are met and that this is the most proportionate response, to differentiate from * below;**
- Consider adult protection orders under the 2007 Act. If the council officer has been refused entry and no other reasonable steps can be taken to conduct the investigations, statutory measures may be necessary (see Protection Orders); or
- No further action. This outcome may be reached on the basis that the adult has requested this; there are no consent or capacity issues and there are no concerns regarding undue pressure or risks to others identified. Records should indicate clearly that the adult has met the criteria as an adult at risk and the reasons why no further action is to be taken at this time. This decision should not be reached without inter-agency agreement or an agreement about an escalation of response if this adult is again referred as an adult at risk.

The adult does not meet the criteria as an adult at risk of harm

Despite the fact the criteria are not met there may be other factors that require to be addressed.

The options could include:

- Referral for assessment under care management (subject to eligibility criteria and agreement of the adult);
- Where the adult is already receiving services, it may be appropriate for the adult to continue under care management arrangements following a review of the existing care plan*;
- Consideration to be given to if a non-ASP Adult Case Conference is appropriate as underpinned by the Adult Case Conference Protocol (Page 42)
- Referral to another appropriate agency; or
- **No further action** is required.

The council officer completing the adult protection investigation will share the findings and conclusions with the adult and all involved agencies as soon as practicable.

Investigations should be completed within 2 weeks (10 working days)

Case Conference

A case conference is a meeting involving the adult and his/her representative (including an advocate) and relevant partner agencies to consider the harm identified and what supportive and/or protective arrangements the adult and the partner agencies agree. Persons involved with decision making may also include carers, family members or a proxy (a welfare attorney or welfare guardian) where appropriate. It is important that the adult is encouraged to participate in this process and steps should be taken to hold a meeting that is meaningful for the adult.

If the adult is unable or unwilling to attend, the reasons must be included along with steps taken to encourage their participation, and their views and wishes communicated by a nominated person and recorded in the minute. The legislation relevant to the adult's circumstances will be taken into account at an initial case conference and can include (Adult Support and Protection (Scotland) Act 2007, Mental Health (Care and Treatment (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000).

The meeting participants will assess the risk the adult is exposed to and agree actions which will form and continue the protection plan originally written at the conclusion of the investigation, prior to the case conference. The plan will detail individual and collective responsibilities with appropriate timescales. A lead person or persons will be identified to coordinate the plan.

Note: A meeting between agencies and professionals is **not** a case conference; this is an Inter-agency Referral Discussion (IRD) or a multi-agency strategy meeting in the case of a large scale investigation. The Case Conference minute template must only be used to record a Case Conference.

Triggers for calling a Case Conference

- Where an adult has been harmed or is at risk of harm and requires a coordinated adult protection plan;
- A failure of the adult to engage with, or a breakdown of existing care plan arrangements and services, leading to the adult being harmed or being at risk of harm;
- Where the adult's needs have changed for reasons not understood by any existing agency, leading to an increase in risk to the adult and/or others;
- When new and complex care arrangements need to be established quickly to prevent the adult from being harmed;
- Where there is continuing conflict or lack of coordination between agencies providing the adult with care and support, therefore placing the adult at risk of harm; or
- Where it has been identified that the adult is at risk of serious harm.[9]

[9] See page 19 for guidance on consideration of serious harm

A **review case conference** will follow within 3 months of the initial case conference and will be necessary in order to review any protection plan to ensure it is working and to consider any changes needed to ensure it is achieving its aims. A date for this will be agreed at the initial case conference.

Timescales
The urgency and complexity of the adult's circumstances will determine how quickly a case conference is required. This should be as soon as practicable and in all cases **within 28 days** from receipt of the report of harm referral.

Organising and chairing case conferences
The council officer undertaking the investigation will be responsible for organising the case conference and ensuring a suitable date and venue to maximise attendance by all relevant parties, in particular, the adult at risk. The council officer will arrange invitations to all participants, including the adult, and will prepare an outline of the reasons for the case conference. This will allow those in attendance to participate more fully during the case conference but it can be withheld if it places the adult at further risk. The adult's invitation should be in a format appropriate to their needs. The chairperson will normally be the council officer's team manager but this can be delegated, by agreement, to another team manager.

Mental Health Officers (MHO) at Case Conferences
If there is evidence that the adult is at risk of harm as a consequence of a mental disorder, consideration should be given to requesting the attendance of a MHO. The specialist training and experience of MHOs can assist in the assessment and risk management of adults at risk with a mental disorder. They can also provide information and assistance in obtaining an assessment of an adult's capacity to make their own welfare decisions.

Where the adult is at risk from harm as the direct result of incapacity a case conference may be required to consider the need for guardianship under the Adults with Incapacity (Scotland) Act 2000. As part of an adult protection plan, an MHO must be invited to attend. Under such circumstances the case conference will also perform the function of a guardianship case conference. Not all case conferences will be treated as guardianship case conferences.

Format of a Case Conference
The format for a case conference involves introductions by the chairperson, explaining the functions of a case conference and the context of adult support and protection guidelines.
Any restricted access or third party information should be discussed at the beginning of the meeting prior to the attendance of the adult and anyone who is accompanying them, including any advocacy worker. This part of the meeting will be minuted separately as part of the restricted access section and will not be circulated to the adult or anyone they have invited to attend.

The council officer who undertook the investigation will present the findings from the report based on the gathered facts.

These will include:

- Details of the initial Report of Harm;
- The type of harm the adult is subject to or at risk of;
- A brief outline of the adult's current living arrangements;
- Existing supports, both paid and informal arrangements;
- Who the adult resides with, if appropriate;
- Whether the adult has a caring responsibility for any child or young person;
- Any issues of capacity, consent or undue pressure; and
- The skills, attributes and resilience factors the adult holds

There will then be an opportunity for the adult and other attendees to comment on the council officer report and express their view on any measures, if any, they think necessary to protect the adult from harm.

If there are disagreements about any information presented, there should be an attempt to resolve these at the time; however, it may be that some disagreements cannot be resolved and may only be acknowledged.

The Chairperson will summarise the discussions and agreed actions.

The adult protection plan will be developed further based on the decisions reached, identifying the owners of actions and allocating time scales for each action.

Where there are agreed protective actions requiring immediate action, these should be progressed without waiting for the case conference minutes or the protection plan to be circulated. A contingency plan should be included in the adult protection plan where a breakdown of the protective measures is anticipated.

The minute and protection plan should be circulated to all those invited to the case conference and those tasked with any actions **within 10 working days** whether or not they attended.

Comments on the accuracy of the minute and adult protection plan should be addressed with the Chairperson within 10 working days of receipt of the minute.

Where the adult at risk has chosen not to attend, there must be agreement and timescales regarding feeding back to the adult the outcome of the case conference.

Core Group Membership and Functions

The Core Group, usually led by the social worker, is generally formed from those with actions in the adult protection plan. The Core Group will include the adult to ensure they remain at the centre of the protection plan outcomes.

The Core Group Lead will meet the adult within 10 working days of the case conference to ensure the adult has understood the process and the protection plan.

The Core Group will meet regularly to check progress on actions and confirm the protection plan is working.

There will be a note kept of attendance and progress for each Core Group meeting.

The Core Group may make minor adjustments to the protection plan but must report back to the Case Conference Chair if the plan is failing or requires significant adjustment.

The Core Group lead will report to the review case conference on behalf of the Core Group.

Adult Case Conference Protocol
This protocol has been agreed by the Adult Support and Protection Committee to authorise and guide relevant statutory agencies to convene a Case Conference in circumstance where an adult is deemed to be at risk or poses risk to others and **DOES NOT MEET** the three-point criteria that defines an adult at risk of harm.

This procedure does not replace agency referral or legal process and should not be used as a referral short cut or as an attempt to pass responsibility to a single agency.

Purpose
This protocol sets out the roles and responsibilities of statutory agencies and other partner agencies in the planning and convening a case discussion where an adult is at risk and a multi-agency approach needs to be considered.
It can be applied in circumstances where an adult –

- Does NOT meet the three-point criteria of an adult at risk of harm
- Is otherwise deemed to be at risk, as noted below (2a) and
- Existing working practices and mechanisms are neither applicable or successful.

Scope
From time to time, adults are referred and/or known to public agencies, including emergency services, who are not adults at risk as defined by the Adult Support and Protection (Scotland) 2007 Act (ASP), but who are deemed to be at risk or pose a risk to others.
The adult may be difficult to support in a way that manages or reduces risk due to factors such as –

- challenging social care supports by presenting risks to self or others, which cannot be managed or contained;
- refusing to engage or cooperate with services;

- having no or limited insight into their circumstances and the risk that this creates;
- self-harming repeatedly or self-neglecting, but does not meet the criteria for admission to hospital;
- having low self-esteem and / or repeatedly engaging in risky behaviour, possibly also compounded by problematic alcohol &/or drugs use;
- having dangerous behaviours, which fall out-with MAPPA, MARAC, Mental Health legislation, or other existing multi-agency processes;
- placing themselves and others at risk from fire;

requiring complex coordinated multi-agency arrangements to reduce or eliminate harm. This may be evident due to repeated referrals, perhaps to a range of agencies, or information suggesting that the risk to, or caused by, the adult may be increasing or there are more minor risks which appear to be accumulating and escalating.

Further consideration of the ASP Multiple Report of Harm Protocol is recommended here and should be followed if relevant. Where it does not apply at this time then this Protocol should be used to convene a multi-agency case conference.

Agencies Responsible
Existing arrangements offer partner agencies the opportunity to explore how to manage risk and how to work cooperatively, however from time to time such informal arrangements are insufficient to manage the risks involved and in such circumstance this Protocol will apply.

The Protocol offers an agreed multi-agency process where an adult meets the above criteria (2a); then **ANY statutory agency may plan and convene a case conference** to consider the adult's circumstances in a multi-disciplinary way. This will also facilitate agencies to meet their duty of care to an adult at risk in the above circumstances. It applies to –

- Fife Council (including Housing Services);
- NHS Fife (including independent health practitioners, allied health professionals and GPs);
- Police Scotland;
- Scottish Fire and Rescue Service;
- the Care Inspectorate;
- the Mental Welfare Commission; and
- the Office of The Public Guardian.

Independent Service Providers in Fife should seek the agreement to the convening and managing of a Case Conference with one of the partners named above, in relevant circumstances.

Responsibility of Agencies
Where an adult meets the above criteria (2a); then **ANY named agency** may plan and convene a case conference to consider the adult's circumstances in

a multi-disciplinary way. For the purposes of this protocol, this agency will be known as **'the lead agency'**.

The Case Conference would normally be –

- Scheduled, convened, and chaired by a manager in 'the lead agency' (as above)
- Informed through relevant other agencies information and participation
- Informed by the attendance and participation of the adult.

When a case conference is convened, it is expected that **other agencies will cooperate** by providing relevant information and an informed manager / relevant staff member will attend the Case Conference.

Purpose of the Adult Case Conference

Care will be taken to ensure that the case conference and any planning is consistent with the principles set out above and respond to any situation including where the adult refuses to cooperate, as noted below.

The purpose of the Case Conference is –

- to share and consider information from relevant agencies;
- to engage with, and hear from, the Adult at risk who should be enabled to participate
- to explore actions that can be taken to minimise risks to the individual and / or from the individual, through a partnership approach in the first instance;
- to develop a shared **'Adult Risk and Protection Plan'** that seeks to eliminate or reduce any risks identified;
- to identify and commit relevant resources that facilitates the 'Adult Risk and Protection Plan';
- to agree a core group to oversee the 'Adult Risk and Protection Plan';
- to agree a timescale for the review of the 'Adult Risk and Protection Plan';

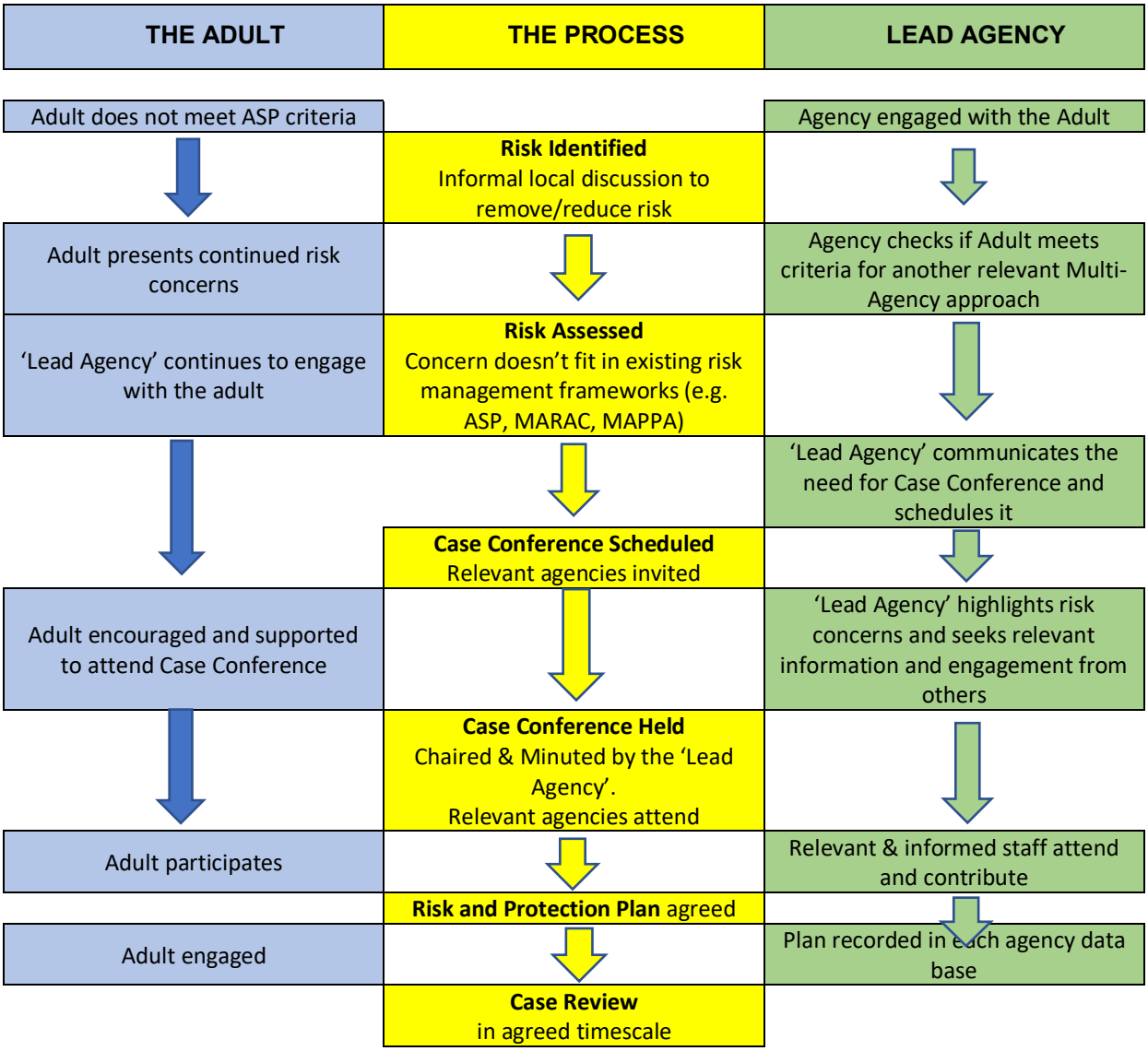
The Case Conference is built on the foundation of multi-agency working, and as such, attendees should not expect that a single agency will assume sole responsibility.

It will explore local solutions to eliminate or reduce the risk and consider relevant services, legislation and innovative options and attendees will seek to agree shared responsibilities. This will include understanding of the roles and responsibilities of relevant agencies, and their staff who will deal with chronic situations of risk and crises and consider steps to enhance this where necessary.

The Case Conference may be alert to gaps in resources, systems and knowledge and seek to advise relevant agencies on this.

THE CASE CONFERENCE FLOW CHART

The following flow-chart sets out the expected process.



Adult Case Conference Practice

The Lead Agency will seek to engage relevant other agencies in a spirit of cooperation around the needs of the adult at risk. Therefore -

- Scheduling and convening the Case Conference will be done in discussion with relevant partners;
- The 'lead agency' will ensure that the Case Conference is chaired by a manager who is familiar with the case;
- The Case Conference will be guided by the 'agenda' as below and attendees will consider all available and relevant information;
- It is expected that other agencies will cooperate by providing relevant information and an informed manager / relevant staff member will attend the Case Conference and participate;
- Relevant other agencies may be invited even if no current involvement where their expertise is required;
- The Case Conference will aim to include and be informed by the attendance and participation of the adult;
- Carers or family members may also be asked to participate where this is considered relevant and appropriate;
- Attendees are expected to be within their own settings and with partner agencies to assist in the management of risk.

The Case Conference will –

- Consider and assess the risk identified and aim to identify relevant supportive arrangements in a collaborative and innovative way and together with the adult create a **'Risk and Protection Plan'**. This will detail individual and collective actions and responsibilities with appropriate timescales;
- Identify a lead person, or a small core group, to co-ordinate the plan, with authority to seek a reconvening of the Case Conference should this be inadequate;
- Set a timescale for the latest date to review the effectiveness of the plan and / or any change in circumstances;
- Commit to share the **'Risk and Protection Plan'** by bringing it to the attention of relevant staff and recording it formally in their respective recording systems.
- Following the Case Conference, the 'Lead Agency' will compile the minutes and the Risk and Protection Plan and circulate it to those present, those who were unable to attend and to any other relevant agency that is required to participate in the plan itself.

RECORDING

It is vital that the Case Conference minutes, and the Risk and Protection Plan are recorded and flagged in all agencies systems for ease of future access and for reference, should circumstances change.

Optimising the Adult's attendance and participation

An invitation to attend is not in itself sufficient, and consideration should be given to ensuring –

- The venue for the case conference is not intimidating to the adult or carers and any access or cultural needs have been considered;
- Ensuring that the number of professionals involved is not overwhelming for the adult which causes them not to attend e.g. reports could be provided by some agencies where their attendance is not essential;
- Appropriate communication aids, translation / sensory impairment services are provided;
- Individuals from minority ethnic communities have access to any relevant translation and communication support where required;
- The purpose and process of the meeting has been fully explained both before and during the meeting including the use of accessible information;
- Attendance for part of the meeting is possible if there are areas which an individual finds too distressing and there is an appropriate facility to support this. Video case conferencing could also be considered;
- When someone is unable to attend or contribute through lack of capacity or illness, advocacy and representation are facilitated;
- Adults at risk should not be required to confront those alleged to have caused harm in any meetings and arrangements should consider this;
- Where the person alleged to have caused harm may also be considered an adult at risk, a separate case conference should be held.

Where the Adult refuses to cooperate

Significant Case Reviews have identified a theme where agencies have difficulty engaging due to the refusal of the adult to cooperate. This can lead to increased risk with the potential of social isolation and a risk to the health and wellbeing of the adult. In these circumstances, and consistent with the scope of this protocol, an Adult Risk and protection Case Conference should be considered.

An Adult Risk and Protection Case Conference should be considered, particularly in circumstances where the risk to self or others is high, to discuss and agree strategies and approaches which may encourage the adult to engage and therefore reduce the risk it is believed they are exposed to.

This will include consideration of –

- the agency that may have the best opportunity of initiating, or building on any current connection that exists, with continuing support from the inter-agency partnership;
- an inter-agency chronology developed for the purposes of guiding understanding and discussion, and helping identify any channels to engagement that have not yet been explored;
- how to maximise engagement, reduce risk, reduce duplication, and aim to achieve a positive outcome;

- Undue Pressure that may influence the adult to decline support and should be considered;
- A Risk and Protection Plan (detailed as above) should be populated at the meeting and circulated to all participants and key actions and contingencies recorded on profile notes.
- Encouraging staff and their agencies to work at the adult's pace, and appreciate that the case may remain open and active for a long period.

Moving forward, a single point of contact should be identified to –

- Maintain contact with the individual if possible;
- Receive updates from partner agencies and maintain the inter-agency chronology.

The Case Conference may require to convene again, or until there is evidence that the level of engagement has increased and level of risk has decreased to a point where the adult no longer poses significant risk to self or others.

Please see below for the Adult Case Conference Invitation Template.

Dear

INVITATION TO ADULT CASE CONFERENCE CONCERNING:…

A Case Conference is to be held, regarding the above-named person, on……. at…….to which you are invited.

You have been identified as someone who may provide a useful contribution in relation to the above mentioned, it would therefore be of great value if you could attend this conference.

Should you be unable to attend personally, having your written comments regarding the contact with the person or family to date, and your assessment of the present situation would assist the conference. It would be helpful if you could notify me of your availability to attend, whether you are sending a representative, or intend to submit a report.

Please note that only the recipient of this invitation or their representative has been invited to the adult case conference, and any other parties who wish to attend must consult with the meeting organiser who will request permission from the above named person

Please complete and return the attached slip within seven working days.

A list of those invited is also attached.

Yours sincerely

Protection Orders

The 2007 Act allows council officers to apply to the court for a range of orders to undertake their investigation or to provide measures of protection to the adult.

In summary the orders that can be sought are:

- Assessment order
- Removal order
- Banning order (and temporary banning order)

A protection order may be sought at any time in the adult support and protection process. Unless a protection order is being sought on an emergency basis, the application must be made in writing by a council solicitor, with accompanying evidence provided by the council officer.

Protection orders can only be applied for where it is known, or there is cause to suspect, that the adult is at risk of **serious** harm. What constitutes serious harm varies and is not defined in the 2007 Act.[10]

The granting of any protection order requires the consent of the adult. If the adult does not consent, but there is evidence that the adult has been subject to undue pressure, and there are no other reasonable steps that could be taken with the adult's consent which would protect the adult from the harm the order is intended to prevent, it may be appropriate to make an application. Where the adult lacks the capacity to consent, it is important to check whether there is a welfare guardian or attorney appointed who is authorised and is willing to consent on the adult's behalf. Where no guardian or attorney exists, a protection order can still be applied for; however, the sheriff will require evidence of incapacity. Advice from council solicitors should be sought.

Assessment Order

An assessment order allows the adult to be taken to a place where they can be interviewed and/or examined by a specified health professional. The sheriff, before granting an order, must be satisfied that:

- The council has reasonable cause to suspect that an adult at risk is being or is likely to be seriously harmed;
- An assessment order is required to establish whether the adult is being seriously harmed or likely to be seriously harmed; and
- There is a suitable and available place where the adult can be interviewed and/or examined.

The purpose of the assessment is to allow the council officer to establish that the adult is at risk of harm and requires measures to be put in place to prevent them from that harm. When an assessment order is granted the sheriff also grants a warrant for entry. The visit to implement the assessment order will be

[10] See page 20 for consideration of serious harm

carried out with the police. A police officer in attendance can use reasonable force to gain entry to the premises.
This order will only be necessary if it is not possible or practical to undertake a section 7 interview and medical examination during a visit. (For example, due to lack of privacy)

An assessment order expires after **seven days**. The adult can be taken to the place specified in the order but cannot be detained.

Removal Order
A removal order is primarily for protection and not for a council officer interview or medical examination. Only the council can apply for a removal order. Before granting a removal order the sheriff must be satisfied that:

- The adult at risk is likely to be seriously harmed if not moved to another place; and
- There is an available, suitable place where the adult at risk can be moved to.

The application for a removal order should also include any voluntary approaches which have been made to protect the adult and all other options explored and exhausted, including consideration of other legislation.

A removal order allows the council officer to remove the adult to a specified place within **72 hours** of the order being granted and for the council to take such reasonable steps as it thinks fit to protect the person from harm. When a removal order is granted the sheriff also grants a warrant for entry. A police officer in attendance can use reasonable force to fulfil the object of the order.

The order expires **seven days** after the adult at risk is moved or after any shorter period that the sheriff may decide when granting the order. The council has a duty to take reasonable steps to ensure that the property of the adult, who is subject to the removal order, is not lost or damaged.

In urgent cases an application for a removal order can be made to a justice of the peace. Before granting a removal order the justice of the peace must be satisfied that:

- The adult at risk is likely to be seriously harmed if not moved to another place;
- That there is an available suitable place where the adult at risk can be moved to;
- It is not practicable to apply to the sheriff; and
- The adult is likely to be seriously harmed if there is a delay in granting the order.

A removal order granted by a justice of the peace allows the adult at risk to be moved within **12 hours** of the order being granted. The order will only have effect for a period of **24 hours**.

The council should reconsider the suitability of a removal order if it considers that the adult will refuse consent to the removal order or that they are unlikely to remain in the place to which they are being moved.

Banning Order/Temporary Banning Order

Council officers and other interested parties**, including the adult at risk** can apply for a banning order. Applications 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; or
- By the council if there is no one else to make the application and the grounds are met.

A banning order or a temporary banning order can be considered where the adult is at risk of serious harm and it would be better for the adult to remain where they are and for the subject of the order to be banned from a specified area or place.

Before granting a banning order the sheriff must be satisfied that:

- The adult at risk is being, or is likely to be, seriously harmed by another person;
- The adult's wellbeing or property would be better safeguarded by banning the other person from the place occupied by the adult than it would be by moving the adult from that place;
- The adult at risk is entitled, or permitted to occupy, the place the subject is being banned from (or neither the adult nor the subject is entitled to occupy the place from which the subject is to be banned). If the adult does not have a right to occupy the property then the subject cannot be banned.

A banning order can last for any period up to a **maximum of 6 months** and may:

- Authorise the ejection of the subject from the place or area;
- Ban the person from a specified place, in the vicinity of a specified place;
- Prohibit the subject from moving any specified thing from the specified place;
- Direct any specific person to take specific measures to preserve any moveable property owned or controlled by the subject;
- Be made subject to specific conditions; or
- Require or authorise any person to do, or refrain from doing, anything else which the sheriff thinks necessary for the proper enforcement of the order.

Application for a temporary banning order may be made where it is inadvisable to wait for a full hearing on a banning order application.

A temporary banning order expires on the date a banning order is made, the date on which it is recalled or any specified expiry date.

A condition specified in a banning order may authorise the subject of the order to be allowed into the place they are banned from for specific reasons, for example, supervised contact.
The sheriff may attach a power of arrest to the banning or temporary banning order if there is a likelihood of the subject breaching the conditions of the order. The power of arrest becomes effective only when served on the subject of the order and will expire at the same time as the order.

Warrant for entry
If, during an investigation, a council officer is refused entry, is likely to be refused entry, or is unable to enter the premises for some other reason, they may apply for a warrant.

A warrant for entry authorises a council officer, accompanied by a police officer, to visit any place specified in the warrant. The warrant authorises a police officer to open lock-fast premises and to do what is reasonably required to assist the council officer making the visit. If the council officer requires the police officer to open the adult's property by force then the council has a duty to take reasonable steps to secure the property and belongings afterwards.
Consideration should be given to the services of a joiner if necessary. The safety of any pets should also be considered.

Application for a warrant
An application for a warrant will be made by a council solicitor. It is therefore good practice for a representative from the legal team to be involved as early as possible in the adult support and protection process.

The sheriff may grant a warrant for entry where they are satisfied that the council officer has been refused entry or is likely to be refused entry and any attempt to visit without a warrant would be of no use. The council officer will, in most cases, need to demonstrate the attempts they have made to enter the premises to visit the adult thought to be at risk. The use of force should be a last resort and should only be considered when all other options have been exhausted. A warrant granted by a sheriff expires after **72 hours** and once executed cannot be used again.

Urgent Application for a warrant
There may be occasions when it is impracticable to make an application to the sheriff and a delay is likely to place the adult at ongoing risk of harm. In these circumstances, an application seeking a warrant for entry can be made to a Justice of the Peace (JP).

A warrant for entry by a JP expires **12 hours** after being granted and once executed cannot be re-used.

Undue Pressure

Undue pressure can be applied by any individual and in some circumstances may not be the person suspected of causing the adult harm. The 2007 Act provides examples of undue pressure:

- Harm being inflicted by a person in whom the adult has confidence or trust and the adult at risk would consent to intervention if they did not have confidence and trust in that person (section 35(4)).
- Undue pressure may also occur when the adult is afraid of, or is being threatened by someone.

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 not be a direct threat or harm for undue pressure to have been applied.

Evidence of undue pressure
The likelihood of undue pressure being brought to bear should always be considered when an adult at risk refuses to give consent.

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 the adult has been unduly pressurised to refuse consent to the action; and there are no steps which could reasonably be taken with the adult's consent which would protect the adult from harm.

Indicators of undue pressure could be:

- Not being allowed time alone with the worker
- Hesitation in talking when certain individual/s are present
- Lack of eye contact
- Personal presentation (appearing fearful in the presence of particular individual/s)
- Expressing fear of abandonment/loneliness
- Belief that the consequences of giving consent will result in the adult at risk experiencing negative consequences.

In court applications, the burden of proof establishing that there has been undue pressure on an adult at risk lies with the council.

Evidence of undue pressure is not required 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.

Significant Case Review (SCR) summary

The full I&SCR Protocol can be accessed on Fife.gov.uk or within your own agency's sites.

The key purpose of an SCR:

- To establish whether there are lessons to be learned about how better to protect adults at risk and to ensure they get the help they need in the future;
- To make recommendations for action, including changes in practice, policy, or procedures.

Which cases qualify for an SCR?

a) When an adult at risk dies, and:

- Harm or neglect is known or suspected to be a factor in the adult's death;
- The death is by suicide, or accidental death; or
- The death is by alleged murder, culpable homicide, reckless conduct, or act of violence.

AND the incident, or accumulation of incidents, gives rise to concerns about professional and/or service involvement or lack of involvement.

b) When an adult at risk has not died, but

- Sustains serious harm or risk of serious harm under one or more of the categories of harm and neglect, as set out in the 2007 Act.

AND the incident, or accumulation of incidents, gives rise to serious concern about professional and/or service involvement or lack of involvement.

This list should not be seen to exclude cases that may not precisely fit the criteria but which nevertheless clearly triggers professional concern.

Exceptions to the above criteria may also include situations where major concerns are identified about a perpetrator. These would include harm in an institutional setting, as part of an abusive culture, and/or has been perpetrated by multiple abusers. The harm may be regarded as intractable or likely to be repeated.

Who can refer?
Referrals can be made by any person, from any agency represented on the Adult Support and Protection Committee. Each agency will agree its own route for referrals but they should usually be made via the agency's senior officer or designated manager.

How to refer?
The Referrer should send an Initial (trigger) Case Review (ICR) referral to the Adult Support and Protection Coordinator using the I/SCR template, within the I/SCR Protocol. The Initial Case Review report should be submitted by email within **one working day** of the case coming to the attention of the agency's senior officer or designated manager. Where it has not been possible to meet this timescale the reason should be noted on the form.

Dissemination of the Report

The circumstances of every case are different and the communication strategy for dissemination of the report or its finding and recommendations will differ.

SECTION C: PRACTICE GUIDANCE

Anticipating Harm

While much of the guidance relates to addressing concerns of harm once they are disclosed or have become apparent, it is also important for individuals and agencies to be aware of circumstances and settings that may make it more likely that harmful conduct may occur. The presence of these indicators does not mean that harm has occurred or will occur, but they should be anticipatory signals to the possibility of harm.

Social isolation: The individual who lives alone or is alone with a carer and is isolated from friends and relatives may be at increased risk. In these circumstances individuals may be particularly at risk of financial harm. However other types of harm can occur in socially isolated settings because there is the opportunity to keep the harm hidden; the presence of others can lead to intervention and sanctions.

Shared living situations: These situations can provide a major risk to individuals because of the increased opportunities for contact. The risk of harm may be increased from staff and other service users in shared settings.

Challenging behaviour: The individual who displays behaviour that challenges others may be at increased risk of harm to themselves and to others. This can be increased where the person has a learning disability and/or communication difficulties.

Carer issues: Where a carer experiences mental illness or misuses alcohol or substances there may be an increased risk of harm to a dependent adult. Additionally, where the carer is heavily dependent on the individual there may be an increased risk of harm.

Undue Pressure: An act of persuasion, coercion or threat that deprives the adult of freewill. The adult may be the victim of undue pressure due to the trust relationship that is required in supportive relationships, and may not be aware that undue pressure is influencing their decisions; see page 43.

Signs of Harm

Harm includes **all** harmful conduct, whether deliberate or unintentional. Harmful conduct also includes acts of omission, e.g. neglect and harm as a consequence of the individual's own behaviour (self-harm). Some sign of harm are described below, but please note, this list is not definitive.

Abrasions: Particularly suspicious are tears to the skin on parts of the body, other than the arms and legs. They may indicate physical harm or neglect.

Bruises: The pattern of the bruise can indicate the cause e.g. finger pattern or fist mark may be retained. "Tramline bruising"; parallel bruises are indicative of injury from a stick. Non-accidental injury bruising is more common on the face, neck, stomach, chest and buttocks.

Burns: Research suggests that burns in older people may be an indicator of neglect or physical harm. Burns may also result from self-neglect.

Dehydration: This may be a consequence of lack of support to maintain fluid intake; failure to provide liquids or to recognise the consequences of inadequate intake. Dehydration may be an indicator of neglect.

Finances: Indicators of financial harm/crime may be an unexplained or sudden inability to pay bills, unexplained or sudden withdrawal of money from accounts, disparity between assets and satisfactory living conditions, extraordinary interest by family members and other people in the adult's assets or inappropriate expenditure of no benefit to the adult.

Fractures: These may result from falls; therefore it is important to check records for relevant details. Fractures of head, spine or trunk are more likely to be the result of physical harm than fractures to limbs.

Hygiene: Indicated by rashes or sores, dirty/smelly clothes, squalid living environment, out of date food, etc. Some individuals may elect to live this way therefore there is a need to take account of the person's past life and habits. This may be an indicator of neglect, self-neglect or financial harm.

Malnutrition: There are a variety of factors that can lead to malnutrition: failure to respect cultural food preferences leading to food refusal; the effect of medication on appetite suppression; poor oral hygiene leading to eating difficulties; insufficient care staff to assist individuals with eating difficulties. Malnutrition may be an indicator of neglect.

Misadministration of medication: Incorrect administration of medication or over/under medication to control the individual may indicate neglect or physical harm.

Pressure sores: These may be an indicator of neglect, especially if the sores have not been brought to the attention of medical staff.

Sexual Harm: Evidence of sexually transmitted diseases, especially when the individual lacks capacity, is an indicator of sexual harm. Bruising of the palate (may indicate forced fellatio); bleeding or bruising to the genital or anal area; difficulty sitting or walking are all indicators of forced sexual activity. In addition, withdrawal, fear, depression, anger, insomnia, increased interest in sexual matters, or increased sexual or aggressive behaviours may be displayed.

The presence of an indicator alone, does not confirm that harm has occurred

Self-Harm

The 2007 Act indicates that an adult is considered at risk of harm

- Where another person's conduct is causing or is likely to cause the adult to be harmed; or

- Where the adult is engaged or likely to engage in conduct which causes self-harm.

Self-harm is a complex topic and any intervention requires to be carefully managed. Practitioners should always be aware of the possible impact of an adult's situation (such as that of an adult who self-harms) on the wellbeing of any children or other adult at risk in that adult's care and should be prepared to raise a concern if necessary

Self-harm includes:

Self-neglect: The failure by an individual to meet his or her own personal, physical and health needs leading to deterioration in their condition. Self-neglect may arise because of a wide range of deteriorating motivational or health conditions.

Self-poisoning: Includes the ingestion of a substance in excess of the prescribed or generally recognised therapeutic dose, or of a recreational or illicit drug in a way that is intended to be self-harmful, rather than in connection with addiction / dependence.

Self-injury: (Also referred to as self-mutilation/self-injurious behaviour/ non-suicidal self-injury) is harm to the body, commonly by cutting with a sharp object, but also by burning/scalding, inserting or swallowing sharp objects, hair-pulling, biting, hitting/punching, banging (head or other body parts), scratching or jumping from height.

Where the three point criteria is met and the definition of harm identified is self-harm, there is a duty to establish whether there is a need to offer support and protection in the same way as when harm is experienced as a consequence of the actions or omissions of another/others.

Self-Harm Resources
Responding to Self-harm, Scottish Government, 2011,
Responding to Self Harm

Self-harm. The Short-Term Physical and Psychological Management and Secondary Prevention of Self-harm in Primary and Secondary Care. National Clinical Practice Guideline Number 16, commissioned by the National Institute for Clinical Excellence 2004
www.nice.org.uk/nicemedia/pdf/CG16FullGuideline.pdf

Self-harm: Longer term Management, NICE Guideline
https://www.nice.org.uk/guidance/CG133

The following national organisations focus specifically on trauma and may also be helpful:

- **Harmless** – A user-led organisation that provides a range of services about self-harm, including support, information, training and

consultancy to people who self-harm, their friends, families and professionals. www.harmless.org.uk
- **LifeSIGNS** – A user-led self-harm guidance and support network. www.lifesigns.org.uk
- **National Self Harm Network (NSHN)** – 0800 622 6000. Survivor-led online support forum for people who self-harm, their friends and families. www.nshn.co.uk
- **www.selfinjurysupport.org.uk** – 0808 800 8088 and 0780 047 2908 (text support). Information and support for women and girls affected by self-harm, trauma and abuse.
- **www.battle-scars-self-harm.org.uk** – Support for anybody affected by self-harm, people who self-harm, and those supporting them
- **www.selfharm.co.uk** – Site dedicated to young people and self-harm. Includes details of helpful organisations, research studies and entries from individuals. Although aimed at young people, this site is also helpful for parents who have children who are self-harming.
- **www.scar-tissue.net** This website has lots of ideas and tips on coping with self-harm.
- **www.seemescotland.org** – A list of useful websites.
- **www.siari.co.uk** – Aimed at supporting the families and friends of people who self-harm.

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; in this case, self-harm.

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 well-being of the individual and potentially to their community. Extreme self-neglect can be known as Diogenes syndrome.

Diogenes syndrome is a disorder characterized by extreme self-neglect, domestic squalor, social withdrawal, apathy, compulsive hoarding of garbage, and lack of shame. Sufferers may also display symptoms of catatonia.

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.

An individual may be considered as self-neglecting and therefore may be 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 learning disability or acquired 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.

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.

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

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 amenable 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 including increased risk from fire

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

Assessment
A comprehensive assessment is essential to assist 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:

- An assessment of capacity does not negate the duty to act for an individual's well being
- The value of kindness in contributing to dignity highlights the principle of doing least harm
- Strike a balance between respect for autonomy and perceived duty to preserve health and wellbeing

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 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.

Multi-agency framework
Because of the complex issues involved multi-agency involvement, collaboration and shared responsibility is essential. Consideration should be given to holding a network meeting when self-neglect has been identified to explore options for intervention that will improve outcomes.

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
Adults with Incapacity (Scotland) Act 2000
Public Health etc. (Scotland) 2000 Act

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)
Working with people who hoard (Orr, Braye and Preston-Shoot 2017)

Financial Harm
In Fife financial harm has been one of the three most frequent types of harm reported in annual data returns to the Scottish Government. Financial harm is complex and requires a collective response to tackling it.

The financial harm strategy was developed from the Fife Adult Support and Protection Committee's Improvement Plan, which included the priority area of responding to harm occurring adults at risk of harm in their own homes.

There are many examples of financial harm but these types have most commonly been reported in Fife.

- theft of money, benefits, property, possessions
- telephone call scams

- unfair trading practices and aggressive sales pitches
- internet scams
- unsolicited mail
- befriending for the purpose of committing crime

1. Reporting financial harm

This should be done using the inter-agency adult support and protection guidance or by contacting Police Scotland if a crime has occurred or been suspected. The adult protection phone line is 01383 602200. A Reporting Harm form should also be completed and emailed to sw.contactctr@fife.gov.uk

Local authorities are under a duty to inquire where they believe or know that an adult is at risk of harm as detailed in the Adult Support and Protection (Scotland) Act 2007. This is the case for adults aged 16 and over. Wherever possible, individuals should be informed of the intention to report the financial harm and to have their views of the circumstances ascertained if possible.

If financial harm is suspected or caused by someone who has been formally appointed to manage the person's finances, such as a financial guardian, financial attorney or benefits appointee these must also be reported where relevant to:
The Office of the Public Guardian www.publicguardian-scotland.gov.uk

The Mental Welfare Commission www.mwcscot.org.uk
Department of Work and Pensions https://www.gov.uk/organisations/department-for-work-pensions

Definition of financial harm
Financial harm is caused by the illegal or improper use of an individual's resources (both financial and property) by another person, without their informed consent or through the exercise of undue pressure.

It can include theft, fraud, internet scamming, identity theft, misuse or stealing of property, possessions or benefits. Other examples may include unfair trading practices and aggressive sales pitches.

Impact of financial harm
It is common that individuals may experience more than one type of harm. Research indicates that financial harm is frequently linked to physical and/or psychological harm and neglect. Evidence of any of these should alert professionals to the potential for financial harm.

The impact of financial harm can leave individuals feeling embarrassed, anxious and distressed, possibly leading to a marked deterioration in health and wellbeing. Loss of confidence may reduce independence. Adults may be unable to recoup monies lost. Financial harm reduces the adult's assets,

which impacts on quality of life and in some cases may increase reliability on state intervention.

For further information on Fife Council's specific Financial Harm strategy, please click on the following link.

Harm Settings

Harm in care homes and other residential settings

The Scottish Government has included harm in care settings as one of their key themes to focus on following the introduction of the Adult Support and Protection (Scotland) Act 2007.

The Adult Support and Protection Committee recommends one approach to both prevention and identification of harm in care settings. It utilises the research based guidance "Early Indicators of Concern in Residential Settings"[11] which has been adapted for use both in settings for adults with a learning disability and for older people. The indicators are very similar for both settings and can help identify early indicators and patterns of concern in advance of harm occurring. They can be used by health and social care practitioners and those with monitoring responsibilities in those settings, who can "log" their concerns against a grid of six indicator areas. The research has established that where concerns are logged across a range of indicators there is an association with harm, abuse or neglect.

This approach does not prove that harm has occurred, and harm can occur without any indicators being apparent. But any pattern of indicators of concern suggests that improvement/changes to service delivery will lower the risk that harm or neglect will happen.

The six indicator areas are:

- Concerns about management and leadership
- Concerns about staff skills, knowledge and practice
- Concerns about residents' behaviours and well being
- Concerns about services resisting the involvement of external people and isolating individuals
- Concerns about the way services are planned and delivered
- Concerns about the quality of basic care and the environment

The indicator grid can be used in three ways:

- An individual can use the grid to record and structure concerns
- A group of people, including families and professionals, can use the grid to collect their concerns about a service from different sources; or
- A team from a service can use the grid to review and reflect on their own service

[11] http://www.gov.scot/Publications/2014/02/4761/1

However used, once your concerns are recorded, share them with a line manager and take action following your agency procedure, including reporting harm, when necessary, to social work.

Resident or user of a regulated service or patient in NHS facility
If the adult at risk is a resident of a care home, group home, etc. or a patient in an NHS facility, consideration should always be given to others who may be at risk of harm. The report of harm should include reference to others who are, or may be, at risk. Social work services may initiate the Large Scale Investigation[12] process where several adults may be collectively at risk.

Unregulated Care
Self-directed support (SDS) empowers individuals to consider, from a range of options, how their assessed needs will be met. Positive risk taking and adult support and protection are an integral part of the SDS process, including assessing and managing risk, support planning and review and decision-making on how best to manage a personal budget. Promoting independence, choice and control and enabling positive risk taking, balanced with a duty of care and ensuring people stay safe, is a challenge. Nevertheless, social work skills and relationship-based working with adults promotes risk enablement as part of SDS, and detects and prevents harm.

Personal budgets are sometimes misunderstood, leading to the idea that people will be left unsupported and will have to take full responsibility for managing risk alone. This is an inaccurate perception, however, where an adult is in receipt of a personal budget and proposes, or is, employing the services of someone who is not connected to any professionally regulated workforce this may present additional risks to the adult which will require careful monitoring with the adult.

Allegations against staff members
Where an allegation of harm is made against a member of staff, it is essential that organisations treat this seriously and report this to the appropriate manager and the social work service as in the ‘Reporting Harm’ section at page 20. The organisation will follow its own employee conduct procedures and this will be in addition to any parallel investigation into the alleged harm led by a council officer on behalf of the social work service. It is expected that there will be cooperation with the social work service to confirm the outcome of any conduct proceedings, for example, as this may impact any safeguarding measures proposed or taken.

Crime and Adult Support and Protection

Where employees of any agency identify an adult at risk of harm, they must consider whether the behaviour may also constitute a crime. Where it is known or believed that an adult is an adult at risk, the police will determine whether a crime has been committed and therefore reporting to the police **as well as** to

[12] Page 37

social work will ensure the adult has appropriate access to the criminal justice process.

Where a crime has been committed or is suspected, consideration must be given to other potential victims. It is necessary for the alleged crime to be reported to the Police in order for a full investigation to be carried out.

Some adults are more at risk of becoming victims of crime where they have increased vulnerability either: because they have a mental disorder, have a physical or mental infirmity, are ill, or have a disability. Those persons may not have the same access to the criminal justice system as others for a number of reasons:

- They may not report what has happened because of fear, pressure from others, a lack of confidence in the judicial system, or lack of awareness that what is happening is wrong
- They may be regarded as less credible or less reliable witnesses
- Overprotective responses to the adult's vulnerability may deny them equal access to the criminal justice system, or
- Some harm is not recognised as being criminal in nature and therefore is not referred to the police.

Similarly, as part of the police process, and to ensure that victims or alleged perpetrators of crime, all have access to appropriate support and protection, consideration should be given to whether they also meet the criteria for an adult at risk.

The table below links types of harm and examples of the possible corresponding crimes.

This is illustrative and not an exhaustive list.

Type of Harm	Examples of Potential Related Crime
Physical	*Assault*: An attack on a person with intent to cause personal injury. *Murder* Causing the death of another human being; *Culpable homicide* Causing death by any unlawful act where the act was intentional but the intent to cause death was not.
Sexual	*Rape; sexual assault*; etc.: Acts of a sexual nature carried out without free consent of the victim
Financial	*Theft*: Appropriation of property belonging to another person, without consent and with the intent to deprive the person of the property *Embezzlement*: Misappropriation of goods to which the accused had been entrusted *Fraud*: Where a person uses a falsehood with the intention to deceive and defraud another, for example, internet and banking scams or bogus callers.
Psychological	*Threatening or Abusive Behaviour:* Behaviour which is

	threatening or abusive and is likely or intended to cause a reasonable person to suffer fear or alarm.

Hate Incidents
A hate incident is one that may or may not be a criminal offence, which is perceived by the victim or any other person to be motivated by prejudice or hate on the basis of

- Age
- Disability
- Gender Reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race or ethnicity
- Religion or faith
- Sex
- Sexual orientation

If the alleged harm may have been motivated by hate, include this in your Report of Harm Referral Form.

Other Relevant Offences

- Ill-treatment and wilful neglect of mentally disordered persons: section 315, Mental Health (Care and Treatment) (Scotland) Act 2003 applies to individuals employed, contracted to or managing the provision of services in a hospital or care setting, who ill-treats or wilfully neglects a patient
- Ill-Treatment and wilful neglect: Part 3 of Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 is broadly similar in terms of who it applies to, except that it is not limited to patients or service users with a mental disorder

Where other people may also be at risk of harm

Pregnancy of adult at risk
If the adult at risk is, or suspected to be, pregnant and there are concerns about potential risks to the unborn baby, **report this at the same time as you report harm about the adult.** Social work and health services will arrange for a pre-birth risk assessment to be undertaken.

Child concerns

Where a child may be at risk of harm, communication must be made with the Social Work Contact Centre (03451 55 15 03) and a referral made on an (inter-agency) Notification of Child Concern Form.

If the child is in immediate danger, requires urgent medical attention, or a crime is suspected, the appropriate emergency services must be called (police, ambulance, or fire service). Any action taken in respect of the child is in addition to action taken for the adult at risk of harm. Note: a young person aged 16 or 17 may be considered both a child and adult when at risk of harm. The most appropriate legislation to support and protect the young person will be followed.

16-17 year olds considered to be at risk of harm.
There is a legal basis underpinned by national policy which needs to be taken account of by personnel in child and families services and across adult services in order to provide the most appropriate response to any young person aged 16 and 17.

These individuals are legally both children **and** adults. Therefore staff who come in contact with young adults must be confident and competent in the law and local procedures for both adult and child services. Accessing relevant learning and development will be essential.

While there are local processes and protocols in place across both child services and adult services, the very nature of risk and vulnerability in this age group requires that professionals discuss and are agreed on the most appropriate course of action.

There is no definitive guide, and professionals are encouraged to utilise this and Child Protection and Adult Support and Protection local guidance where appropriate while also applying their collective professional judgement.

Indicative areas where need may arise (this is not an exhaustive list):

- Child sexual exploitation
- Trafficked young person
- Internet safety and internet-enabled offending
- Young adult at risk of harm: all harmful conduct, including physical, sexual, psychological, financial, neglect, self-harm
- CAMHS (Child & Adolescent Mental Health Service) and Adult Mental Health Services
- Young People in transition from child to adult services
- Young adult at risk of harm and who are also a parent
- Young adult harming another adult at risk
- Both young adult and older adult at risk of harm from a third party
- Young adult at risk of harm from an older adult at risk
- Forced Marriage of young adult at risk
- Radicalisation

- Young adult exposed to Domestic Violence where parent has an additional vulnerability
- Female Genital Mutilation

Where the circumstances are indicative that adult or child protection measures may be relevant then local procedures (Adult Support and Protection or Child Protection Procedures) should be followed taking account of best practice regarding information sharing and inter- and intra-agency collaborative working.

Other harmful situations which may require an adult support and protection response

Missing Persons

Definitions of a missing person:

- Anyone whose whereabouts are unknown and:
- Where the circumstances are out of character; or
- The context suggests the person may be subject to a crime;
- The person is at risk of harm to themselves or others

In May 2017 the Scottish Government launched a National Missing Persons Framework for Scotland. http://www.gov.scot/Publications/2017/05/1901
The aim is to build on existing good work and principally to;

- Prevent people from going missing in the first place: and
- Limit the harm associated with people going missing.

It has four closely interconnected objectives:

- To introduce **preventative** measures to reduce the number of episodes of people going missing.
- To **respond** consistently and appropriately to missing persons episodes.
- To provide the best possible **support** to missing people and their families.
- To **protect** vulnerable people to reduce the risk of harm.

There is a clear interface with adult support and protection as there are times when individuals already identified as an adult at risk go missing, and some individuals will become adults at risk at the point where they go missing because of an additional vulnerability which may impact on their ability to keep themselves safe.

Key aspects of the response, building on current best practice, is dynamic assessment of risk both before (where this risk has already been identified) and after an individual goes missing.

The national strategy recommends return interviews, which are:

- available to all
- conducted, where possible, by a trained professional/practitioner[13]
- when appropriate, conducted by an interviewer who is trusted and who may have a relationship with the person who has been missing
- able to sensitively address confidentiality and what information may need to be passed on

One aim of a return interview is to try to establish any reason for the adult to have gone missing so that where possible, any cause can be addressed. Clearly some individuals may be unable to express the reasons because of a cognitive or communication difficulty. It will still be important to undertake a review of the circumstances with the adult and other individuals who may be able to contribute to the possible motivations and make plans to change or adapt support arrangements to take account of both the risks to the adult but also their aspirations.

The Mental Welfare Commission have produced several guidance resources which should be taken into consideration when developing and implementing any missing person risk assessment.

- Rights Risks and Limits to Freedom http://www.mwcscot.org.uk/media/125247/rights_risks_2013_edition_web_version.pdf
- Decisions about Technology http://www.mwcscot.org.uk/media/241012/decisions_about_technology.pdf

Human Trafficking[14]

The Human Trafficking and Exploitation (Scotland) Act 2015 Guide provides a useful overview of the 2007 Act. Some individuals who have been trafficked or subject to exploitation may meet the criteria of an adult at risk.

Human trafficking is a form of modern day slavery. People may be taken from their communities by force, fraud or coercion mainly for:

a) Slavery, servitude and forced or compulsory labour;
b) Prostitution or sexual exploitation;
c) Removal of organs;
d) Securing services and benefits.

Travel from one place to another is not a required action for there to be an offence of human trafficking in Scotland.

There are no definitive ways to identify victims of trafficking and not all victims are illegal immigrants. Some are trafficked from the EU and other countries, and others are victims of domestic trafficking within the UK. Potential signs commonly associated with trafficking are:

[13] This training was rolled out nationally from January 2018.
[14] Human trafficking: adapted from 'What health workers need to know about human trafficking 2012'

- Trauma symptoms
- Injuries associated with harm
- Injuries or illnesses associated with unprotected labour and poor exploitative working or living conditions.

Other indicators of trafficking may be the presence of a minder, or an adult who is fearful and distrustful and who may not speak English.

Contact with someone in the health service may be the first and only chance for the adult to tell their story or ask for help.

You can:

- Prioritise their safety
- Notify the police if you suspect they are in immediate danger
- Try to see the adult alone, even if they have a minder
- Record as much information as possible, and additionally,
- Inform social work where the adult appears to meet the criteria of an adult at risk under the 2007 Act

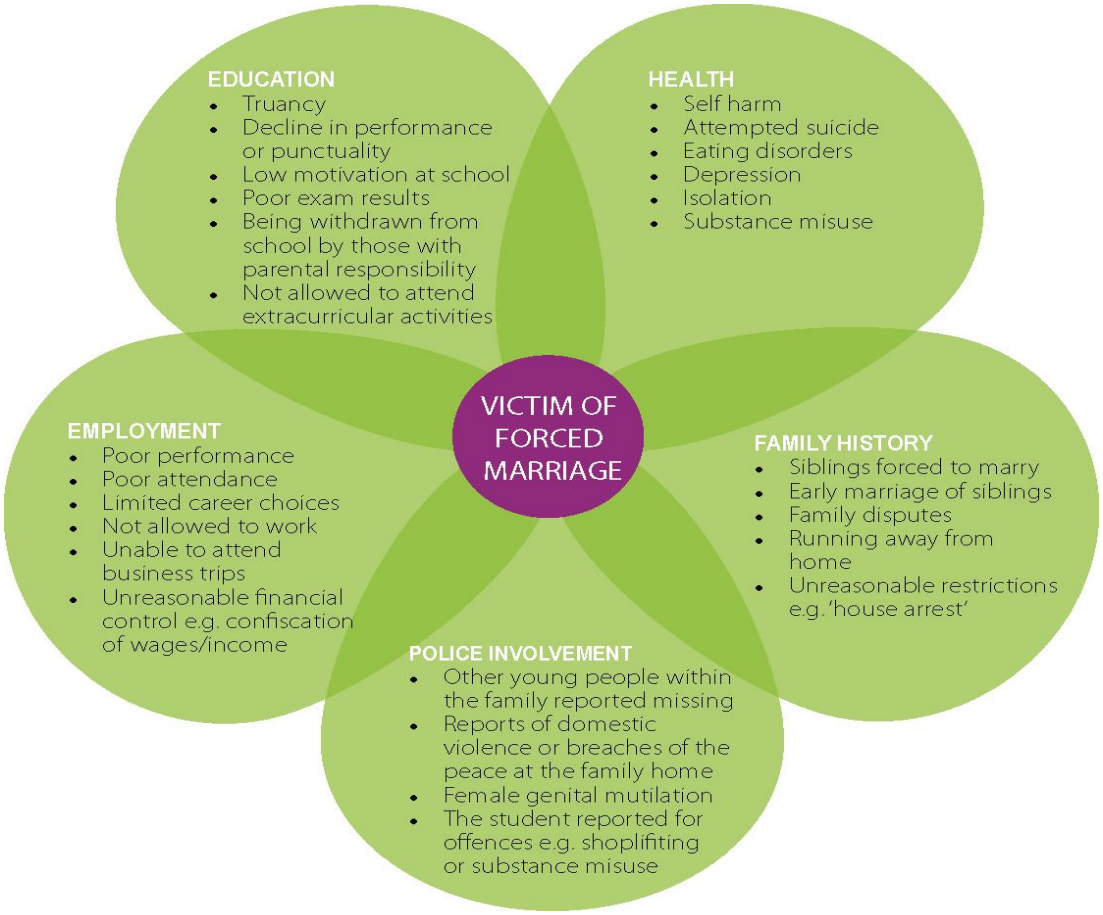
Domestic Abuse/Gender-based Violence

While women and children are most commonly the victims, men can also experience a range of harmful behaviours linked to their relationships. Domestic abuse or abuse by a relative in a family home is not specifically covered in this guidance. It is, however, recognised that the use of the guidance may be appropriate in certain cases of domestic abuse. It will be particularly relevant when one of the partners meets the definition of an 'adult at risk'.

Forced Marriage

A forced marriage is a marriage in which one or both spouses do not (or, in the case of children and some adults at risk, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure, threatening conduct, harassment, threat of blackmail, use of deception and other means. Duress may be caused by parents, other family members and the wider community. It is also ‘force’ to knowingly take advantage of a person’s incapacity to consent to, or understand the nature of, the marriage.

The Forced Marriage etc. (Protection and Jurisdiction) (Scotland) Act 2011 protects people from being forced to marry without their free and full consent as well as people who have already been forced to do so. Always remember the ***one chance rule***: you may only have one chance to speak to a potential victim of forced marriage and, therefore, only one chance to save a life.



For more information see link below

Publications - Practitioner Guide - Supporting Those at Risk of Forced Marriage

Radicalisation and Extremism

The Scottish Government has produced revised national PREVENT Guidance, released in April 2021 for public bodies in relation to the Counter-Terrorism and Security Act 2015 with the aim of preventing people from being drawn into terrorism.
https://www.gov.uk/government/publications/prevent-duty-guidance/revised-prevent-duty-guidance-for-scotland

Individuals at risk of being radicalised may fit a similar picture to individuals that frontline health and social care staff may encounter as "vulnerable" in the course of their work. In the context of extremism the term vulnerable is used to describe factors and characteristics associated with being susceptible to radicalisation.

Susceptibility factors:
In terms of personal vulnerability, the following factors may make individuals susceptible to radicalisation. None of these are conclusive themselves and therefore should not be considered in isolation but in conjunction with the particular circumstances and any other signs of radicalisation.

- Identity crisis: Young adults exploring issues of identity can feel distanced from their parents/family, cultural and religious heritage and uncomfortable with their place in society. Radicalisers exploit this by providing a sense of purpose or feelings of belonging. Where this occurs, it can often manifest itself in a change in a person's behaviour, their circle of friends, the way they interact with others and the way they spend their time.
- Personal crisis: This may for example, include significant tensions within the family that produce a sense of isolation in the vulnerable individual from the traditional certainties of family life.
- Personal circumstances: The experience of migration, local tensions or events affecting families in countries of origin may contribute to alienation from UK values and a decision to cause harm to symbols of the community or state.
- Adults at risk: Adults who may be at risk, as defined by the Adult Support and Protection (Scotland) Act 2007 who are:
    - unable to safeguard their own wellbeing, property, rights or other interests,
    - at risk of harm, and 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.

There is an expectation that where the staff member knows or believes that an individual may be at risk of radicalisation that this will be reported so that support can be provided to those individuals identified to be at risk of exploitation. The important relationship of trust and confidence between patient or client and staff member should be balanced against the staff member's professional duty of care and their responsibility to protect wider public safety.

Therefore, it is important that agencies

- recognise when vulnerable individuals may be exploited
- are aware of how to escalate their concerns
- know where to access advice and support
- are aware of who their PREVENT contact is within their organisation.

Early intervention can prevent a vulnerable individual from engaging in criminal acts of terrorism. By working closely with statutory partners, as happens in relation to adult and child protection, there is an opportunity to improve effectiveness in protecting vulnerable individuals from harm, or from causing harm to themselves or the wider community.

Reporting mechanism: If you know or believe an adult is at risk of harm from radicalisation then use the Adult Support and Protection Reporting Harm process. Use the Adult Support and Protection phone line: 01383 602200 and complete the Inter-agency Report of Harm Referral Form on the page. The form has been amended to include radicalisation/extremism as a category of harm.

Photography and Adult Support and Protection

This guidance advises on considerations which should be taken before taking photographs of adults who may fit the criteria of an adult at risk of harm. This guidance relates to all types of photography, including mobile phone, video, film and digital imaging.

Non-medical photography

The use of photography in staffed, shared living settings is common. It has a wide range of applications: in communication passports for those with communication difficulties; picture exchange communication tools; photographic signifiers; individual activity planners; to assist confirmation of identity for medication administration; etc. Photographs are also commonly used within individual personal plans to augment the written word and make the document more person-centred.

The general use of photography for these purposes is regarded positively and best practice suggests that speech and language specialists and, where appropriate, psychology and physiotherapy services would be involved and consulted on the introduction of these communication aids.

In addition, photographs of special occasions and friends and family are frequently displayed in both communal and private areas in shared living settings and serve as points of reference, as reminiscence aids and to make the environment homely.

The vast majority of occasions when people take and display photos of adults supported in shared living settings are valid and do not raise privacy or safety concerns. Unfortunately there are some occasions when this is not the case and which do represent potential risks, for example:

- The identification of individual adults to facilitate harm;
- The identification of adults in vulnerable circumstances; or
- The collection, circulation and misuse of images.

This guidance is intended to raise awareness of these potential risks and how to reduce or remove them.

Clinical Photography

Within NHS clinical settings photography has specific applications in treating and assessing conditions. Photography is also used for education, research, publication and auditing purposes. All photography, video or audio recording related to these specific clinical purposes are strictly controlled.

Images would only be taken by members of the Department of Medical Illustration in ensure that digital images are controlled and safeguarded. It is unlikely that any other setting would have an appropriate clinical requirement or responsibility to use photography for treating or assessing conditions.

Medical Photography in Regulated Care Settings

Any medical photography undertaken out-with NHS Fife (i.e. within regulated services) must follow the same rigorous clinical standards, and adhere to the legislation and best practice outlined in this guidance. Photography undertaken to support medical intervention or treatment must be agreed with the overseeing or responsible clinician and may be considered by the Care Inspectorate as part of its inspection and regulatory activities, It may also be subject to monitoring by Contract Services monitoring.

The Mental Welfare Commission has advised that using body drawings, descriptions and measurements are safer and less intrusive than photography, because of the significant risks of duplication and distribution and the invasion of privacy.

Privacy Issues

The photographing of adults at risk of harm may, depending on the context, be subject to data protection legislation, including the General Data Protection Regulation, and the Human Rights Act 1998. Data protection safeguards the rights of individuals to have information of a personal nature treated in an appropriate manner, and human rights legislation protects the privacy of individuals and families. In addition, restrictions on photography may arise from issues of adult protection as outlined above, and in relation to capacity.

When the adult agrees to accept the care service (or, where there are capacity issues, this is agreed on their behalf) this agreement will usually include an expectation that the provision of this service will include the necessary collection and sharing (where appropriate) of personal information. This may include taking photographs to aid assessment and treatment.

It is good practice to only collect the minimum information necessary. In a photography context this could equate to:

- Only taking photographs where this type of information is required / necessary for the care of the individual.
- Ensuring that identifiable information is kept to a minimum.
- Using appropriate file naming – for example using an identifier to name the image rather than the name of the person.
- Restricting access to authorised users only, and ensuring the images are taken and stored securely.
- Applying an appropriate retention schedule. For example, there may be different timescales or outcomes for images of different conditions. In general, this would be five years after the last action on the case or three years after death of the adult. However you should check where any exemptions apply to these records
- Restricting the number of images collected – for example retain one image of the condition, rather than multiple images of the same condition. In some scenarios repeat images will be required to evidence changes in condition.

Reason and Purpose

Photos must only be taken by an authorised person, who has a specific, agreed and ethical reason to take them. Agencies should consider who the most appropriate person is to have this responsibility and must follow their organisations' policies and procedures on photography. Responsibilities will include a duty to keep the photo images safe, secure and to prevent any unauthorised use or access. Staff personal devices must not be used to take photographs, and uploading of images to web sites like Facebook must not be undertaken.

Identification of subjects

In general, photographs should not identify the adult or allow their location to be discovered. This is particularly important where an adult is subject to support and protection under the 2007 Act or other protective legislation. Further guidance on making and using visual and audio recordings of patients is available on the General Medical Council website.

Video surveillance

The Mental Welfare Commission Good Practice Guide: Rights, risks and limits to freedom includes a section on points to consider if planning to use surveillance equipment in a care setting (3.6).

Where good practice in this regard is not followed the individuals involved may be considered to be at risk of harm from intrusive surveillance techniques

Further information

If you are unsure whether taking photographs of adults in a particular setting is appropriate, or you are aware of practices which cause concerns, please contact your line manager for advice.

Chronology Guidance

This guidance has been developed to provide all practitioners working and/or involved with adults, their families and carers across Fife, with clear practice guidance on the effective use of
Chronologies.

Legislative and Policy Context

This guidance reflects the national adult protection legislation and policy context, findings from the most recent Inspection and in particular the following key publications:

- The Adult Support and Protection (Scotland) Act 2007
- Adults With Incapacity (Scotland) Act 2000
- Practice Guide to Chronologies (Care Inspectorate: 2017)
- The Data Protection Act 2018
- The General Data Protection Regulation (GDPR)
- Standards and Guidelines under the Criminal Justice (Scotland) Act 2003
- Community Care 2018
- Chronologies Practice Guide (Social Work Inspection Agency: 2010)

Chronologies provide a key link in the chain of understanding needs and risks; including the need for protection from harm. Setting out key events in sequential date order, chronologies give a summary timeline of an individual's circumstances, patterns of behaviour and trends in lifestyle, that may greatly assist any assessment, analysis and planning. They are a logical, methodical and systematic means of organising, merging and helping make sense of information. They also help to highlight gaps and omitted details that require further exploration.

Chronologies can and should also be used to promote engagement with the service/agency users. The content of chronologies is however determined by **professional judgement** as to what is in fact **significant** in an individual's life. They should not replicate, or attempt to substitute for case recording, but should provide a clear outline of the most important elements of individual or family circumstances.

Chronologies can be **single-agency** or **multi-agency** and can be used for a variety of purposes. A good chronology is a critical tool in helping make sense of the complexity of an individual's life and circumstances. It also establishes a sound foundation for future understandings and analysis where professional staff change, or new staff / services / agencies come on board. Chronologies are, however, not an end in themselves; they constitute one key element of the suite of tools that we use to inform the analysis of needs and risks in assessments and interventions. Chronologies also inform planning. As dynamic tools, chronologies should be accurate, informative and up-to-date.

1.0 Practice guidance on chronologies outlines ten core features:

1. They are a useful tool in assessment and practice
2. They are not an assessment - but may form part of an assessment
3. They are not an end in itself – a working tool which promotes engagement with people who use services
4. They must be accurate – and rely on good, up-to-date case recording
5. They must contain sufficient detail but are not a substitute for recording in the file
6. They need to be flexible- detail collected may be increased if risk increases
7. They must be reviewed and analysed – a chronology which is not reviewed regularly is of limited relevance
8. The reason for chronology development may change the construction e.g. current “real time” work and examining historical events (Significant Case Review Guidance)
9. Single agency and multi-agency chronologies set different demands and expectations
10. Record what was done at the time. Many chronologies list events, dates etc., but do not have a column which sets out the action which was taken at the time. The column should also include a note when there was no action.

2.0 Key elements in compiling chronologies:

- Identifying the key events to be recorded
- Making sure that what is recorded is accurate and in date order
- Recording facts, events in the person’s life
- Taking account of the perspective of the adult at the centre of the significant event

3.0 Purpose of Chronologies completion at IRD stage of Adult Protection referral

A chronology should make key information easily accessible and connectable to information within the case record. A chronology should act as an index which directs the reader to an appropriate assessment or case note within the case record. Chronologies should be managed and maintained by the allocated worker or Council Officer for a case at the earliest stage of Adult Protection intervention. The chronology acts as a part of a professionally skilled approach and an essential part of on-going assessment and care management by:

- Presenting a range of issues coherently (identified either on a single agency or a multi-agency basis)
- Providing an overview of factual and precise information which can assist practitioners to identify patterns of behaviour to guide appropriate and timely intervention in line with the Adult Support and Protection (Scotland) Act 2007

- Enabling the significance of individual issues to be better understood and links made between the past and the present
- Being used on a routine basis by the practitioner for regular review and analysis of the individual's situation
- Strengthening partnership working with individuals through the sharing and reviewing of information within the chronology
- Highlighting risks, concerns, patterns, and themes, areas of weakness, strengths, resilience and supportive factors

4.0 Assessment and care management team chronologies

Using the information below, staff must, in consultation with their manager, complete a mandatory chronology at the IRD stage when an Adult Protection concern is submitted. The essential purpose of this chronology is to draw together important information and assist understanding, highlighting early indications of emerging patterns of concern. This should be completed as a stand-alone document, on the agreed template (See practice example below) and saved as a SharePoint working document within the Assessment folder. This means that the chronology can continue to be updated throughout the Adult Protection process as required.

The stand-alone chronology minimises duplication of work. With initial completion at the IRD stage, this removes the requirement for this information to be copied and pasted into the Council Officer's Report. This is also true in terms of Fife Council's Adult Protection Engagement and Escalation protocol. Guidance states that the "inter-agency chronology triggered by multiple reports of harm will be key to the first engagement escalation meeting". Therefore, by having a chronology at IRD stage onwards, allocated workers/Council Officers are ensuring more information is available and available earlier in the AP process as a whole.

Prior to any Adult Protection related case closure being authorised, the chronology should be completed by the allocated worker/Council Officer.

The chronology must be:

- Accurate and evidence-based
- A record of facts, events, action taken or a note that no action was taken and if known the outcome (e.g. Support services provided).
- Succinct – a very brief note of an event e.g. bruising discovered, attended A&E., change in adult's presentation/behaviour.
- Concise, avoiding acronyms or professional jargon.

The Practice Example provided at end of this section should be considered when recording a chronology and any relevant significant events and actions/outcomes.

5.0 Assessment and care management team chronologies-What is a significant event?

Within the confines of this guidance, it is not possible to specify what type of incidents and/or events are considered significant enough to warrant inclusion in a Multi-Agency Adult Chronology. In most cases, practitioners will require to exercise their own professional judgement.

Any changes, which are considered to have a key impact on the adult, whether they be positive or negative, strength or a weakness, should be considered as a possible significant incident and/or event.

However, the following list provides some guidance for practitioners and as to what information should be included in any chronology.

- The person has been open to Social Work previously
- Any previous assessment completed by Social Work
- Any Police involvement related to Adult Protection concerns
- Any Adult Protection related hospital admissions
- Any other changes that indicate a change in the adult's adult protection status, including protective factors and risk factors.

Intervention under the following legislation should be included in any chronology:

- Mental Health Care and Treatment Act – Compulsory Treatment Orders – Dates and Outcomes
- Adults with Incapacity Act – Welfare and Financial Guardian Case Discussions and Outcomes
- Adult Support and Protection activity, including referrals – details and decisions made and action taken (with reference, as necessary, to the multiple referral protocol)
- Adult Protection Meetings (including reviews) and completion date of the Adult Protection Plan
- When a case is being considered under the Significant Case Review Guidance
- Chronologies should be discussed with and shared with the service user; this ensures accuracy and enhances engagement.

Please also refer to the Care Inspectorate Practice Guide to Chronologies
Click here

PRACTICE EXAMPLE

Chronologies can be an important part of an individual's case record and can provide an "index" of events which are of significance to that person. A chronology should complement a good assessment, not be a replacement for one. The essential purpose of the chronology is to draw together important information and assist understanding, highlighting early indications of emerging patterns of concern.

It would be reasonable to expect to see a chronology in case files of:

- Adults who are, or may be, at risk of harm from others; or self-harm;

- Adults who pose, or may pose, a risk of causing serious harm to others;
- Individuals with complex life circumstances.

The following highlights various examples of what might feature on a good chronology. This list is not exhaustive however it serves as an example of how you should approach writing an incident in a chronology.

Date of Event	Significant Event	Action Taken & Outcome if Known	Agency/ Individual
20/2/2018	Report of harm received	3 point criteria met in reference to Fife Guidelines. AP investigation progressed See profile notes dated- 20 -21st March	SW Contact Centre Via Police
6/3/2018	NHS Contact – Suffered Stroke	Discussion with ward Charge nurse, advised Nurse to place SW contact details on nursing notes. See profile notes 6th March	NHS/Ward 1
15/3/2018	Home is unsafe to return to from hospital. Deep clean requested	Arrange with Fife Council environmental service - contact – Mr Clean	Housing provider – Happy Homes
18/3/2018	Fire risks at home – various issues raised	Arranged for Fire safety officer to recommend safety plan and telecare assessment arranged	SW Contact Centre Via Fire service
24/3/2018	Allegation that XX subject to sexually inappropriate behaviour from other resident	IRD completed, 3 point criteria met, Care Inspectorate contacted, progressed to AP Investigation. See profile notes 24-26th March	Care home – Happy Valley Care Home
30/04/2018	Home Visit with GP – resulting from emergency request, Service user requesting she be admitted to hospital due to her mental health. Contact made with appropriate Health professional and XX was admitted to ward.	MHCT Act 2003 protocols followed, Admission to Psychiatric ward at QMH hospital. Report to be completed and passed to MHO team manager within MHCT guidelines.	Social Work MHO Team
1/05/2018	Significant Occurrence received from care home - relating to complaint re care staff from family member of resident	Significant occurrence recorded with Social Work Contracts, Care Inspectorate and followed up by Social Worker duty worker (see profile notes 1/5/2018).	Happy Valley Care Home

Adult Support and Protection Committee Competency Framework

(The full document is available at:
https://www.fife.gov.uk/kb/docs/articles/health-and-social-care2/help-for-adults-and-older-people/adult-support-and-protection/staff-information-and-training

Introduction

This booklet outlines key areas of the Adult Support and Protection (ASP) competency framework that services and agencies in Fife involved with adults at risk should consider, in respect of their learning and development needs.

The booklet and appendices are designed to support managers across services and agencies in Fife. The appendices are designed for use with teams and individuals as part of continued professional learning through a supervisory process. The checklists can be used to stimulate discussion and identify gaps in learning. Where gaps are identified, managers can help direct staff to consider the opportunities afforded by the Adult Support and Protection Committee multi-agency training calendar, through their own service/agency internal training calendar and consider other ways in which identified needs can be met.

The National Framework

The material in this Framework is designed to be used alongside existing guidance and documents e.g. the 'NHS Knowledge & Skills Framework' (KSF) and 'The Framework for Continuous Learning in Social Services' (SSSC). It can be used to focus specifically on ensuring that relevant workers have the competences, knowledge and skills they need to carry out their roles in supporting and protecting adults at risk of harm. It can also be used to review what the workforce already know and understand, support 'Learning and Development Needs Analysis' and identify ongoing opportunities for this. It should inform and enhance practice for those who need a particular set of skills and can be used as a tool when writing job descriptions.

Adult Support and Protection and workforce development should be seen as an essential part of continuous improvement, and the Framework is designed for use as part of agencies' continued professional learning. The individual learning and development needs of each worker should to be considered and reviewed, including Adult Support and Protection where relevant, in how workers and managers will meet the Continued Professional Learning (CPL) requirements of particular roles. The competences, knowledge and skills can be 'mapped' at an individual level (to any other forms of learning and development that workers take part in).

The Framework should not be considered in isolation. It should be read alongside other legislation, policy, strategy and CPL material relevant to specific agencies. It does not replace any local multi-agency or single agency frameworks, but aims to enhance and support them. It should be considered

alongside these by each agency, and those responsible for their continued professional learning needs, and used to reflect local circumstances.

Implementing the Framework

This Framework can be used:

- To identify continued professional learning needs
- To plan personal and professional learning
- To support the personal learning planning and review process.

Each worksheet is easily downloadable for completion in consultation with the supervisor/line manager. This will serve to identify strengths and/or gaps in knowledge and skills which may need developmental attention and maintains a record for evidential purposes.

Supervisor/Line Managers should:

- Ensure they themselves have the competences, knowledge and skills in relation to Adult Support and Protection required to perform their management/supervisory role.
- Ensure that workers (paid or unpaid) fully understand their roles.
- Help to identify and assess the learning and development needs of their workforce, ensuring they have the competences, knowledge and skills required for their practice.

Single Agencies, Professional Bodies and Services

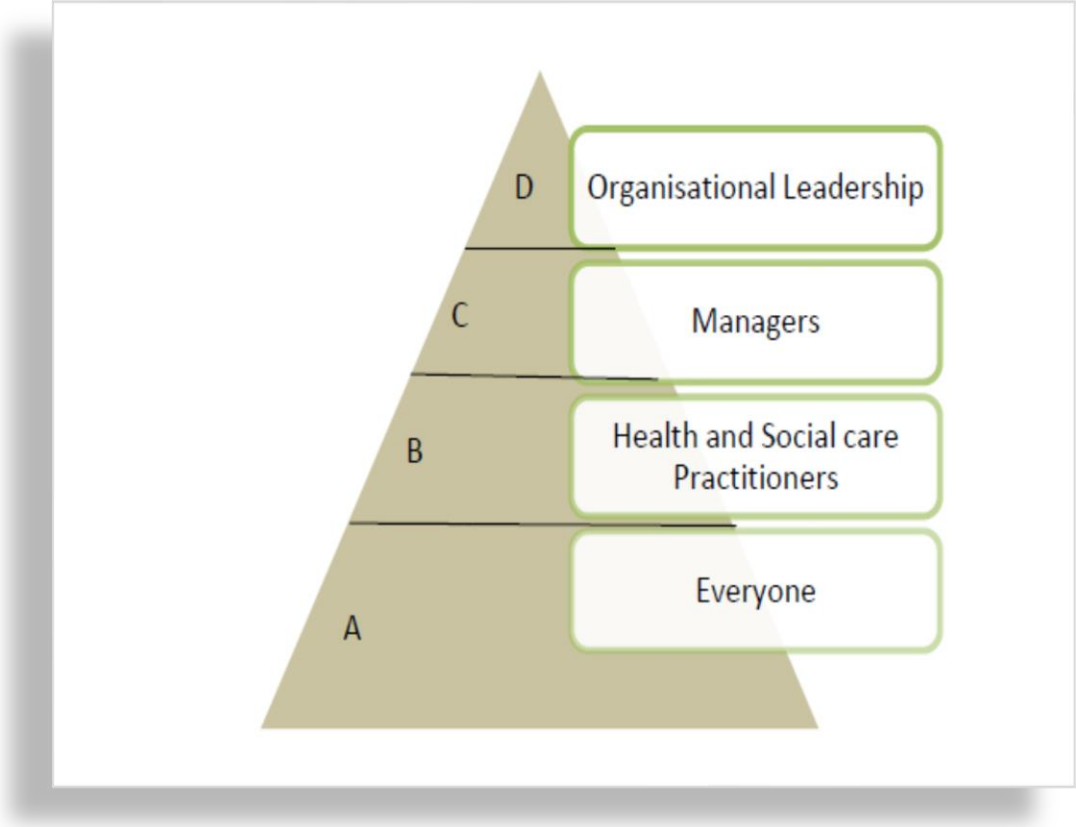
All single agencies, professional bodies and services should:

- Have a clear overview of Adult Support and Protection continued professional learning needs and the opportunities available.
- Recognise that different workforce groups have different responsibilities, need to demonstrate different competences, knowledge and skills, and therefore have different continued professional learning needs.
- Identify these needs and how these will be met, ensuring consistency with local multi-agency work.
- Ensure that their workforce has access to appropriate continued professional learning opportunities, including multi-agency; and is resourced to be competent and confident in carrying out their responsibilities for supporting and protecting adults at risk, recognising their own roles and how these fit into the wider picture.
- Ensure, where services are commissioned, that any external agency is competent and confident in carrying out their responsibilities for the support and protection of adults at risk. This is normally a requirement of the contract and commissioning process.
- Ensure that all of those involved in Adult Support and Protection have access to high quality advice, support, supervision and monitoring; which should help identify continued professional learning needs, evaluate provision, and ensure that they have the skills to provide an effective service.

- Contribute to the evaluation of continued professional learning and the continuing identification of needs.

Who should complete the Competency Framework?

Fife Health and Social Care Partnership believes that Adult Support and Protection is everybody's business. Because of this all staff should be assessed as being competent within Adult Support and Protection. This needs to be relevant to their occupation, role and responsibilities within their organisation.



Each staff member should read the table above and identify which Group describes their current role. Once this has been established they will be aware of which competences they need to be able to demonstrate within their own work environment and be able to use this framework in order to evidence them appropriately.

Group A – Competences 1-5

Members of this group have a responsibility to contribute to Adult Support and Protection, but do not have specific organisational responsibility or statutory authority to intervene.

- All Support Staff in Health and Social Care
- Day service Staff
- Housing Staff
- Council Based Office Staff

- HR Staff
- Elected Members
- Volunteers
- Befrienders
- Charity Trustees
- Drivers, other transport staff

Staff Group B - Competences 1-12

This group have considerable professional and organisational responsibility for Adult Support and Protection. They have to be able to act on concerns and contribute appropriately to local and national policies, legislation and procedures. This group needs to work within an inter or multi-agency context.

- Social Workers
- Nurses
- Frontline Managers
- Team Managers
- Health and Social Care Providers Service Managers
- Senior Support Workers

Staff Group C - Competences 1-16

This Group is responsible for ensuring the management and delivery of Adult Support and Protection Services is effective and efficient. In addition they will have oversight of the development of systems, policies and procedures within their own organisations to facilitate good working partnerships with allied agencies to ensure consistency in approach and quality services.

- Operational Managers
- Senior Management
- Heads of Assessment and Care Managers
- Service Managers
- Senior Social Workers

Staff Group D - Competences 1-5 and 16-20

This Group is responsible in ensuring their organisation is, at all levels, fully committed to Safeguarding Adults and have in place appropriate systems and resources to support this work in an intra- and inter-agency context.

- Senior Leadership Team
- Chief Executive

Demonstrating Competence

To demonstrate competence staff should present a combination of evidence to their line managers. This could include formal training, completion of vocational/professional awards and work products. The line managers may wish to carry out a professional discussion, question / answer session with you in order to ensure competency in a specific area. A full list of suggested evidence can be found at the end of this document (appendix 2)

If you are required to demonstrate more than one set of competences, for example your current role is within both B and C - you may want to look at both of these competences as you should be able to cross reference your evidence for competences in other groups.

Staff Group A

All Staff to complete this section:

Competencies 1-5	Description	Evidence or Demonstration of Competence/Confidence in this area	Any development Required?	Review Date (minimum of 12 monthly)
1.	I understand that "*adult support and protection is everyone's business*"			
2.	I am able to recognise an adult potentially in need of Adult Support and Protection intervention and take action.			
3.	I understand how to make an ASP referral.			
4.	I understand dignity and respect when working with individuals.			
5.	I have knowledge of Fife Health and Social Care Partnership's			

	multi-agency ASP Procedures.			

Staff Signature …… Line Managers Signature ……..

Date ……....

Staff Group B & C to complete this section

Competence in working with people and delivering Safeguarding Services Competence

Competencies 6-12	Description	Evidence or Demonstration of Competence/Confidence in this area	Any development Required?	Review Date (minimum of 12 monthly)
6.	I have the required knowledge and skills to contribute fully to the Adult Support and Protection process.			
7.	I am aware of and can apply local policy and procedural frameworks when undertaking Adult Support and Protection Activity.			
8.	I ensure service users/carer's are supported appropriately to understand			

	Adult Support and Protection issues.			
9.	I am able to distinguish between observation, facts, information and opinion gained from others in gathering evidence with regard to ASP issues			
10.	I know and understand the legislative context of Adult Support and Protection i.e. Adults with Incapacity (Scotland) Act 2000 and Mental Health Care and Treatment (Scotland) Act 2003			
11.	I maintain accurate, complete and up to date records.			
12.	I am able to demonstrate the required level of skills and knowledge to undertake an Adult Support and Protection Investigation.			

Staff Signature …… Line Managers Signature ……..

Date ……..

Staff Group C (Need to complete B & A also)

Competence in Strategic Management and Leadership of Safeguarding Services

Competencies 13-16	Description	Evidence or Demonstration of Competence/Confidence in this area	Any development Required?	Review Date (minimum of 12 monthly)
13.	I actively engage in supporting a positive multi-agency approach to Adult Support and Protection work.			
14.	I support the development of robust internal systems to provide consistent, high quality Adult Support and Protection service.			
15.	I chair Adult Support and Protection meetings such as IRD discussions OR Case Conferences. (This only applies to Senior Practitioners or Team Managers who role involves chairing ASP			

	meetings)			
16.	I ensure record systems are robust and fit for purpose.			

Staff Signature …… Line Managers Signature ……..

Date ……....

Staff Group D (need to complete A also)

Competence in Strategic Management and Leadership of Safeguarding Services

Competencies 17-20	Description	Evidence or Demonstration of Competence/Confidence in this area	Any development Required?	Review Date (minimum of 12 monthly)
17.	I lead the development of effective policy and procedures for Adult Support and Protection services in my organisation.			
18.	I ensure plans and targets for Adult Support and Protection are embedded at a strategic level across the organisation.			
19.	I promote awareness of Adult Support and Protections systems within and			

	outside my organisation.			
20.	I develop and maintain systems to ensure the involvement of service users in developing Adult Support and Protection services.			

Development of Competence-Appendix 1

Please make notes of how any competences that have not been demonstrated, can be evidenced in the foreseeable future and dates to when this will be assessed.

Competence:	Actions:	Target Date:
For example, I have knowledge of Fife's Health and Social Care Partnership's inter-agency ASP procedures	CB requires to broaden his understanding of Council Officer training. To attend CO training.	Within next 6 months.

Examples of Evidence to Support Competence Level-Appendix 2

<u>Suggested Evidence Group A</u>

- Clear understanding of their role in making an alert and an Adult Support and Protection referral.
- Clear understanding of their organisation's policy and procedures.
- Understand limits to confidentiality.
- Be able to define 'adult at risk of harm'.
- Know the different types of abuse and how to recognise indicators/signs.
- Contact emergency services where appropriate.
- Know how to make an alert and a referral.
- Know how to record appropriately.
- Value individuality and be non-judgmental.
- Be aware of how own values and attitudes influence understanding of situations.

- Understand how to 'whistleblow' using Local procedures.

Suggested Evidence Group B

- Responds to referrals within specified timescales.
- Identify and reduce potential and actual risks after an allegation of abuse has been made.
- Convene relevant ASP meetings such as IRD or Case Conference meetings as appropriate within specified time scales.
- Contribute effectively to all information sharing.
- Develop protective strategies for those who refuse services.
- Show a clear understanding of the thresholds and pathways for investigating in response to an Adult Support and Protection referral.
- Describe the purpose of a IRD Meeting and Case Conference.
- Describe the purpose of a Protection Plan.
- Use of appropriate forms and recording systems.
- Understand the use of legislation within Adult Support and Protection work including:-
  - Adult Support and Protection (Scotland) Act 2007
  - Mental Health Care and Treatment (Scotland) Act 2003
  - Adults with Incapacity (Scotland) Act 2000
- Recognise service users' rights to freedom of choice.
- Understand the impact that abuse can have on individuals.
- Provide information on local support services that may provide support.
- Provide written and verbal information on Adult Support and Protection processes.
- Demonstrate knowledge of gathering, evaluating and preserving evidence.

Suggested Evidence Group C

- Evidence of protection planning.
- Evidence of report writing.
- Evidence of multi-agency working.
- Explicit understanding of confidentiality and data protection issues
- Demonstrate a thorough knowledge and application of purpose, duties, tasks involved in Adult Support and Protection investigations.
- Plan and carry our agreed strategy to protect an adult from harm during and following an investigation.
- Understand the different roles and responsibilities of the different agencies involved in investigating allegations of harm.
- Demonstrate a clear understanding of Fife Health and Social Care Partnership multiagency policy and procedures.
- Ensure supervision is carried out regularly to support safeguarding activity.

- Ensure effective performance management systems are in place and implemented when poor Adult Support and Protection practice is identified.
- Ensure the workforce has the necessary skills and knowledge to carry our effective safeguarding activity.
- Chair relevant Adult Support and Protection meetings and conferences in line with local policy and procedures.
- Demonstrate effective systems are in place to maintain records including investigation reports, minutes and protection plans.

Suggested Evidence Group D

- Have a strategic understanding of the scope of Adult Support and Protection services across the organisation.
- Work in partnership with a range of key agencies to promote Adult Support and Protection Services.
- Promote the Fife Health and Social Care Partnership's Adult Support and Protection Committee work plan and key priorities.
- Effectively communicates a proactive approach to Adult Support and Protection within your organisation.
- Be able to account for your organisations Adult Support and Protection practice
- Ensure that internal audit systems are robust and meet the requirements for external scrutiny.
- Have a comprehensive knowledge of Care Inspectorate inspection findings and how these will be implemented to support service development in your organisation.
- Be aware of the findings from serious case reviews and any Adult Support and Protection implications for service delivery in your organisation.
- Identify systems and structures in place used to raise awareness of Adult Support and Protection locally.
- Evidence that service users, patients and carers are supported and involved in all aspects of activity, and that their feedback impacts upon service planning and delivery.

Roles and Responsibilities of Teams & Agencies

Letter of Chief Officers Public Safety Group

15th February 2021

Dear Colleague,

INFORMATION SHARING

The protection of children, young people and adults at risk, is ***"everyone's responsibility and everyone's job"*** this cuts across all aspects of private life and professional business. We all have a duty, individually and collectively, to protect vulnerable people in our communities.

On many occasions, this will require staff to seek and exchange personal information about individuals. We are however aware that questions of privacy and confidentiality can and sometimes do get in the way of ensuring the safety of children, young people and adults at risk. We wish to clarify the position and reinforce the importance of sharing and exchanging information where the protection of these client groups are concerned.

Children, young people and adults at risk have a right to privacy and the utmost care should be taken when handling personal information. We endorse the need for a sensitive and legal approach when working in partnership with children, young people and adults at risk, together with their families and carers.

Where you have a concern about a child, young person or adult at risk of harm or you are made aware of such a concern you have a responsibility to share and exchange relevant information with other professionals. You should do so without delay and with confidence, following your own agency/service procedures.

All staff should be aware that their own agency will support them if they have shared personal information in these circumstances using their professional judgment.

Recent reviews have highlighted misconceptions about information sharing. We remind you that existing legislation does not prevent you from sharing and/or exchanging relevant information where you believe there are concerns about the protection of children, young people and adults at risk. In addition, you are lawfully able to share confidential information where disclosure is necessary to protect the individual or another third party. This extends to all practitioners working with adults who may be self-harming or neglecting themselves.

We would draw your attention to the Scottish Government's *Sharing Information About Children at Risk: A Guide to Good Practice (2003)* which states:-

> *"If there is reasonable concern that a child may be at risk of harm this will always override a professional or agency requirement to keep information confidential. All professionals and service providers have a responsibility to act to make sure that a child whose safety or welfare may be at risk is protected from harm."*

And the National Guidance for Child Protection 2014 which states:

> *"**Harm**" means the ill treatment or the impairment of the health or development of the child, including, for example, impairment suffered as a result of seeing or hearing the ill treatment of another. In this context, "development" can mean physical, intellectual, emotional, social or behavioural development and "health" can mean physical or mental health."*

The Adult Support and Protection (Scotland) Act 2007 places a duty on those agencies named in the Act to:

> *co-operate with the council making inquiries about adults thought to be at risk of harm and each other. This may include the examination of records*

Harm – Section 53 states harm includes all harmful conduct and, in particular, includes:
conduct which causes physical harm;
conduct which causes psychological harm (for example by causing fear, alarm or distress);
unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft, fraud, embezzlement or extortion); or
conduct which causes self-harm.

Risk of harm – Section 3(2) makes clear that an adult is at risk of harm if:
another person's conduct is causing (or is likely to cause) the adult harm; or
the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.

It is important that we are open and transparent and make people aware that we will share information when we suspect a child or an adult is at risk of harm. It is also important that you record any decision to share or not to share information and your reasons for doing so.

We hope this will support your confidence and decision making in sharing relevant information. In doing so, you will add to the protection of children, young people and adults at risk in Fife and improve the quality of life for the most vulnerable in our community.

For further advice and guidance we would encourage you to speak directly with your supervisor manager or your organisation's Data Protection expert as follows:

Fife Council: dataprotection@fife.gov.uk.
NHS Fife: Fife-UHB.DataProtection@nhs.scot
Police Scotland: Information.Assurance@scotland.pnn.police.uk.



Steve Grimmond	Derek McEwan	Carol Potter
Chief Executive	Divisional Commander	Chief Executive
Fife Council	'P' Division Police Scotland	NHS Fife

Statutory Agencies

Social Work

Social Work Team Manager

- Lead the investigation from the point the Report of Harm referral has been received
- Fully discuss the report of harm referral with the social worker conducting the inquiry
- Agree the most appropriate partner agency with which to conduct any joint investigation, e.g. the Care Inspectorate, police, health, etc.
- Agree the level of harm for the adult at risk at the point of inquiry and the reasons for a particular timescale
- Provide professional advice, guidance and supervision on carrying out an investigation for the council officer appointed to conduct the investigation
- Consider independent advocacy to represent or support the views of the adult at risk
- Assure the quality of investigation work of the team, including recording, completion of paperwork and timescales.
- Chair case conferences and ensure minutes are accurate and include all relevant information.

Council Officer

- Council officer refers to a registered social worker with at least 12 months post qualifying experience (section 53(1), 2007 Act), appointed by Fife social work service, and who has undertaken relevant training in adult support and protection
- Can also be an individual appointed by a council under section 64 of the Local Government (Scotland) Act 1973
- Conduct an investigation to establish if an adult is at risk of harm and to decide what measure/s should be put in place to provide protection, but should not be the officer who acts as welfare guardian on behalf of the chief social work officer
- Carry out investigations through visits and interviews and through examination of financial or other records (except health records)
- Can require health records to be produced in respect of an adult at risk, but these records can only be examined by a health professional such as a doctor or nurse
- Have a duty to consider the importance of the provision of appropriate services to the adult, including, in particular, independent advocacy and communication support if relevant.

Social Work Service Contracts

- To report to the social work contact centre any potential or suspected harm which may arise from the monitoring of contracts or complaint investigations

- To monitor whether provider agencies are working in accordance with the Fife inter-agency adult protection processes
- To investigate any breach of contract/service level agreement
- To ensure adequate monitoring based on any concerns raised through an adult protection investigation; this may include the development of a robust action plan to improve the service
- When appropriate, collaborate with the Care Inspectorate (or other relevant regulator) to ensure a joint approach to monitoring and investigation
- Follow up any contractual issues and actions agreed at the Adult Support and Protection Committee or sub-committees
- Support the adult support and protection process where there are recommendations of suspension or reinstatement of service provider contracts
- Pass on any information to other local authority contract departments where appropriate, when an adult placed in Fife is subject to a report of harm referral.
- Monitor the recruitment and selection process followed by provider agencies
- Produce reports, as requested by the Adult Support and Protection Committee, contributing towards any serious case review.

Police Scotland

- Officers will ensure that a Vulnerable Persons Database (VPD) entry is created accurately and timeously
- The Public Protection Unit (PPU) Concern Hub will ensure that adult VPDs are assessed and shared with partner agencies.
- Participate in Inter-Agency Referral Discussions to identify if there is a requirement for a joint adult protection investigation and if a criminal investigation is necessary
- Discuss and agree strategies with the relevant social work team, regarding best practice for interviewing an adult at risk, witnesses and perpetrators, involved in any adult support and protection investigation. Consideration should always be given to the use of an appropriate adult in accordance with guidance.
- Ensure that criminal investigations are conducted in a professional manner and that all relevant evidence in the investigation is obtained
- Officers will submit crime reports, Scottish Intelligence Database (SID) entries and Standard Prosecution Reports (SPR) when appropriate and in accordance with the prescribed timescales
- The PPU Concern Hub will assess attendance at inter-agency case discussions and conferences and facilitate the sharing of information held on police systems about the adult at risk, perpetrator or other significant person(s)
- The PPU Concern Hub will provide a single point of contact for information sharing in line with legislative requirements and provide assistance to Local Policing Divisions

- Police will ensure feedback is provided to the relevant social work team regarding the outcome of any Police investigation or criminal proceedings
- Police will provide any files for inspection or audit purposes as directed to do so by the Adult Support and Protection Committee
- Police will produce reports as requested by the Adult Support and Protection Committee which contribute towards any serious case review

GPs and the NHS

GPs and healthcare professionals have key roles to play in adult support and protection. They may be the first professionals to notice signs of potential harm, and are crucial in helping to develop effective inter-agency responses. As part of inter-agency adult support and protection arrangements it is expected that they will consider favourably requests to carry out examinations and other activity under the 2007 Act.

Overview of responsibilities

There are several main ways in which GPs and healthcare professionals are most likely to be involved in adult support and protection:

- Reporting all cases where they identify possible adult support and protection concerns;
- Carrying out medical examinations (see section below);
- Providing relevant information from healthcare records (see section below);
- Participating in case conferences, either by attendance or through the provision of reports. GP reports are key factors in comprehensive decision making, particularly in complex cases involving both health and welfare protection concerns.
- There is also the possibility of attending court as professional witnesses if criminal proceedings are brought. Fees may be payable, please consult the Primary Care Manager for details.

Medical Examinations

The 2007 Act creates powers for councils to ask health professionals[15] to undertake medical examinations to establish whether an adult is at risk and whether any further action is required. In most cases, the adult's GP may be the most appropriate health professional to carry out a medical examination. Two parts of the 2007 Act address medical examinations:

- Section 7: Where a council officer visits a person who is, or may be, an adult at risk of harm, and considers that a medical examination is necessary. The council officer must be accompanied by a health professional and the adult must be informed of his/her right to refuse before any examination is carried out.

[15] In the context of the 2007 Act, “health professional” means a doctor or a nurse.

- Section 11: Allows a medical examination in private to be carried out where there is an application for an assessment order.

Best practice:

- Councils should ask GPs or other health professionals who know the adult and GPs should be involved from the outset of a case where possible.
- A GP will not be compelled to perform an examination if there is a valid reason for not doing so; e.g. the adult is unwilling to agree to a medical examination, or if doing so would damage the doctor-patient relationship.
- GPs (and other health professionals) should be given sufficient notice that s/he may be asked to carry out a medical examination. This allows preparation and arranging locum cover where necessary, although it may not always be possible to give advance notice.
- Where a GP carries out an initial medical examination and indicates that a further examination is required to identify the specific cause of harm, it will be necessary to involve a specialist medical professional.
- If the police are involved in a case, it is likely that a Forensic Physician will carry out a medical examination of the adult. In such cases, the GP may still have a role to play, particularly where the adult is well-known to them.

Inspection of Health Records

In order for a council officer to carry out inquiries and investigations, s/he may request health records of an adult known, or believed, to be an adult at risk of harm. This can 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. It can allow appropriate support and protection to be offered to the adult, and may lead to action being taken against the person who caused the harm.

- Health records must be disclosed to a council officer carrying out an adult support and protection inquiry or investigation (section 10, 2007 Act).
- It is an offence for a person to refuse or otherwise fail to comply with a request made under section 10, without reasonable excuse (section 49(2)).
- The council officer should provide the GP with context as to why the records are being requested and to discuss the nature of the case.
- The council officer will decide jointly with the GP what medical information is required for this purpose.
- Only a health professional may physically inspect health records[16] and they must be passed to a health professional for examination.

[16] The Adult Support and Protection (Scotland) Act 2007 (Restriction on the Authorisation of Council Officers) Order 2008 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.

- Only information relevant to the assessment of risk and 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.
- It is not necessary for the information to be in writing; 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.

Best practice:

- GPs considering a request for information must take account of the confidentiality of the patient.
- The request should be discussed with the adult to ensure they understand the reasons for it and the likely benefits.
- Even where consent to share information has not been granted, GPs and other health professionals are under a legal obligation to provide relevant records (section 10, 2007 Act).
- Close joint working between GPs, NHS professionals and council officers may help overcome any obstacles.
- GPs and healthcare professionals 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.

Other Agencies

Care Inspectorate

The Care Inspectorate has various responsibilities under the 2007 Act:

- To submit a report of harm to the social work contact centre where an adult at risk has been identified in a regulated service.
- To participate in an inter-agency referral discussion where there is a regulated service or individual involved.
- To monitor whether regulated establishments and agencies are working in accordance with the relevant National Care Standards and regulations.
- To investigate any breach of regulations established by the Public Reform Act 2011 and take action accordingly.
- To produce reports as requested by the Adult Support and Protection Committee to contribute towards any serious case review.

Healthcare Improvement Scotland (HIS)

HIS inspects and regulates Health Care Services across Scotland. It also has responsibilities to:

- Submit a report of harm referral to the social work contact centre where an adult at risk has been identified in a regulated service.
- Participate in an inter-agency referral discussion where there is a regulated service or individual involved.

- Monitor whether regulated establishments and agencies are working in accordance with the established standards.
- Investigate any breach of regulations established by the Public Reform Act (Joint Inspections) (Scotland) 2011 and take action accordingly.
- Produce reports as requested by the Adult Support and Protection Committee to contribute towards any serious case review

Housing and Neighbourhood Services

Housing and Neighbourhood Services provide a range of housing, accommodation and related support services to respond to the needs of individuals. The Service engages with individuals to provide advice and assistance, including addressing housing needs, homelessness, resettlement, debt management, estates management and general tenancy issues.

In adult support and protection situations, the following roles may be required:

- Take all reasonable steps to protect adults at risk of harm, and respect their rights at all times.
- Take all suspicions and allegations of harm seriously and take action in accordance with service procedures and Reporting Harm Protocol to ensure the safety of an adult at risk of harm.
- Work cooperatively with relevant agencies, treating information as confidential, and sharing information in accordance with the principles set out in the Information Sharing Protocol
- Participate fully at appropriate meetings or adult support and protection case conferences providing relevant reports.
- Contribute to the adult support and protection planning process if appropriate.
- Contribute to inter-agency self-evaluation processes
- Produce reports as requested by the Adult Support and Protection Committee which contributes to any significant case review.

Independent Advocacy

Independent advocacy aims to help people by supporting them to express their own needs and make their own informed decisions. Independent advocates support people to gain access to information and explore and understand the options available to them.

- Included in the 2007 Act is the principle that the adult should participate as fully as possible in the adult support and protection process and that the adult should be given information and support to enable them to do so.
- Section 6 places a duty on the council to consider the provision of appropriate services, including independent advocacy service, if it considers that it needs to intervene in order to protect an adult at risk of harm after making inquiries under section 4 of the 2007 Act.
- Independent advocacy should be considered even where the legal protective measures being considered are under the Adults with Incapacity (Scotland) Act 2000.

- Adults who are being protected using Mental Health (Care and Treatment) (Scotland) Act 2003 **must** be offered independent advocacy.
- The advocate will produce reports as requested by the social work contracts section as related to adult support and protection advocacy provision, on behalf of the ASPC.

Mental Welfare Commission (MWC) for Scotland
The Mental Welfare Commission aims to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions.

Their statutory duties focus on five main areas of work:

- Visiting
- Monitoring the Acts
- Investigations
- Information and advice
- Influencing and challenging

The Mental Welfare Commission provides assistance to individuals in the NHS/local authority/independent sector services in determining whether an incident or issue should be notified to the MWC and the form that notification should take. This information can be found on their website.

Office of the Public Guardian (OPG) Scotland
The function of the OPG is to supervise appointed individuals who manage the financial and/or property affairs of adults who lack the capacity to do so themselves. In terms of adult support and protection, the OPG has a responsibility to ensure good information sharing and collaborative working.

Trading Standards Scotland
Trading Standards enforces a wide range of consumer legislation. As part of this, Officers carry out inspections of trade premises and take action against individuals or businesses who disregard the laws. In relation to adult protection, Trading Standards have a role in prevention and investigation of doorstep crime, these are:

- To submit a Report of Harm to the social work contact centre where an adult at risk has been identified in doorstep crime;
- To participate in inter-agency referral discussion; and
- To produce reports as requested by the Adult Support and Protection Committee to contribute towards any serious case review.

SECTION D: RESOURCES

Legislation and Codes of Practice

Adults with Incapacity (Scotland) Act 2000
http://www.legislation.gov.uk/asp/2000/4/contents

Adults with Incapacity (Scotland) Act 2000 Code of Practice
http://www.scotland.gov.uk/Publications/2008/03/18094148/0

Adult Support and Protection (Scotland) Act 2007
http://www.legislation.gov.uk/asp/2007/10/contents

Adult Support and Protection (Scotland) Act 2007 Code of Practice
https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-local-authorities-exercising-functions-under-2000-act/

Communication Toolkit related to Adult Support and Protection
AP Communication Toolkit

Competency Framework
Staff information and training | Fife Council

FGM Multi-agency Guidance
http://www.gov.scot/Resource/0052/00528145.pdf

Financial Harm Guidance
Staff information and training | Fife Council

Forced Marriage Statutory Guidance
http://www.scotland.gov.uk/Publications/2011/11/25115331/0

Practitioner Guidance on Forced Marriage
https://www.gov.scot/publications/understanding-forced-marriage-scotland/pages/3/

Human Trafficking: What health workers need to know about human trafficking 2012
http://www.gbv.scot.nhs.uk/wp-content/uploads/2012/07/Human-Trafficking-document-final.pdf

Human Rights Act 1998
http://www.legislation.gov.uk/ukpga/1998/42/contents

Mental Health (Care and Treatment) (Scotland) Act 2003
http://www.legislation.gov.uk/asp/2003/13/contents

Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice

http://www.scotland.gov.uk/Publications/2005/08/29100428/04289
Nursing and Midwifery Council Code
http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/

Protection of Vulnerable Groups (Scotland) Act 2007
https://www.legislation.gov.uk/asp/2007/14/contents

National Care Standards
http://www.newcarestandards.scot/

Protection of Vulnerable Groups (Scotland) Act 2007 draft Guidance
http://www.scotland.gov.uk/Publications/2009/11/05140540/10

Protection of Vulnerable Groups Scheme
https://www.mygov.scot/pvg-scheme/?via=https://www.disclosurescotland.co.uk/disclosureinformation/pvgscheme.htm

National Missing Persons Framework for Scotland
http://www.gov.scot/Resource/0051/00517676.pdf

Responding to Forced Marriage: Multi-agency Practice Guidelines
http://www.scotland.gov.uk/Publications/2013/01/4056

Respect For All: The National Approach to Anti-Bullying for Scotland's Children and Young People
http://www.gov.scot/Resource/0052/00527674.pdf

Scottish Accord on the Sharing of Personal Information (SASPI) Guidance: Information Sharing Protocol for Fife Adult Protection Committee
SASPI Guidance

Scottish Social Services Council Codes of Practice
http://www.sssc.uk.com/about-the-sssc/codes-of-practice/what-are-the-codes-of-practice

Sexual Offences (Scotland) Act 2009
http://www.legislation.gov.uk/asp/2009/9/contents

Vulnerable Witnesses
https://victimsupport.scot/information-support/going-to-court/special-measures-for-vulnerable-witnesses/

Vulnerable Witness Information Guide
Vulnerable Witness Information Guide

Reporting Forms

Inter-agency Report of Harm Referral Form
Staff information and training | Fife Council

Notification of Child Concern Form
Notification of Child Concern Form

Service User Post Intervention Questionnaire

Methodology

The post intervention questionnaire developed has been underpinned by the Making Safeguarding Personal (MSP) Toolkit. MSP is underpinned by the Care Act 2014 which emphasises a shift in culture and practice, focusing on what we know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is a way of working that should be adopted across all practice areas, not limited to Adult Support and Protection, where practice is person-centred, outcomes focused and strengths-based.

MSP is a sector-led initiative through the Local Government Association, supported by ADASS (Association of Directors of Adult Social Care) which aim to develop an outcomes focus to ASP work, and a range of responses to support people to improve or resolve their circumstances.

This approach is about engaging the person in conversation about how best to respond to their safeguarding situation in a way that enhances their involvement, choice and control as well as improving quality of life, wellbeing and safety. This means taking a strengths-based approach and involves a shift from a process supported by conversations to a series of conversations supported by a process.

There are 6 key principles of MSP.

1) Empowerment: This is about people being supported and encouraged to make their own decisions with informed consent.

2) Protection: Providing support and representation for those in greatest need.

3) Prevention: It is better to take action before harm occurs.

4) Proportionality: Any intervention should be proportionate and least intrusive response appropriate to the risk presented.

5) Partnership: Providing local solutions through services working with communities.

6) Accountability: Accountability and transparency in delivering safeguarding.

Historically within Adult Support and Protection, very little information has been collected in relation to quality of services or interventions and on the differences they make for people. Instead, the information has focused on process rather than outcomes, on quantitative data (how many investigations, how often) rather than qualitative data that would indicate how well things have been done, or how helpful or effective the interventions have been for the person at risk.

MSP aims to set a framework for response options to ensure a greater focus on the needs and requirements of the person at the centre, and make it easier

to ascertain and measure the difference that has been made by an ASP intervention.

As a result, this questionnaire is being done to change this, so we can find out if you feel the work taken place has been helpful and effective.

Please see below for the survey tool, which can be copied and pasted for the area teams to distribute. Workers would use their professional judgement when encouraging a client to complete it. For example, it would not be recommended for families to assist with this if they have been the alleged harmer for example. In circumstances such as these, advocacy would be the best option to support its completion.

Questionnaire

• This questionnaire will be posted or emailed to you at the end of the adult protection enquiry.

• You can fill this out on your own, with support from family, carers or advocacy services.

• If you want a hard copy, included will be a pre-paid envelope to return this questionnaire if you wish.

• You do not have to take part in the questionnaire if you do not want to, and there are no repercussions for not participating.

• If you wish, please answer all questions as fully and as honestly as you can.

• These questions will allow us to accurately measure how effective our adult support and protection interventions are across Fife, and most importantly how you feel about the intervention as a whole.

This evaluation is being done to gather information to find out how well things have been done, and how helpful and effective you feel the adult support and protection intervention has been.

1) At the beginning of the adult support and protection process, were you asked what you wanted to achieve from it?

2) Did you feel your worker was acting in your interest? -If yes, why? -If no, why not?
3) Do you feel you saw your worker enough during the adult support and protection process? -If no, in what way do you feel they could have been more involved?
4) Did you feel supported by your worker?

5) Did you feel listened to during conversations with your worker?
6) Did you become more involved with any other services as a result of the adult support and protection enquiry?
7) If a similar situation occurred in future, do you feel confident you would know what to do to seek help?

8) Has the adult support and protection process helped you feel able to recognise signs of harm?
9) Did your social worker effectively explain their role to you?
10) Do you feel you achieved a positive outcome alongside your social worker? -If yes, what was this

11) On a scale of 1 to 10, with 10 being the most safe, how safe did you feel prior to the adult support and protection enquiry?
12) On a scale of 1 to 10, with 10 being the most safe, how safe did you feel after the adult support and protection intervention was complete?

Various Agencies and Organisations (in alphabetical order)

Hourglass Scotland (Safer ageing – Stopping abuse)
https://wearehourglass.scot/scotland

Action Fraud: Details of scams can be passed on to 0300 123 2040
https://www.actionfraud.police.uk/

Advocacy Forum
https://fifeadvocacyforum.org.uk/

Breathing Space: a free, confidential telephone advice and signposting service for people who are feeling down or stressed (0800 83 85 87).
www.breathingspacescotland.co.uk

Choose Life: a national strategy and action plan to prevent suicide in Scotland
www.chooselife.net

Citizens' Advice Consumer Helpline: Non urgent advice or information 03454 040506.
https://www.cas.org.uk/

Cruse Bereavement Care Scotland: a registered charity which offers free bereavement care and support to people who have experienced the loss of someone close
www.crusescotland.org.uk

General Medical Council: advice making and using visual and audio recordings of patients
Making and using visual and audio recordings of patients

Healthcare Improvement Scotland: improving the quality of the care and experience of every person in Scotland every time they access healthcare
www.healthcareimprovementscotland.org

In Care Survivors Service Scotland: a support service for adults who suffered childhood abuse in care and for their families. Call: 0800 121 6027
http://edspace.org.uk/service/in-care-survivors-service-scotland/

Living Life to the Full: a free online life skills resource aiming to help users change the ways in which they think, and to respond in new ways to the challenges faced in life
https://llttf.com/

Mental Health Foundation: outlines the charity's work in research, policy, service development and service user involvement
www.mentalhealth.org.uk

Mental Welfare Commission for Scotland: aims to ensure that care, treatment and support are lawful and respects the rights and promotes the welfare of individuals with mental illness, learning disability and related conditions
http://www.mwcscot.org.uk

Respectme: Scottish anti-bullying: training, information, advice and other resources to help tackle bullying
www.respectme.org.uk

Respond: works with children and adults with learning disabilities who have experienced abuse or trauma, as well as those who have abused others
http://respond.org.uk/

Samaritans: 24-hour support for people in distress or despair, including those feeling suicidal (116 123)
https://www.samaritans.org/your-community/samaritans-ireland-scotland-and-wales/samaritans-scotland

Scottish Association for Mental Health (SAMH): provides local community support services offering practical and emotional support, social activities, advice on employment and education and help with health issues
www.samh.org.uk

Seasons for Growth: a loss and grief education programme catering for young people aged 6-18 years
http://www.seasonsforgrowth.org.uk/

Survivor Scotland: National Strategy for survivors of childhood abuse
http://www.gov.scot/Resource/0048/00486712.pdf

Trading Standards:
https://www.fife.gov.uk/kb/docs/articles/community-life2/trading-standards

Victim Support
https://www.victimsupportsco.org.uk/

Fife Violence Against Women Partnership (FVAWP) Tel: 01592 583690
www.fife.gov.uk/kb/docs/articles/health-and-social-care2/violence-against-women

Review and Comments Feedback

The Adult Support and Protection Committee is keen to ensure that any future reviews of its policies and procedures are informed by those who will be either using or affected by these procedures therefore your comments, ideas and suggestions are welcomed.

Please send your feedback to: Amanda.Law@fife.gov.uk

Thank you for taking the time to respond

Acknowledgements

- ELBEG, Adult Support and Protection: Ensuring Rights and Preventing Harm 2009
- Grampian Adult Protection Multi-agency Guidance
- Perth and Kinross Multi-agency Guidelines
- Dundee City Multi-agency Procedural Guidance on Adult Support and Protection
- Shropshire Multi-agency Adult Protection Procedures

Fife Adult Support & Protection Committee

Adult Protection Phone Line
01383 602200

Adult Support and Protection webpage
on www.fife.gov.uk

Information to support communication with the adult can be found at:
www.fife.gov.uk on the Easy Read webpage