Grampian
Interagency Procedures
for
Adult Support and Protection

Approvals:	
Aberdeen City Adult Protection Committee	29/08/2024
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Moray Adult Protection Committee	23/08/2024

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Responsibilities for review of this document:	
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Revision History: (If there is no previous document please insert N/A into the boxes into the boxes in the top row of the table below).

Revision Date:	Previous Revision Date:	Summary of Changes (Descriptive summary of the changes made)	Changes Marked * (Identify page numbers and section heading)
05 2021	08 2017	Full list of changes can be sought from Aberdeenshire Adult Protection Network	
07 2024	05 2021	The format has been changed to allow clear links with the Codes Of Practice (COP). Where information is contained within the COP this has been removed from the Grampian Procedure to prevent duplication. Various appendices were removed as they require only to be accessed by a single agency and are included in the operational procedures of each organisation.	Throughout document

*Changes marked should detail the section(s) of the document that have been amended i.e., page number and section heading.

This document is also available in large print, other formats and languages upon request. Please call NHS Grampian Corporate Communications on 01224 551116 or email gram.communications@nhs.scot

Contents

Section 1 – Setting the Scene

Section 2 - Principles and Definition of Adult at Risk

Section 3 - Duties and Powers of the Council and Other Agencies

Section 4 – Adult Participation

Section 5 – Information Gathering Process

Section 6 - Adult Protection Investigative Powers

Section 7 - Assessing and Managing the Risk of Harm

Section 8 – Protection Orders

Forms and Appendices

1. Grampian Capacity Decision-Specific Screening Tool
2. Thresholds Guidance
3. Adult Protection Reporting Form
4. Information Sharing Protocol
5. Large Scale Investigation Protocol.
6. Escalation Process
7. IRD Protocol
8. Plan for ASP Interview
9. Adult Protection Risk Assessment Matrix
10. Learning Review Guidance

Section 1 – Setting the Scene

Introduction

Most adults with mental ill-health, physical or learning disabilities or mental or physical infirmities, manage to live their lives comfortably and securely. They do this either independently or with assistance from relatives, friends, neighbours, professionals, or volunteers.

For a small number, they may experience conflict, exploitation, harm, or abuse and be unable to safeguard against this. This can be harm or abuse can be perpetrated by others but can also include self-harm and/or self-neglect and everyone has a responsibility to support and protect adults from the risk of harm.

What is this document?

This inter-agency procedure represents the commitment of agencies within Grampian to:

- put adults at risk at the centre of the protection process.
- unite in the prevention of and protection from harm, mistreatment, and neglect of adults at risk aged 16 years and over.
- ensure situations of actual or suspected harm, exploitation, mistreatment, and neglect are identified, reported, recorded and investigated; and
- provide support and protection for adults at risk who are experiencing harm.

The current version of this inter-agency procedure is in direct response to the updated Code of Practice for the Adult Support and Protection Act 2007, published in 2022, which gives all staff the framework to undertake their ASP duties. **It is important that all readers of this document should be aware that it must not be read in isolation, but in conjunction with the CoP and additional local procedures and/or guidance.**

Specific guidance was also published for General Practice in July 2022 – to which professionals are also requested to refer where it is appropriate.

> Look for boxes styled like this whilst reading this document – they indicate where reference needs to be made to the CoP.

Partners

In Grampian, the partners who have signed up to this multi-agency procedure are:

- NHS Grampian
- Councils in Aberdeen City, Aberdeenshire and Moray
- Health and Social Care Partnerships in Aberdeen City, Aberdeenshire, and Moray
- Police Scotland
- Scottish Fire and Rescue Service
- Scottish Ambulance Service
- Third Sector

Legislation and Related Guidance

The Adult Support and Protection (Scotland) Act 2007 puts in place key powers, duties, and responsibilities to support the protection of adults at risk.

These are:

- Placing a duty on Councils (the "Lead Agency") to make the necessary inquiries to establish whether or not an adult is at risk of harm and whether further action is required to protect the adult's well-being, property, or financial affairs;
- Placing a duty on certain public bodies and office holders to cooperate in inquiries;
- Introducing a duty to consider the provision of advocacy or other services;
- Responsibilities to provide support and protection for adults at risk who are experiencing harm;
- Permitting, in certain circumstances, the medical examination of a person known or believed to be at risk of harm;
- Requiring access to records held by agencies in pursuance of an inquiry;
- Introducing a range of protection orders which are defined in The Act, namely:
    - Assessment orders
    - Removal orders
    - Banning orders

Everything contained within this inter-agency procedure is consistent and supports the provisions, powers and duties as described within the CoP. This inter-agency procedure should be read in conjunction with, and with due reference to, The Adult Support and Protection Act (Scotland) 2007.

Chapter 1 of the ASP CoP gives significant detail on other relevant legislation and social policy relating to adult protection. This includes the interplay between adult protection legislation and mental health/adults with incapacity law; and also, the wider context in which ASP legislation sits (including Human Rights legislation and UN Conventions). All professionals working in Adult Support and Protection should familiarise themselves with this information.

Principles When Supporting and Protecting Adults at Risk of Harm

All agencies who have signed up to this inter-agency procedure have agreed the following foundational principles will apply consistently across Grampian. Agencies will:

- Work within the principles laid down by the Act and its associated code of practice.
- Work within the principles laid down by the Health and Social Care Standards i.e. individuals should be treated with dignity and respect, compassion and be included in decisions.

- Work within the Key Principles of Trauma Informed Practice laid down in Trauma-Informed Practice: A Toolkit for Scotland i.e. Safety, Trustworthiness, Choice, Collaboration, Empowerment.
- Work together within an interagency framework.

A Person-Centred Approach

The key principles of the 2007 Act focus on both respecting the wishes of the adult at risk and ensuring they participate as fully as possible in any ASP activity. This requires a commitment to a true person-centred trauma informed and human rights based approach from all partners and professionals.

When protecting adults at risk from harm we need to ensure that individuals and their care givers are empowered by knowing what they can expect, understanding their rights and being able to access a responsive advocacy and complaints service.

This Person-Centred Approach will be referenced throughout this document – however it is mentioned explicitly in this introduction due to its key importance to all Adult Support and Protection activity.

Working Across Legislation

The Adult Support and Protection, Adults with Incapacity, Mental Health Acts and Social Work Scotland Act all contain information that relate and can be used to protect adults at risk of harm. Consideration should be given as to which legislation would be most effective and least restrictive to the adult at risk. Where required Council Officers should seek advice from the Council's Legal Advisor/Solicitor to enable a full assessment of the legal options available.

During adult protection work there may be instances where it overlaps with other public protection workstreams. These must be borne in mind and referrals must be made where other protection matters are identified.

The Duty of Candour Procedure (Scotland) Regulation 2018 sets out that organisations providing health services, care services and social work services are required to undertake specific actions when there has been an unintended or unexpected incident that results in death or harm, or additional treatment is required to prevent injury that would result in death or harm. Consideration should be given to the nature of the ASP incident and if it meets the criteria that it should be considered under duty of candour. Local procedures for undertaking any duty of candour actions should be followed in parallel to any ASP duties.

What Other Support/Guidance is There?

Alongside this document, the CoP and other National Guidance, each agency will have its own operational procedures that govern how it meets its own specific duties and responsibilities for Adult Support and Protection.

In addition, ongoing training will be provided to those involved in supporting and protecting adults. This will be on both a multi-agency and single agency basis. All training in relation to ASP should be in alignment with Protecting Adults in Grampian – A learning and Development Strategic Framework. Professionals/practitioners

should consult with their own training services/teams in the first instance to access dedicated ASP training.

The Social Care Institute of Excellence (SCIE) has a specific "Safeguarding Hub" and Iriss has an Adult Support and Protection site. Both are excellent repositories of research, guidance and learning resources.

Supporting and protecting adults at risk of harm can be complex. We acknowledge that this guidance cannot cover all eventualities; however, it is intended for universal use.

Useful Contact Details

Adult Protection Teams	
• Aberdeen City Council	(24 hours) 0800 731 5520 apsw@aberdeencity.gov.uk
• Aberdeenshire Council	01467 533100 0345 6081206 Out of hours adultprotectionnetwork@aberdeenshire.gov.uk
• Moray Council	01343 563999 accesscareteam@moray.gov.uk
Police Scotland	Service Centre: 101 Emergency: 999
NHS Board • NHS Grampian • NHS 24 • NHS Grampian Public Protection	 0345 456 6000 111 Gram.publicprotection@nhs.scot
Other Bodies • Mental Welfare Commission • Office of Public Guardian • Care Inspectorate • Advocacy -Aberdeen City • Advocacy -Aberdeenshire • Advocacy-Moray	 0131 313 8777 01324 678 350 0345 600 9527 01224 332314 01467 652604 01343 556546

Consultation and Comments

This document will be reviewed and amended by the Grampian Adult Protection Group in line with changing legislation and experience from practice. If you have any comments regarding this document, please record them here.

Section 2 - Principles and Definition of Adult at Risk

It is important that this section be read in conjunction with the National Code of Practice for ASP (CoP) and any existing local agency procedures relating to operational adult protection activity.

Chapter 2 of the CoP

- Provides a description of the principles of the Act, which apply to any public body or office holder authorising or carrying out a function under the Act.
- Provides definitions of 'adults at risk' and explores the use of the three-point-criteria in regard to types of harm, being more vulnerable to harm and being unable to safeguard.
- Explores circumstances such as trauma, suicide prevention, substance dependency, homelessness, hoarding, financial harm.
- Discusses the overlap in legislation and support relating to young people.

Definitions

The CoP gives a clear definition of who is an adult at risk of harm. Examples are provided of what makes a person more vulnerable to harm, types of harm and how someone may be unable to safeguard themselves. In addition, the CoP considers the impact of mental incapacity but makes it clear that a person can retain mental capacity and still be an adult at risk of harm. It also gives guidance around considering if a person is unable or unwilling to safeguard themselves. coercive control. undue pressure and how these can impact on a person's decision making are also dsicussed

Signs of Potential Harm

Suspected harm can come to light in a number of ways. The clearest indicator is a statement or comment by the adult themselves, by their regular carer, or by others, disclosing or suggesting harm. Such statements must be acted on.

Disclosing harm can be difficult for an individual and therefore it is important to recognise other signs which may indicate harm. These might include a change in presentation or behaviour or circumstances. It is important for staff to be professionally curious in order to establish if support is required and/or if there is a need to report under ASP.

Assessing Capacity

The CoP states that while someone who lacks capacity may be unable to safeguard their own well-being, property, rights and other interests, it should never be assumed that an adult who has capacity is automatically able to do so. Additonally any decision regarding whether an adult is an adult at risk, should not be delayed for an assessment of capacity to be undertaken. Capacity assessments may, however, be of benefit as means of identifying other legislative options available to support the individual.

Where there is doubt about the adult's capacity the Grampian Decision-Specific Capacity Screening Tool should be used. This tool aims to assist the practitioner consider the various elements involved in the decision-making process. It may be used to gather evidence of an adult having or lacking capacity in relation to specific decisions and also to consider whether a more formal assessment is required in order to pursue measures under the Adult with Incapacity (Scotland) Act 2000.

There is also now a Grampian-wide Capacity Pathway for Protection Based Decisions. This Pathway should be used for capacity assessments that are required as part of Adult Support and Protection activity.

Trauma Informed Approach for Adult Support and Protection

In the CoP there is greater emphasis on the impact of trauma on an adult's ability to safeguard and it encourages consideration of this when assessing if an adult is at risk of harm, explicitly stating that experience of trauma 'may very well have rendered some people effectively unable, through reliable decision making or action, to safeguard themselves.'

Similarly, the CoP encourages practitioners to consider the impact of coercive control or undue pressure on the adult's ability to safeguard themselves.

Many adults affected by trauma and adverse childhood experiences remain able to safeguard their own wellbeing. However, for some, the complexity, severity, and persistence of post traumatic reactions may impact to the extent that these individuals repeatedly take decisions that place them at risk of harm. It is vital that staff understand the prevalence of trauma among people and the impact this trauma may have had on them.

The CoP draws attention to considerations that must be given when someone presents with suicidal ideation, dependent on substances, homeless or hoarding. When assessing anyone to be an adult at risk it is vital that their presentation is not seen in isolation and that a person's ability to safeguard is considered within their individual circumstances.

Concern over risk taking can stifle and constrain providers of care, leading to an inappropriate restriction of the individual's rights. There is a challenge for people working with adults at risk of harm to define a way forward where they can take calculated risks. All decisions must be based on informed choice and the measures taken to address the risk are proportionate to the likely outcome and least restrictive.

Whilst the Act provides clear definitions of an Adult at Risk and harmful behaviour, there remain situations that are 'borderline' where the distinction between a more general concern about care/support and an Adult Support and Protection matter are unclear. In some cases, it can be the repetition of minor actions or omissions that collectively will amount to harmful conduct.

Thresholds Guidelines are intended to assist staff in determining whether the concern is an example of poor practice which requires action by the care organisation or if it requires to be reported for Adult Support and Protection procedures to be instigated.

An assessment that intervention under the Act is not necessary does not absolve authorities of responsibility to consider intervention under other legislation, such as the NHS and Community Care (Scotland) Act 1990, or to offer other services. Actions taken or the reason for no action being taken should be recorded. Consideration should be given to practical and emotional support provided by social work, health, and independent and third sector and private sector providers. For example, the provision of mainstream health and social care services such as housing, independent living, financial, occupational therapy, counselling, support for carers, and Health and Social Care Partnerships.

Young People

The CoP notes the cross over where both the ASP Act and Children Services legislation are both relevant. It notes the importance of robust systems being in place for the sharing of information and any necessary transfer of responsibilities between agencies and services. It also notes that the provision of assessment and support should be based on individual circumstance.

Where a concern is noted about an adult who is 16 years or over, the concern must be reported to the relevant adult council service (Useful Contact Details). The council should then carry out appropriate checks on local case recording systems to establish if other Social Work Services are involved.

The definition of an Adult at Risk includes people aged 16 and over. Other legislation and provisions relating to children exists which include persons up to age 26. Support under these other provisions may be more appropriate for some young persons. Adult Protection practitioners should pay particular attention to the needs and risks experienced by young people in transition from youth to adulthood, who are more vulnerable to harm than others.

Each Council Area has its own protocols/guidance relating to young people in transition and these should be referred to. Where there is a cross over in legislation protocols and services being provided, discussion will occur between the Adult and Children services as to which service is most appropriate to lead necessary inquiries.

The outcome of any decisions and/or investigations must be clearly recorded.

Section 3 - Duties and Powers of the Council and Other Agencies

It is important that this section be read in conjunction with the National Code of Practice for ASP and any existing local procedures relating to operations.

Chapter 3 of the CoP outlines the duties and powers of the main ASP partnership organisations and the role of individual staff within the organisations.

Topics covered include:

- Councils duties and powers and who can be appointed as a council officer.
- The duty to refer and co-operate.
- Role of General Practice, Scottish Fire and Rescue Service, Scottish Prison Service.
- Role of Independent and third-sector providers;
- Information Sharing.

Making a Referral

The CoP outlines the need to:

- Contact emergency services if the adult is in immediate danger
- Report to the police if a crime is known or suspected to have occurred
- Outlines the 4 R's of Referrals **– Recognise, Report, Refer, Record**
- Provide information and resources to assist decision making regarding sharing information and consideration around consent.

If an adult is known or believed to be at risk of harm the facts and circumstances of the case should be reported to the council for the area where they believe the adult to be located without delay. The Out of Hours Social Work Service should be used if required. All individuals within organisations must complete the Adult Protection Reporting Form (unless a national agreed alternative is available i.e. Police Scotland, NHS24, SAS) and submit to the appropriate council.

Information regarding concerns should include:

- Nature/substance of concerns.
- Initial discussions and decisions, and reason for decisions.
- Details of care giver/significant others.
- Details of person alleged to have caused harm including current whereabouts and likely contact with the service user, if known.
- Details of any specific incidents, e.g., dates, times, injuries, witnesses, and evidence, such as bruising/marks, bank statements.
- Background or any previous concerns.
- Discussion with the Adult, carers, person alleged to have caused harm regarding the concerns being reported and their views

For clarity, allegations of harm against adults at risk where the alleged perpetrator holds a position of trust (i.e. member of staff) must be reported under ASP processes. Internal HR and staffing processes are not sufficient in such circumstances.

Incidents of concern, suspected/actual harm must be reported centrally within each council area using the locally agreed system. This will ensure that, wherever possible, no incidents of harm are missed.

Under the ASP legislation it is not necessary to obtain consent to share information, where it is known, or believed, that a person may be at risk of harm. Any disclosure must be relevant, proportionate, and necessary to the harm that is being investigated. It is best practice for the adult at risk to be involved and informed about any decision to report ASP concerns unless this would have a negative impact on their safety.

Whilst action to secure the safety and well-being of the adult is the priority, there should be no unnecessary delay in ensuring that feedback is provided to the referrer. The timing and nature of the feedback must take account of the role and status of the person to whom it is being given. Data Protection legislation requirements and principles must be adhered to.

Information Sharing

Sharing information about the adult is vital; the information held by one person or agency may only be part of a more concerning picture. As mentioned above, the Act imposes a duty on certain bodies and office holders to co-operate with a council which is making inquiries regarding the adult. This includes a legal requirement to share information. Good practice would be that all relevant stakeholders should co-operate, not only those who have a duty to do so.

Chapter 15 of CoP outlines that is an offence to prevent or obstruct any person from doing anything they are authorised or entitled to do under the Act, without reasonable excuse.

ASP Guidance for General Practice P9 -10 gives further guidance on Information Sharing.

Information should be shared in accordance with the Grampian Adults at Risk Information Sharing Protocol.

Confidentiality is important but it is not an absolute right. Sharing information is essential to enable the council to undertake the necessary adult protection inquiries. Proportionate information should only be shared with those who need to know and only if it is relevant to the concern identified.

In general, agencies and professionals should:

- follow relevant requirements of their regulatory body.
- Involve the adult in information sharing practice by informing them that information may be shared, with whom and why, seeking agreement from the adult but also stressing that their safety will be the overriding consideration when sharing information.

- make sure information is accurate, up to date, and necessary for the purpose it is being shared for, share only with those who need to see it, and share securely.
- always record the reason for the decision: whether it is to share or not.
- seek advice when in doubt.

Any information received in the course of an inquiry is treated with the utmost confidence and will not be disclosed to any third parties other than in accordance with the provisions of the Act.

Recording Information

Each organisation must have a formal agreement as to how information about the adult is recorded. This must be adhered to, with records being kept up-to-date and accurate at all times.

All information recorded should clearly state whether it is based on information known to be factually accurate by the worker or based on suspicions, observations or allegations which have been reported.

Duty and Powers of Councils and Council Officers

The CoP outlines:

- Councils have a duty to make necessary inquiries to establish if action is required to stop or prevent harm from occurring where it knows or believes an adult is at risk of harm. The intention of the Act is to allow engagement with people where it has yet to be determined whether they are an adult at risk and therefore inquiries will often take place before a determination has been made that the adult is at risk of harm
- Councils have powers under the Act that enables inquiries to occur i.e., visits, interviews, medical examinations, examination of records (financial, medical, other), applying for a protection order.
- The duties that must be undertaken by the Council Officer and the requirements that must be met before a person is appointed as a Council Officer by the Council

The Council is the lead agency for adult protection and has the primary responsibility for investigating any adult protection issue relating to adults at risk of harm within its area. All concerns must be reported to the Council who will coordinate any subsequent inquiries/investigations with partner agencies.

Adult Protection teams operate in Aberdeen City, Aberdeenshire, and Moray. These units are responsible for co-ordinating adult protection functions on behalf of the council. Certain functions under the Act can only be carried out by a designated Council Officer. Council Officers are required to be council or health board employees with the appropriate professional registration. Council Officers will have completed

the Council Officer ASP training and have 12 months post qualifying experience of identifying, assessing, and managing adults at risk.

Duty and Powers of Other Relevant Organisations

The CoP outlines:

- The multi-agency nature of adult support and protection work is crucial to the work of protecting adults from harm and effective intervention will only come about as a result of productive cooperation and communication between a range of agencies and professionals.
- The Act places a duty on certain public bodies or office holders to make a referral and co-operate with the Council when making inquiries.
- Good practice is that all relevant stakeholders will co-operate with making referrals and assisting with inquiries, not only those who have a duty to do so under the Act.
- Offences under the Act. It is an offence to, without reasonable cause, prevent or obstruct any person from doing anything they are authorised or entitled to do under the Act.
- Specific information relating to the role of General Practices, SFRS, SPS, Independent and third-sector providers

Police - Where there is an allegation of criminality the Police will take the lead in the investigation and fulfil their duty to report criminal offences/crimes to the Procurator Fiscal in the usual manner. The Police will co-ordinate any forensic medical examination where a crime is suspected. Information and records regarding the adult will be provided to the Council when requested under the Act. On receipt of a request submitted through an approved process, information will also be provided on those who are suspected of perpetrating the harm. Police also have a national process to escalate to the Care Inspectorate Care Homes that repeatedly come to police attention.

NHS Grampian - A doctor may be asked to conduct a medical examination and a nurse or midwife may be asked to carry out an examination (if it is within their competence and confidence) under the Act during a visit or as part of an Assessment Order. They may also be asked by a Council Officer to examine health records.

General Practice - GPs have a key role to play in adult protection. They may be the first professional to see signs of potential harm and are crucial not only in helping to protect adults, but also in helping to develop effective multi-agency responses. Guidance for General Practice was revised by the Scottish Government in 2022.

Care Inspectorate - Where harm is suspected or alleged to have occurred in a registered service the role of the Care Inspectorate will be to:

- Assist the council and Police in their enquiries.
- Attend Adult Protection Case Conferences and Large Scale Investigations.
- Assess what, if any, regulatory action needs to be taken.
- Liaise with the council/Police, to make sure that the outcome of any investigation is reflected in their ongoing regulatory duties and activities.

Where it is found that a service is operating in a manner which fails to adequately protect adults, the Care Inspectorate will consider whether enforcement action is required. Such enforcement action may include the imposition of conditions on registration, serving an improvement notice, or making application for a Section 18 cancellation of registration.

Independent and Third Sector Providers - while independent organisations do not have specific legal duties or powers under the Act, care providers have a responsibility to involve themselves with the Act where appropriate by making referrals, assisting inquiries and through the provision of services to support people at risk of harm. These organisations should discuss and share information they have about adults who may be at risk of harm with the council. These organisations along with user and carer groups may also be a source of advice and expertise for statutory agencies working with adults with disabilities, communication difficulties or other needs.

Organisations have a legal duty to comply with requests for examination of records.

All Organisations that are commissioned by the council need to ensure they are compliant with the adult protection provisions as stated in their contract.

Governance

The Act requires that each local Council area establish an Adult Protection Committee. A revised Codes of Practice for Adult Protection Committee was published in 2022.

Aberdeen City, Aberdeenshire and Moray have an Adult Protection Committee. Each APC is located within local public protection governance structures including reporting to Chief Officer Groups. Chief Officers are ultimately responsible and accountable for improving the experience of and outcomes for adults who may need protection and for having assurance reporting frameworks in place to ensure that all staff within their organisations are competent in discharging their adult protection responsibilities. The local APC is the statutorily mandated inter-agency mechanism to take forward this work.

Each APC is chaired by an Independent Convenor. The Convenors do not work for any of the statutory agencies involved with adult support and protection and are therefore able to operate independently.

The Grampian Adult Protection Group is a permanent subgroup of the Aberdeen City, Aberdeenshire, and Moray APC's. The role of the Grampian Group is to undertake a co-ordinating role on behalf of these APCs where work identified, is agreed to be a cross Grampian priority. It also encourages and promotes joint working and the sharing of good practice across the multi-disciplinary context. The Grampian Group provides the opportunity for the identification, and debate, of ASP matters that affect, or are of interest to, all of the APCs.

This group has standing sub-groups relating to learning and development, financial harm and learning from external learning reviews. Short life working groups are convened as necessary to address specific needs.

Professional Disagreements

Learning from Significant Case Reviews across Scotland has highlighted the need for practitioners and managers across all agencies to have a clear understanding about their responsibility for professional challenge and to know how to escalate concerns about decisions made where it relates to the safety of an adult.

Disagreements can arise in a number of areas, but are most likely to arise around thresholds, roles and responsibilities, the need for action and communication or service provision.

Professional differences are not, intrinsically, a negative thing when working in an area of such complexity as Adult Support and Protection. One of the key reasons for multiagency working in this area is the recognition and understanding that no single profession of professional will have the answer or solution in isolation. It should therefore be expected that, at times, professionals may see particular situations in different ways. What is most important, however, is that all professionals should feel comfortable with both challenging a particular view or opinion respectfully AND with accepting such challenges occurring.

The escalation process aims to support positive resolution of professional difference between agencies. This process is specifically aimed at colleagues across all services and agencies in Grampian working with adults at risk. It relates specifically to multi agency disagreement and does not cover disagreement within single agencies which should be addressed by agencies own internal escalation arrangements.

Staff Support

Working in the field of Adult Protection can be very rewarding but can also be very challenging and demanding. Whilst the nature of that support may vary depending on the organisations and professionals involved there is an absolute expectation that all staff will be supported. Some of the more complex investigations and inquiries can be particularly difficult and may take a toll on members of staff who are involved. For this reason, it is essential that all agencies ensure that staff involved in Adult Protection work are offered appropriate support.

Staff leading adult protection work should receive formal 1:1 supervision from their first line manager or another appropriate superior.

Debriefing opportunities should be made available following particularly challenging, traumatic, or complex situations. These can be tailored to be delivered on a 1:1 basis but consideration should be given to the benefits of multi-agency debriefing sessions, where appropriate. Peer support within and between agencies should be encouraged and facilitated, where necessary.

Agencies should also ensure that staff are aware of independent, confidential support and counselling should they wish to use this.

Section 4 – Adult Participation

It is important that this section be read in conjunction with the National Code of Practice for ASP (CoP) and any existing local agency procedures relating to operational adult protection activity.

Chapter 4 of the CoP outlines the principle of ensuring that full regard is given to the wishes and feelings of the adult, and the principle of the adult participating as fully as possible in all aspects of the adult protection process. It also covers the importance of providing advocacy and other services. This chapter is relevant for all aspects of ASP activity, including an adult's participation in inquiries, investigative processes, risk assessment, case conferences, protection planning and implementation

Topics covered include:
• Taking account of undue pressure;
• The need to record decisions relating to adult participation in the process;
• The use of supported decision-making;
• The provision of appropriate communication supports / assistance, including interpreters;
• Independent Advocacy Services;
• Involving the adult in ASP meetings;
• Seeking the views of family / carers / other representatives etc; and
• The requirement for APC's to undertake regular audits of the extent to which adults are enabled to participate fully in decision making.

The following should be taken into account alongside the CoP.

Trauma Informed Approach

By using a Trauma Informed Approach staff are more likely to effectively support an adult to engage in their ASP Journey.

Trauma informed practice is a strength-based approach that seeks to understand and respond to the impact of trauma on people's lives. The approach emphasises physical, psychological, and emotional safety for everyone and aims to empower individuals to re-establish control of their lives. It is client-led with a focus on future outcomes and strengths that people bring to a problem or crisis.

The key principles of a trauma informed response are:

- Recognise and respond to trauma - It is vital that staff understand the prevalence of trauma among people and the impact this trauma may have had on them.
- Provide safe environments - Help foster and sustain safe environments by putting collaboration, informed choice and empowerment for service users at the heart.
- Take a strengths-based view - Build on what people are capable of doing to create positive possibilities.
- Build empowering relationships - Give the adult a say over how services are delivered and focus on being respectful, compassionate, and trusting so that the user is not in a position of powerlessness.
- Promote equality of access - Everyone deserves equal access to good quality treatment which takes account of the unique context of their life.

These principles work together to create an environment that is conducive to healing and recovery for those who have experienced trauma. Agencies should also ensure that staff working in ASP are aware and are supported to undertake Trauma Informed training and encouraged to use a trauma informed approach when working with adults at risk of harm.

Feedback from Adults at Risk/Carers

Gaining feedback from adults and carers on the different stages of the ASP process is vital for learning what works, what we could do better and whether our approach to risk management supports the adult and their carer to make choices and live safely and independently.

Getting useful user feedback can be tricky but continuous collaboration and giving each service user a feeling of participation is essential for improving their user experiences and satisfaction and can be a key driver to improving our own skills and services.

Advocacy Services can help the service user and/or their carer who have been or are going through the local ASP process to express their views and needs effectively and support people to understand and to have their say.

Lead agencies and practitioners must consider the experiences of adults and carers to ensure their views are being heard and rights are respected. Provide the information that people need when there is an investigation into alleged abuse e.g., when to involve an advocate and how to access advocacy services so that they are able to make choices and participate in decisions about their lives and talk about whether the value of the adult’s own outcomes was acknowledged and adhered to.

Section 5 – The information gathering process

It is important that this section be read in conjunction with the National Code of Practice for ASP (CoP) and any existing local agency procedures relating to operational adult protection activity.

Chapter 5 of the CoP documents the importance of the information gathering stage. The section shares good practice guidance all practitioners should have regard to whenundertaking their duties. The gathering of information in this section will be referred to as the Inquiry and IRD stage.

Topics covered include:

- Referrals – the need for a considered and measured approach when undertaking inquiry
- Welfare concerns – Police Concern Reports; Scottish Ambulance Service Referrals and Scottish Fire and Rescue Referrals as well as concerns from other organisations
- Sharing of Information to the Lead Agency when it is thought an individual may be at risk of harm
- Communication and consultation with the Adult
- Inter-agency Discussions (referred to as Initial Referral Discussions in Grampian)
- Recording of decisions

The following should be taken into account alongside the Code of Practice in this regard:

Referrals

All Adult Support and Protection Referrals are received by a single point of contact within each Local Authority – you will find more information about referrals in Section 3.

Where there is information that a number of adults are considered to be or are at risk of harm, a large-scale investigation will be considered in line with the Large Scale Investigation Protocol.

Initial Referral Discussions (IRD)

Across Grampian all three Local Authorities and partnerships have adopted the Grampian IRD Protocol. This is a multiagency document that sets out the criteria and mechanisms (across agencies) for IRD's to be initiated. IRD's allow professionals to consider an adult support and protection report, share initial research and information, and then agree a response on a multi-agency basis. Normally, it will be the three key statutory partners (Council; NHS Grampian; and Police Scotland) who attend and participate in IRD's – though in exceptional circumstances, this membership may be expanded.

An IRD can be called following the receipt of any Adult Support and Protection report – there is no minimum threshold for triggering an IRD. However, in Grampian, there is an agreed maximum threshold where an IRD must always be triggered, regardless of the nature and type of ASP report received, as detailed below.

The Five Report Maximum Threshold

Case experience and previous case/learning reviews have shown that an adult's circumstances; risks; vulnerabilities; and abilities to safeguard themselves are often dynamic rather than static. It is therefore incredibly important that agencies and professionals never fall into the trap of assuming that because an individual did not meet ASP criteria during a previous referral, that they will not require the support of ASP processes at subsequent periods of contact.

Therefore, for the avoidance of doubt, the following arrangements apply where an adult has been subject to five previous adult protection referrals over a rolling 2 year-period, where all of the referrals have had an outcome of no further ASP action.

In such circumstances an IRD must always be called to consider the individuals situation and potential risk factors. This is an important 'safety net' built into the multiagency processes to ensure that potential 'adults at risk' are not missed.

The only exception to the requirement to call an IRD at the '5 report threshold' is when the lead agency makes a professional decision to undertake more substantive ASP activity instead of an IRD. This may include triggering an inquiry (with investigative powers) or calling a formal professionals meeting to allow more in-depth discussion and analysis than an IRD would allow. Even with these exceptions, the principle of the 5 report maximum threshold remains the same – namely - that no individual should be subject to multiple episodes of ASP reporting without some form of multiagency discussion and consideration.

Disagreeing With a Decision

The Social Work Teams undertaking the screening of an Adult Support and Protection Referral may decide that no further ASP action is required. This will be recorded and should be reported back to the referrer. If a referrer disagrees with the decision of the screening social work team to not proceed under ASP, they should firstly have an open and professional discussion with the screening social work team. If the disagreement cannot be resolved, the matter should be escalated using the agreed multiagency escalation process.

Sharing of Information

Chapter 3 of this protocol discusses the duties of other organisations and partners in relation to Adult Support and Protection.

Section 6 – Adult Protection Investigative Powers

It is important that this section be read in conjunction with the National Code of Practice for ASP (CoP) and any existing local agency procedures relating to operational adult protection activity.

Chapter 6 - 7 of the CoP gives an overview of the powers contained within the ASP Act and the role of the Council Officer in utilising these powers:

Topics covered include:

- Investigative powers used during inquiries
- ASP visits to the person – the purpose and how these should be conducted
- What action can be taken if entry is refused including granting of warrants and what to do in emergency situations.
- How an interview should be conducted and the adult's rights during the interview
- Other persons who may also be interviewed

Chapter 9 of the CoP provides guidance on Section 9 of the Act which allows health professionals to conduct a medical examination.

Chapter 10 of the CoP provides guidance on Section 10 of the Act which enables the council officer to access records to establish if further action is required to protect the adult from harm.

The following should be considered alongside the CoP:

Cross Boundary Working

If more than one Council is involved with an adult, because the adult lives in a different place from their home address, the Council where the adult lives will lead any investigation. Relevant professionals from the other Council must be informed and their views considered.

Visits and Interviews

Although the CoP states that the Council Officer may be accompanied by another person (p52) in Grampian the Council Officer **must** be accompanied by a second person. The second person should be an appropriate person defined by either qualification, experience, or existing relationship with the adult. Regardless of the background of the second person the Council Officer must be satisfied that they are able to work in a trauma informed and person-centred manner.

Interviews need to be co-ordinated in a way that promotes the best outcome for the adult. The way in which interviews are carried out can play a significant part in minimising any distress to the adult and their family/carers. This increases the likelihood of maintaining constructive working relationships and using a trauma informed approach. It is important that the professionals carrying out the interview are

prepared by having a pre-interview discussion. Decisions made in this meeting can be recorded on the Plan for Adult Protection Interview.

Joint planning ensures that best evidence is gathered on which to make decisions and support any legal proceedings by:

- ensuring that the immediate safety of the adult is considered and secured
- considering and addressing any issues relating to the capacity of the adult or their ability to communicate, in order to facilitate participation in the interview.
- enabling effective information gathering so the adult is not subjected to repeat inquiries, interviews or medical examinations.
- ensuring issues of race, ethnicity, religion and culture of the adult, and the potential impact on the interview, are considered and appropriate action is taken.

Consideration should be given to the following practicalities surrounding the interview/visit:

- Who should be interviewed, for what purpose, by whom, where and when
- Who should lead the interview; taking account of the experience of professionals involved, likely preference of the adult, previous involvement with the adult, nature of the allegation
- The timing and handling of interviews with the adult, their family/carers and witnesses
- How the interview will be recorded and how information will be shared between interviewers, interviewees, and other relevant agencies

Every effort should be made to visit the adult's home environment and/or the environment where the alleged harm took place and undertake a professional assessment of that environment. In visiting these settings, care should be taken about personal safety.

If an allegation of harm involving a crime has been made and reported to the Police, staff need to be aware of the need to balance the requirement to preserve forensic evidence against the needs or wishes of the adult. Where there is a belief that something may be a piece of evidence or be relevant to a police investigation, it should be preserved and kept securely until it can be handed to the police. Forensic evidence may include bank statements, items of clothing, photographs, or correspondence, etc.

Council Officers may experience barriers to their visit because of; the adult's chaotic routine, a refusal to co-operate or a concern that the visit will cause significant distress. Carers or family members, who may or may not be the harmer, could also present barriers to the visit. Council Officers need to consider how best to proceed, taking into account any risks identified and alternative actions available. Where barriers persist, support should be sought from Line Management or appropriate persons within the organisation.

The following may feature in an agreed plan to gain access where barriers exist: (this list is not exhaustive)

- Police safe and well check

- Involvement of other agencies
- Seeing the adult out with their home
- Application for a Warrant for Entry to allow entry should they be refused

When working with adults under the Act it is always best practice to support the adult to participate as fully as possible – please see Section 4.

The CoP provides guidance on circumstances which allow a healthcare professional to conduct a medical examination in private where adults are known or believed to be at risk of harm.

It discusses:

- Who may conduct a medical examination.
- The purpose of the medical examination.
- When a medical examination should be undertaken.
- Considerations to the adults wishes regarding the medical examination and their consent.
- Where it is not possible to obtain informed consent from the adult due to a lack of mental capacity or an ability to communicate.

Medical Examinations

There is also separate guidance for General Practice and Primary Care which can be found here.

Under the Act, medical examinations can occur during a Council Officer visit or as part of an Assessment Order. A health professional may conduct a medical examination in private, this could include a physical, psychological, or psychiatric assessment or examination. The examination can be carried out during a visit even if an Assessment Order has been granted to enable a medical examination elsewhere.

Within Grampian, a Council Officer should request this examination by completion of the ASP Medical Examination Request Form, except in circumstances where the adult requires immediate medical treatment.

If the medical examination relates to issues regarding the mental capacity of the adult at risk to make particular decisions and/or judgements, there is a Multiagency Decision Specific Capacity Screening Tool available to support such requests for assessment.

A 'standard' medical examination does not then rule out a forensic examination being requested by the police, but on occasion may inform the need for a forensic medical examination. Police Scotland will always lead on requests for forensic examinations due to the potential criminality involved.

On completion of the medical examination, the findings will be detailed by the health professional on the Medical Examination Request Form. This form will be retained in the adult's medical notes and a copy retained by the Council Officer.

The CoP provides guidance on Section 10 of the Act, which provides that a council officer may require any person holding health, financial or other records relating to an adult known or believed to be at risk, to make these records available to the officer, if this is required to establish whether further action is needed to protect that adult from harm.

It discusses:

- Information Sharing and Confidentiality;
- Whether as adult has to consent to access to their records;
- Who may access the inspect records;
- How records may be accessed; and
- Whether the record keeper must comply with the request for access.

Examination of Records

Records should be accessed, and information shared only where disclosure will provide benefit to the adult which could not reasonably be provided without such an intervention.

A Council Officer may request records including those held in electronic, audio, visual or other formats. This can be requested during a visit. Records can also be requested in writing using the following documents;

- Protocol for Requesting Information from Financial Institutions Under Section 10 Adult Support and Protection (Scotland) Act 2007
- Health Information Request Form

Section 7 – Assessing and Managing the Risk of Harm

It is important that this section be read in conjunction with the National Code of Practice for ASP (CoP) and any existing local agency procedures relating to operational adult protection activity.

Chapter 8 of the CoP addresses some of the matters that partnerships should bear in mind in relation to multi-agency risk assessment and decision making processes, and also with regard to large scale investigations and learning reviews.

Topics covered include:

- Risk Assessment and Risk Management
- Chronologies
- Case Conferences
- Large Scale Investigations
- Learning Review

The following should also be taken into account alongside the CoP:

Impact of the Adults Capacity

The Council Officer has to form an initial view on capacity. The Council Officer may then need to move to seek a capacity assessment using the Decision Specific Capacity Screening Tool and Capacity Assessment Pathway. Certain legal interventions require a medical practitioner to undertake an assessment of an adult's capacity. Best practice dictates that any such assessments should be based on multi-disciplinary information and feedback. Therefore, the initial judgement on whether an adult has capacity may not necessarily be the final judgment. By law an adult must be assumed to have capacity unless found otherwise.

The initial assessment of capacity should be based on contemporary knowledge from care providers/family members/guardian and any known formal assessments recorded in the adult's files.

Where the adult appears to lack capacity, consideration should be given to alternative relevant legislation such as the Adults with Incapacity and Mental Health Acts. Where a decision has to be made urgently about capacity, consideration must be given to the circumstances/risks and immediate actions required.

A Capacity Pathway for Protection Based Decisions is in place to support professionals requiring capacity assessments in Adult Support and Protection cases.

In all circumstances, account should be taken of an individual's present and past wishes, while noting that these may not necessarily change the outcome/decisions made.

Risk Assessment and Risk Management

Risk is the possibility of harm occurring and the severity of that harm. Risk assessment is the process of identifying risk and enabling decisions to be taken about whether new or improved risk controls, or protective measures, are required. Effective person-

focused risk assessment relies on the active participation of all agencies/teams involved. Legislation requires that risk assessment be "suitable and sufficient". This means that the degree of effort put into risk assessment needs to be proportionate to the risk involved.

Informal risk assessments are carried out every day upon both professional and personal experience, enabling risk to be recognised and necessary precautions to be taken. These everyday judgements and decisions are an individual's responsibility and a core professional competence which underpins everything we do. Formal risk assessments are a documented evaluation of risk including potential severity of consequences and the likelihood of such an occurrence along with the preventative and protective measures in place to control the risk. The aim is to weigh up whether existing support is adequate or whether more should be done to reduce the risk to an acceptable level through improved protective measures or contingency plans.

Risk assessments must be shared between all agencies/ teams involved to ensure the consistency of response and of care provided. A multi-agency risk assessment enables commitment of all involved to implement and comply with any protective measures agreed as essential to ensure the Health & Safety of the adult, staff, and any other persons who could be affected. In respect of environmental or low-level personal risks the risk assessment forms may be completed by one member of staff. The multi-disciplinary adult protection risk assessment must be completed with full input from all professionals who are supporting an adult.

The Preliminary Risk Identification Form is completed by the Council Officer during the ASP inquiry. This information will be used by the multi-agency team around the person to complete the Adult Protection Risk Assessment.

An up-to-date chronology, if not already available, should be completed, by the Council Officer when using Investigatory powers. A comprehensive, up-to-date and well-balanced multi-agency chronology should underpin the associated risk assessment and protection plan. Care Inspectorate guidance on producing chronologies should be referred to when undertaking this work.

Case Conferences

An ASP Case Conference will be chaired by a Council Officer with supervisory experience.

Information shared at case conferences must be in line with the Grampian Information Sharing Protocol. There may be circumstances where a closed information sharing section for professionals only is necessary. This would be to allow for the sharing and discussion of information that cannot be disclosed to the adult or their representatives. Such information could include: police intelligence disclosures; third party information; and/or particularly sensitive and distressing information.

Whilst it is recognised that such restricted material may have to be shared in some circumstances, Chairs must remain mindful of their responsibilities to be both person centred, trauma informed, and involve the adult as much as possible. As a result, every effort should be made – where possible - to avoid circumstances where an adult at risk feels they are being "spoken about" when not present. Specific arrangements will vary based on the adult at risk's circumstances, but should attempt to minimise any distress whilst remaining honest with the adult that some discussions may need to be

held without them present. It is recognised that this will require specific skills and knowledge by the Chair of the case conference process.

Involvement of the adult in a case conference is a fundamental part of the process, as is them being supported through the process. There may be times when they want this support to be provided by a friend, other relative or professional or an independent service such as Advocacy or Victim Support. Their attendance should be positively encouraged.

Where the adult has not attended the case conference or is not invited, the reasons for this should be detailed in the Case Conference minute along with detail of how their views have been gathered.

Grounds for exclusion of the family/representative would be when:

- a level of conflict or tension exists with the family/representative; or
- there is substantive evidence to believe that there is a likelihood of serious disruption to the Case Conference.

Where family/representative have information or views that are relevant to the case conference, attempts should be made to facilitate their involvement i.e., separate attendance from adult/view gained prior to meeting.

The Case Conference will confirm the adult at risk's status, assess risk and produce a protection/action plan. This will include, but not limited to, consideration of:

- any immediate action required to protect the adult.
- whether to apply for any formal ASP protection orders.
- Requirement for capacity assessment
- using other legislation (AWI / MHCT).
- contract compliance.
- training needs.
- what support may be required for the adult / family /carers and who will provide this what monitoring arrangements will be put in place.
- involvement of agencies including but not limited to the Council Services, Police, Health Services, Care Inspectorate, Mental Welfare Commission and the Office of the Public Guardian

Once a decision has been made on the support and protection considered necessary, the Case Conference chair will identify explicitly who will be responsible for completing tasks, timescales, and a sequence of events.

The case will continue to be subject of review until the risk has been removed or reduced to an acceptable level. A review date must be agreed within a maximum of 6 months of the original Case Conference.

Where there is no clear consensus regarding an assessment if a person is an adult at risk of harm, the Chair will use his or her professional judgement to make the final decision, based on an analysis of the issues raised.

The Chair will confirm the accuracy of the minute. Third party restricted information will not be shared within the minute. Following this the minute must be made available to all who were invited, together with a copy of the Adult Support and Protection Plan (if applicable), within 14 days of the Case Conference. The minute and plan must also be made available to any other professional actively involved in the adult's support.

It is vital that the adult and any relevant family receive appropriate information from the meeting. This could be through sharing the minute however consideration needs to be given to alternatives, so information is presented in a person centred and trauma informed way in line with the adults preferences and communication needs. This will be discussed at the case conference.

Should there be any concerns in relation to sharing information, reference should be made to the Information Sharing Protocol.

Protection Plans

Informed by the risk assessment, the Case Conference will produce an Adult Protection Plan. The protection plan will detail the actions required to manage the identified risks. This could include, but is not limited to:

- Existing control measures, as identified in the risk identification/assessment e.g., informal support networks, existing services, the adults own resilience, etc
- Statutory interventions e.g., Adult Protection Orders, AWI processes, etc
- Any other interventions or measures that have been identified through discussion at case conference.

Protection plans should be developed in line with the ASP principles and the adult should be encouraged to be actively involved in the development and implementation of their plan as far as is possible. The protection plan should be a key document and focus for all professionals working with the adult or with responsibility for monitoring risks. The plan will detail responsible parties for all actions, including for monitoring and reviewing. It will be the basis for discussion at the formal Adult Protection review, where the effectiveness of the plan will be considered against the identified risk.

There is a tendency to believe that adults at risk of harm should be protected and that their right to choose is secondary to this. This is not the case; Adults at risk are individuals and, if they are deemed to have capacity, and if there is no evidence of undue pressure, they must be allowed to exercise their rights, even if that means they choose to remain in a situation some people would consider inappropriate or harmful. Every effort should be made to support the adult to consider the impact of the choice they may be making and to offer viable alternatives. This should include reviewing existing support arrangements.

Large Scale Investigations (LSIs)

Local processes can be found in the Interagency Procedure for Large Scale Investigations of Adults at Risk of Harm in Managed Care Settings, contained within the appendices.

Learning Reviews

Learning reviews were formerly known as initial or serious case reviews. Local guidance can be found in the Grampian Adult Protection Committee Learning Review Procedures.

Section 8 – Protection Orders

It is important that this section be read in conjunction with the National Code of Practice for ASP (CoP) and any existing local agency procedures relating to operational adult protection activity.

Chapter 11 of the CoP covers:

- What to consider before applying for a protection order
- The issue of the adult's 'consent' in relation to protection orders, including 'capacity' and 'undue pressure'

Chapters 12 to 14 include specific information in relation to the three types of order, including:

- What each order is, when it should be considered, and who should apply for it;
- Criteria for granting each type of order;
- Requirements relating to Notifications and Hearings (as relevant);
- Relevant timescales;
- Warrants for entry;
- Cases of urgency; and
- Expiry of the order / if the adult no longer wishes to consent.

Protection orders (a term used in section 35 of the Act) cover:

- **assessment orders** (which involve taking a person from a place in order to carry out an interview or medical examination);
- **removal orders** (removal of an adult at risk); and
- **banning orders or temporary banning orders with or without a power of arrest** (banning of the person causing, or likely to cause, the harm from being in a specified place and/ or preserving property)

Applications for protection orders must be made by the council, except for banning orders where the application may also be made by or on behalf of the adult whose well-being or property would be safeguarded by the order or any other person who is entitled to occupy the place concerned. This section will apply to applications made by the council.

The decision to apply for a protection order will be a multi-agency decision. The council will then arrange for the submission of the application. Evidence must then be given on oath to the sheriff, as per section 38(2). Multi-agency collaboration should continue as necessary in relation to the use of protection orders for specific individuals.

In relation to Banning Orders, as well as sending a copy of the Order with power of arrest to the Chief Constable of Police Scotland A copy of the paperwork will be sent to inform local Police Officers. This is done by emailing the Harm Reduction Unit:

NorthEastHarmReduction@scotland.police.uk

Appendices

APPENDIX 1

NHS Grampian | Aberdeen City Health & Social Care Partnership — A caring partnership | Aberdeenshire Health & Social Care Partnership | HEALTH & SOCIAL CARE MORAY

DECISION-SPECIFIC SCREENING TOOL
To assist with assessment of capacity

WHAT IS THIS TOOL?
This tool provides a structured way for professionals to consider systematically whether an adult requires a formal assessment of their capacity for decision making. It is designed to support professionals to consider key factors relating to an adult's capacity at an early point and record that information. It consists of two main parts and an appendix:

- **Part 1** – Captures standard biographical information about the adult for whom there is a query about capacity; the reason for the decision to refer for assessment; the presence of current risks to the adult; the adults views; and any practical considerations relating to facilitating an assessment of capacity.
- **Part 2** – Asks specific questions about various aspects of the adult's decision making abilities. This section allows professionals to focus on and capture where there may be concerns about capacity for decision making.
- **Appendix** – Contains a flowchart which clearly outlines the process to be followed in seeking a capacity assessment.

WHO IS IT FOR?
This tool is primarily designed for non-medical members of professional teams working with adults where there is a query in relation to an individual's capacity for decision making. It is designed to support such professionals in considering, and then agreeing, whether a formal assessment of capacity should be sought.

Any referral for assessment of capacity should be:

- **Specific** with regard to a particular decision to be made
- **Focused**, rather than a number of questions we would encourage referrers to focus on one or two questions which need examined
- **Timely**, i.e., assessed at the time the person is required to make the decision
- With a **clear potential outcome**, such as considering Guardianship under the Adults with Incapacity (Scotland) Act 2000

It is also important that a person has been given information and all necessary support regarding their choices and communication to allow them the opportunity to make a decision and/or express their preferences. This is a key principle of supported decision making.

WHAT HAPPENS NEXT

Once the tool is completed, and it indicates the need for a capacity assessment, the document should be sent to the appropriate professional/team. This will vary depending on the adult's needs and circumstances. If the capacity assessment is related to **protection based decisions (such as Adult Support and Protection matters)** there is an agreed Capacity Pathway which will tell you where to send this document.

Each referral will be discussed once received and allocated to the most appropriate professional. Input may be multidisciplinary, requiring specific input from multiple professionals e.g. speech and language therapy, clinical psychology.

Some standard timelines have been agreed for the delivery of capacity assessments

Type of Request	Target Timeline
Urgent Assessment [Adult Support and Protection cases and other cases where there is clear potential risk of harm to the adult or others]	Maximum **4 weeks** from receipt of tool (may be earlier)
Standard Assessment	Maximum **3 months** from receipt of tool (may be earlier)

Please note, some assessments may take longer than the indicated timelines to complete, due to the clinical complexity of the person being assessed.

Additionally, regardless of whether the outcome of this tool is to refer for a capacity assessment, if professionals have concerns about an adult's vulnerability and risk – they must consider and follow the appropriate **Adult Support and Protection** referral processes. If there are issues or concerns about the process of seeking a capacity assessment, these should be **escalated** to your line manager immediately.

APPENDIX 1

FURTHER READING:

- [Adults with Incapacity (Scotland) Act 2000: Communication and Assessing Capacity: A guide for social work and health care staff]
- [Mental Welfare Commission Good Practice Guide: Supported Decision Making]

PART 1

<table>
<tr><td>Name of Adult</td><td></td><td>CareFirst No.</td><td></td><td>CHI:</td><td></td></tr>
<tr><td>Worker Details</td><td></td><td>Date</td><td></td><td colspan="2"></td></tr>
<tr><td colspan="6">Capacity is the ability to understand information relevant to a particular decision or action; understand the benefits, risks and alternatives of the decision; ability to weigh up the possible outcomes in order to arrive at a decision; ability to communicate the decision to others, ability to remember the decision or show consistency in decision making and ability to act on the decision.</td></tr>
<tr><td colspan="6">This tool aims to assist the practitioner consider the various elements involved in the decision making process. It may be used to gather evidence of an adult having or lacking capacity in relation to specific decisions and also to consider whether a more formal assessment is required in order to pursue measures under the Adult with Incapacity (Scotland) Act 2000.</td></tr>
<tr><td colspan="2">Reason for assessment:
What are the current concerns (including Child and Adult Protection)

How long has there been a concern regarding capacity?</td><td colspan="4"></td></tr>
<tr><td colspan="2">Are there risks to the person of concern?</td><td colspan="4"></td></tr>
</table>

APPENDIX 1

<table>
<tr><td colspan="2">NB it is the referrer's responsibility to implement a reasonable risk management plan.</td><td colspan="2"></td></tr>
<tr><td colspan="2">Details of the adults views on the decision to be made or action to be taken</td><td colspan="2"></td></tr>
<tr><td colspan="2">Where should the person be seen?

Are there any known risks to staff?</td><td colspan="2"></td></tr>
<tr><td colspan="2">What are the key decisions facing the adult for which capacity is being queried?</td><td colspan="2"></td></tr>
<tr><td colspan="4">Who was consulted in forming your opinion of the adult's decision-making ability?</td></tr>
<tr><td>Name</td><td>Relationship with Adult</td><td>Contact Details</td><td>View</td></tr>
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APPENDIX 1

PART 2

Q: Does the adult have a mental disorder (diagnosed or suspected) or are they unable to communicate because of a physical disability?	**Yes**	**No**	**Not Sure**	*For example: dementia, learning disability, brain injury, personality disorder, neurological condition, mental illness etc.*	**Condition**

If you have answered No to this question a capacity assessment is not applicable, however an adult may still be unable to safeguard themselves and appropriate Adult Support and Protection measures should be considered.

If you are not sure whether someone has a mental disorder, or what kind of mental disorder they have, seek assessment of this through the usual referral channels.

APPENDIX 1

Q1: Do you consider the adult **able** to **understand** the information relevant to the decision? Has this information been provided in way that he/she is able to understand?	**Yes**	**No**	**Not Sure**	*For example: a lady with learning disabilities who has never managed her own finances may need to receive information in an accessible manner. Information may need to be repeated.*	**Supporting Evidence**
Q2: Do you consider the adult **able** to **retain the information** for long enough to use it in order to make a choice or an effective decision?	**Yes**	**No**	**Not Sure**	*An adult may need to be asked on several occasions to confirm the consistency of their response. Where a person has difficulty remembering the decision but answers consistently this makes their decision valid.*	**Supporting Evidence**
Q3: Do you consider the adult able to weigh up the information about this decision?	**Yes**	**No**	**Not Sure**	*This may include understanding the consequences of the decision for themselves and others and weighing up the possible outcomes in order to arrive at a decision.*	**Supporting Evidence**

Q4: Do you consider the adult **able** to **communicate** the decision?	**Yes**	**No**	**Not Sure**	*Every effort should be made to facilitate communication including talking mats, sign language, interpreter, engaging Speech and Language Therapy etc.*	**Supporting Evidence**
Q5: Do you consider the adult **able** to **act upon** the decision?	**Yes**	**No**	**Not Sure**	*A person may show good reasoning and ability to understand and make the decision however when confronted with the situation, may not be able to use this reasoning to act, due to mental illness or cognitive impairment.* *For example: an adult with hoarding disorder may have shown capacity to understand and make a decision about others assisting with tidying however does not act on his/her decision by allowing entry to his/her home, due to emotional response*	**Supporting Evidence**

				associated with their hoarding disorder *For example: an adult with brain injury and executive functioning difficulties may have shown capacity to understand and make decisions about day to day budgeting however when shopping in town spends a month's allowance on new clothes due to difficulties inhibiting response in the situation.*	
Q6: Have efforts been made to support the person to make the decision themselves?	**Yes**	**No**	**Not Sure**	*Interventions can be used to improve an individuals'* • *Ability to make decisions'* • *Memory or attention* • *Ability to organise and process information e.g. Speech and Language Therapy, Advocacy, Assisted Communication Aids, Translators and neuropsychology*	**Supporting Evidence**
Q7: Overall, do you consider on the	**Yes**	**No**	**Not Sure**	**Any additional supporting evidence**	

balance of probability that the impairment or disability is sufficient that the adult lacks the capacity to make this particular decision?					
Any Further Comments:					

If you have answered **YES** consistently to Q1-Q6, and **NO** to Q7, the adult is considered on the balance of probability, **to have the capacity to make this particular decision at this time**. However consideration should still be given to other legislation e.g. Adult Support and Protection. Additionally Power of Attorney should also be considered.

Sign/date this form and record the outcome within the adult's records

If you have answered NOT SURE or NO to any of the questions, sign and date the form and **send this completed tool and any supporting documents to request a formal capacity assessment.**

Signature		**Date Assessment Completed**	

Acknowledgement: Adapted from documentation in use in NHS Forth Valley, NHS Lothian and City of Edinburgh Council.

Add in capacity

THRESHOLDS

Grampian Adult Protection - Good Practice Guidelines

Approvals			
Aberdeen City APC		23 April 2024	
Aberdeenshire APC		24 June 2024	
Moray APC		14 June 2024	
Review Date	On the same frequency as the over-arching Grampian Interagency Procedures for ASP)		
Responsibilities for review of this document: GWG Policy Sub Group			
Lead Author/Co-ordinator	Chair of GWG Policy Sub Group		
Revision History: (If there is no previous document please insert N/A into the boxes in the top row of the table below).			
Revision Date:	Previous Revision Date:	Summary of Changes (Descriptive summary of the changes made)	Changes Marked * (Identify page numbers and section heading)
Date agreed by APCs	March 2023 (draft) April 2024 (Final)	• Revisions to reflect revised National Code of Practice for ASP, • National Minimum Dataset (in particular, new sections on Discriminatory Harm & Domestic Abuse; section on Organisational Neglect now included with Neglect & Acts of Omission • Key contact details added • Adjustments based on evolving professional experience, expertise and knowledge	Page 5: Key Considerations Page 6: Adult's Views

Contents

	Page
Introduction	4
Definitions	4
Key Considerations	5
Adult's Views	6
Threshold Decision-Making Guidance	7
PHYSICAL HARM	8
SEXUAL HARM	9
PSYCHOLOGICAL / EMOTIONAL HARM	10
FINANCIAL / MATERIAL HARM	11
*NEGLECT / ACTS OF OMMISSION	12
*DISCRIMINATORY HARM	14
SELF-NEGLECT	15
SELF-HARM	16
*DOMESTIC ABUSE	17

Introduction

IT IS IMPORTANT TO CONSIDER IN THE FIRST INSTANCE WHETHER SOMEONE IS IN IMMEDIATE DANGER - OR HAS BEEN THE SUBJECT OF A CRIME. CRIMINAL ACTS MUST BE REPORTED TO THE POLICE AND/OR EMERGENCY TREATMENT SHOULD BE SOUGHT WHERE NECESSARY.

This document should be read in conjunction with the Grampian Interagency Procedures for Adult Support and Protection and the National Code of Practice.

Thresholds in the field of Adult Support and Protection have been a much-discussed issue, particularly since the implementation of the Adult Support and Protection (Scotland) Act 2007 ('the Act'). Whilst the Act provides clear definitions of an Adult at Risk and harmful behaviour, there remain situations that are 'borderline' where the distinction between a more general concern about care and support and an Adult Support and Protection matter may be unclear.

This guide seeks to support practitioners, partners and providers, working within the adult care services, to report and respond to concerns at the appropriate level and to have a consistency of approach across agencies. This guidance is not a substitute for professional judgement, but should be used to assist decision-making and to support professional judgement.

Definitions

Who is at risk? (Three Point Test)

The Act defines an 'adult at risk' as a person aged 16 years or over who:

- **is unable to safeguard her / his own well-being, property, rights or other interests; <u>and</u>**
- **is at risk of harm; <u>and</u>**
- **because they are affected by disability, mental disorder, illness or physical or mental infirmity are more vulnerable to being harmed than adults who are not so affected.**

The presence of a particular condition does not automatically mean an adult is an 'adult at risk'. An adult may have a disability but be able to safeguard their well-being etc**.**

It is important to stress that all three elements of this definition must be met. It is the whole of an adult's particular circumstances which can combine to make them more vulnerable to harm than others.

Harm

Harm is an emotive term and can be subject to wide interpretation. Within the Act, harm is defined as including all harmful conduct and in particular:

- conduct which causes physical harm (including that of a sexual nature).
- 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).

- conduct which causes self-harm.

Harm can happen anywhere, including at private addresses, in hospital and registered care settings or in the community. Harm may involve elements of a power imbalance, exploitation and the absence of full consent. It can be the result of neglect, by self or others.

Key Considerations

- **Is someone in immediate danger? Have they been the subject of a crime? If so, report to the Police and / or seek emergency treatment as necessary.**
- How long has the alleged abuse been occurring?
- What is the seriousness or impact of the suspected harm on the individual?
- Is there a pattern of abuse?
- Has trauma impacted the adult's ability to keep themselves safe?
- Have there been previous concerns – not just safeguarding adult referrals, but other issues related to the adult, e.g. Anti-social behaviour, hate crime incidents and also in relation to the person alleged to be causing harm?
- Has a previous plan to mitigate the concern not been successful – has it lacked robustness or implementation?
- Are any other adults at risk?
- Is the situation monitored?
- Are the incidents increasing in frequency and/or severity?
- Are there children present? If so, consider making a referral to Children's Services.
- *Make any notifications to relevant regulatory bodies (e.g. Care Inspectorate, OPG, MWC)

Adult's Views

Whether an incident is low risk or high risk, the adult's views and wishes are central to the assessment and support. When considering the impact, always identify and record the adult's feelings regarding the incident. What effect did it have on the individual? In accordance with the principles of the Act, any intervention in an adult's affairs should provide benefit to the adult which could not reasonably be provided without intervening in the adult's affairs, and be the option that is least restrictive to the adult's freedom. *Consideration should be given to what help the adult might need to put across their views and wishes, and also possible referral to an independent advocacy service.

****For further advice****

If, after reading this Guidance, you are still in doubt about whether or not to make an ASP Referral, **please contact the following Adult Social Work teams in each area:**

Area	Telephone	Email
Aberdeen City	0800 731 5520	apsw@aberdeencity.gov.uk
Aberdeenshire	01467 533100	adultprotectionnetwork@aberdeenshire.gov.uk
Moray	01343 563999	Accesscareteam@moray.gov.uk

For local independent advocacy services, contact:

Area	Advocacy Service	Telephone	Email
Aberdeen City	Advocacy Service Aberdeen	01224 332314	asa@advocacy.org.uk

Aberdeenshire	Advocacy North East	01467 651604	admin@advocacyne.org.uk
Moray	Circles Advocacy, Moray	01343 559546	Info.moray@circlesnetwork.org.uk

Threshold Decision-Making Guidance

Level of Risk	Risk Tolerance
Low	Low risk incident where threshold of further enquires under ASP are unlikely to be met. Agencies should keep a record of the incident, following own internal process. Where there are a number of low-risk incidents, consideration should be given as to whether the threshold is met to report under ASP due to increased risk.
Medium	Incidents at this level should be discussed with the local adult protection service. After the conversation, they may request you formally report the concern as Adult Support and Protection.
High	Incidents at this level should be reported to your local adult protection service. NB: You may also need to contact the police/emergency services.

The tables below provide examples of incidents and possible actions that should be considered. **These are offered as examples only and should not be considered exhaustive**. It is also important to review all incidents previously recorded, as an accumulation of incidents may meet the criteria for an adult protection referral.

APPENDIX 2

Refer also to 3 Point Test on Page 4, and Threshold Decision-Making Guidance on Page 7

Type of harm	Non-Reportable	Requires Consultation	Reportable
	Low risk No impact	Medium risk Some harm or risk of harm	High risk Significant harm or risk of harm
PHYSICAL **When a person is mistreated harmed physically.** Hitting, slapping, pushing, kicking, misuse of medication, restraint or inappropriate sanctions, force-feeding, burning, or scalding.	No harm/impact has occurred. Isolated incident, unlikely to happen again. Robust recording is in place. Relevant and appropriate risk assessments/action plan in place. • Physical contact but not with sufficient force to cause a mark or bruise, and adult is not distressed. • Error by staff causing little/no harm e.g. skin mark due to ill-fitting hoist. • Appropriate moving and handling plan / procedures not followed on one occasion not resulting in a fall or harm. • One off incident of falling which was witnessed or easily explained, where no harm has occurred	Repeated incidents/patterns of similar concerns / Accumulation of minor incidents. Risk can be managed appropriately with current supports in place. Incident not caused by a person of trust i.e. carer, staff member. • Unexplained minor marking or lesions, minor cuts or grips marks found on a number of occasions or on a number of service users cared for by the same team/ carer • Carer breakdown • Appropriate moving and handling plan / procedures not followed on more than one occasion whether of not they in harm. • Multiple incidents or unexplained falling which may or may not result in harm and there are concerns about their ongoing management • Minor physical assault, where there is no significant injury or distress	Unexplained, significant injuries. Incident caused by a person of trust i.e. carer, staff member. Risk cannot be managed appropriately with current professional oversight supports in place • Assault Intended harm towards a service user • Deliberately withholding food, drinks, aids to independence or medication • Physical assaults or actions that result in significant harm or where there is ongoing distress to the adult. • Predictable and preventable incident between adults where injuries have been sustained or emotional distressed caused • Any inappropriate restraint whether or not medical treatment is required • Disregard to moving and handling plan / procedure that causes injury • Fall, whether witnessed or not, resulting in significant injury, and there are concerns about the management of the fall risk
Actions/Outcomes to consider at every stage.	Support to vulnerable adult – provide medical support, provide advice and reassurance. Ensuring immediate safety and ongoing safety planning. Advice, information, review of needs/services/care plans, risk management planning, referral to other agency, staff training, disciplinary process, Carer's assessment, GP appointment.		**Make an ASP Referral**. If there is an indication a criminal act has occurred, the police MUST be contacted. Immediate safety plans must be implemented. Consider also Actions / Outcomes as identified for Low and Medium Risk

APPENDIX 2

Refer also to 3 Point Test on Page 4, and Threshold Decision-Making Guidance on Page 7

Type of harm	Non-Reportable	Requires Consultation	Reportable
	Low risk **No impact**	**Medium risk** **Some harm or risk of harm**	**High risk** **Significant harm or risk of harm**
SEXUAL **When a person is mistreated or harmed sexually.** Can include rape and sexual assault or sexual acts to which the adult at risk has not consented, could not consent or was pressured into consenting. Also inappropriate touching, sexual assault or using inappropriate sexual language. Does not have to be physical contact and can happen online. Domestic abuse / coercive control.	Not committed by a person of trust i.e carer, staff member, AND isolated incident or unwanted attention, either verbal or physical where there is no or low impact on the adult. Where robust recording and relevant and appropriate risk assessments/action plan are in place. • Isolated incident when an inappropriate sexualised remark is made to an adult and no distress is caused.	• Non-contact sexualised behaviour which causes distress to the person at risk • Verbal sexualised teasing or harassment • Being subject to indecent exposure	• Concern of grooming or sexual exploitation (including online) e.g. made to look at sexually explicit material against their will or where consent cannot be given • Rape, sexual assault, voyeurism, sexual harassment • Contact or non-contact sexualised behaviour which causes distress • Indecent exposure that causes distress • Any sexual act without valid consent or pressure to consent • Sex activity within a relationship characterised by authority, inequality or exploitation e.g. receiving something in return for carrying out sexual act (Could become risky for the individual) • Being subject to indecent exposure • Individual responsible for the harm is also a vulnerable adult Any concerns regarding a person of trust i.e carer, staff member.
Actions/Outcomes to consider at every stage.	• Education around safe sexual relationships and conduct. Case management, review of care plan and risk assessments. • Complaints, disciplinary processes, information for service users around expected standards of conduct, increased monitoring for specified period. Consider referrals to health and police. • Consider potential harm to others.		**Make an ASP Referral**. If there is an indication a criminal act has occurred, the police MUST be contacted. Immediate safety plans must be implemented. Consider also Actions / Outcomes as identified for Low and Medium Risk

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Type of harm	Non-Reportable	Requires Consultation	Reportable
	Low risk No impact	Medium risk Some harm or risk of harm	High risk Significant harm or risk of harm
PSYCHOLOGICAL/ EMOTIONAL **When a person is mistreated or harmed emotionally.** Including emotional abuse, threats of harm/abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services / supportive networks. Causing fear or distress, not giving the person an opportunity to express their views.	No impact has occurred. Simply resolved, internal policies and procedures followed, robust recording is in place, relevant and appropriate risk assessments/action plan in place. • Isolated incident where adult is spoken to in a rude or other inappropriate way – respect is undermined but no distress is caused. • Infrequent taunt or outbursts from other vulnerable adults that cause no distress. • Withholding information from an adult, where this is not intended to disempower them.	Repeated incidents/patterns of similar concerns. Risk can/cannot be managed appropriately with current professional oversight or universal services. • Carer breakdown. • The withholding of information leading to disempowerment but minor impact. • Occasional taunts or verbal outburst that do cause distress. • Repeated incidents of denying or failing to value an individual's opinion, particularly in relation to service or care they receive.	• Coercive Control • Denial of Human Rights/civil liberties, • forced marriage, • Prolonged intimidation • Vicious, personalised verbal attacks • Emotional blackmail • Frequent and frightening verbal outburst or harassment • Intentional restriction of personal choice or opinion • Concerns regarding "cuckooing" • Cyberbullying • Radicalisation. Any concerns regarding harm being caused by a person of trust i.e carer, staff member.
Actions/Outcomes to consider at every stage.	Support to adult – advice and reassurance. Ensuring immediate safety. Safety planning. Building resilience. Mental Health Support Referral to other organisations. Multi-agency Care planning and review. Undertake or review risk assessment.		**Make an ASP Referral**. If there is an indication a criminal act has occurred, the police MUST be contacted. Immediate safety plans must be implemented. Consider also Actions / Outcomes as identified for Low and Medium Risk

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FINANCIAL / MATERIAL **When a person's money or material goods are subject to theft, fraud or exploitation.** Can include theft, fraud, exploitation, pressure in connection with wills, property, inheritance, financial transactions, or the misuse or misappropriation of property, possessions or benefits.	No impact has occurred. • Failure by relatives to pay care fees/ charges where no harm occurs and adult receives personal allowance or has access to other personal monies. • Money is not recorded safely or properly. • Risks can be managed by current professional oversight or Universal Services • Incident of staff personally benefiting from the support they offer in a way that does not involve the actual abuse of money • Isolated and unwanted cold calling/door step visits Not caused by a person in a position of trust.	Repeated incidents/patterns of similar concerns. Risk can/cannot be managed appropriately with current professional oversight or universal services. Incident impacts on person's wellbeing or causes distress. • High level of antisocial behaviour • High level of visitors to property and service user appears unable to say "No" (including bogus workmen) • Adult monies kept in joint bank account – unclear arrangements for equitable sharing of interest • Adult not routinely involved in decisions about how their money is spent or kept safe • Non-payment of care fees putting the persons care at risk Incident not caused by person in a position of trust.	• Restricted access to personal finances, property and/or possessions • Personal finances removed from adult's control without legal authority • Fraud/exploitation relating to benefits, income, property or legal documents. • Adult coerced or misled into giving over money or property. • Misuse/misappropriation of property, possessions or benefits by, or incident involving, a person in a position of trust or control, including Power of Attorney
Actions/Outcomes to consider at every stage.	Support to Adult – debt advice, safe money management, scam awareness, support to liaise with DWP, banks, other agencies. Referrals to Adult Social Care, Legal, Neighbourhood Policing, Trading Standards. Review of care plan. Consider technology to reduce risk. Organisational processes in place to reduce risk of financial harm.		**Make an ASP Referral.** If there is an indication a criminal act has occurred, the police MUST be contacted. Immediate safety plans must be implemented. Consider also Actions / Outcomes as identified for Low and Medium Risk

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Type of harm	Non-Reportable	Requires Consultation	Reportable
	Low risk **No impact**	**Medium risk** **Some harm or risk of harm**	**High risk** **Significant harm or risk of harm**
NEGLECT/ ACTS OF OMISSION **When a person is deprived of the means to meet their basic physical and psychological needs** Can include ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, withholding necessities of life, such as medication, adequate nutrition or heating. Including as a result of the structure, policies, processes or practices within an organisation resulting in ongoing neglect or poor care.	No harm has occurred. Relevant and appropriate risk assessments/action plan in place. Appropriate care plan in place. Care needs not fully met but no harm or distress occurs • Issues or complaints around an adult's admission and/or discharge from Hospital where no harm has occurred • Isolated missed home visit where no harm occurs • Poor quality of care or professional practice that does not result in harm, albeit adult may be dissatisfied with service, eg Isolated incident of an adult not supported with food/drink and reasonable explanation is given; Adult not being bathed as per agreed care planning • Not having access to aids to independence. • Failure to administer medication which results in little or no impact on the person's physical or mental health or pain management. • Short term lack of stimulation or opportunities for people to engage in meaningful social and leisure activities and where no harm occurs • Single incident of insufficient staffing to meet all client needs in a timely fashion but causing no harm • Service design where groups of adults live together and are not compatible but no harm occurs	Repeated incidents/patterns of similar concerns. Risk can/cannot be managed appropriately with current professional oversight or universal services. • Health and wellbeing compromised due to ongoing lack of care • Carer breakdown. • Repeated health appointments missed due to unmet needs • Failure to administer medication that has a notable impact on the person's physical or mental health or pain management. • Rigid inflexible routines that are not always in the service user's best interests • Recurrent bad practice lacks management oversight and is not being reported to commissioners • Denying adult at risk access to professional support and services such as advocacy • Bad/poor practice not being reported and going unchecked.	Gross neglect. Continued failure to adhere with care plan. Lack of action resulting in serious injury or death. • Care plans not reflective of individuals' current needs leading to risk of significant harm • Failure to arrange access to lifesaving services or medical treatment • Ongoing lack of care to the extent that health and wellbeing deteriorate significantly resulting in, e.g. dehydration, malnutrition, loss of independence • Missed, late or failed visit/s where the provider has failed to take appropriate action and harm has occurred • Medication mismanagement that has a significant impact on the person's physical or mental health or pain management. • Intentionally or knowingly failing to adhere to relevant legislation and legal duties • Rigid or inflexible routines leading to service user's dignity being undermined • Punitive responses to challenging behaviours • Failure to refer disclosure of abuse. • Staff misusing their position of power over service users • Overmedication and/or inappropriate restraint managing behaviour • Recurrent incidents of ill treatment by care provider to more than one service over a period of time • Service design where group of adults living together are incompatible and harm occurs • All unsafe / unhygienic living environments
Actions/Outcomes to consider at every stage.	Support to the vulnerable adult – consider impact of other harms. Consideration of ways to increase dignity.		**Make an ASP Referral.** If there is an indication a criminal act has occurred, the police MUST be

APPENDIX 2

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	Referral to other agencies. Carer support. Multiagency care planning and reviews. Review of placement, consultation with family or service user. Reference to Guidance on Wilful Neglect, Ill Treatment and Corporate Homicide. Education/awareness raising to improve practice to both formal and informal care providers. Disciplinary processes and referral to regulatory bodies, eg Care Inspectorate. Commissioning referral, quality improvement plan, training, disciplinary action, complaint.	contacted. Immediate safety plans must be implemented. Consider also Actions / Outcomes as identified for Low and Medium Risk

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No impact</td><td>Medium risk
Some harm or risk of harm</td><td>High risk
Significant harm or risk of harm</td></tr>
<tr><td>*DISCRIMINATORY HARM

Includes actions (or omissions) and / or remarks of a prejudicial nature focusing on a person's age, gender, disability, race, colour, sexual or religious orientation.</td><td>No impact has occurred. Relevant and appropriate risk assessments/action plan in place. Good leadership and Management can be demonstrated. Incidents or behaviours do not cause any harm or disadvantage to the person or group affected by discrimination, or that are resolved quickly and satisfactorily.

• A person makes a joke based on a stereotype, but apologises and stops when challenged by someone else.
• A person uses an outdated or inappropriate term to refer to a protected characteristic, but corrects themselves and learns from their mistake.
• A person expresses curiosity or interest in a different culture or identity, but respects the boundaries and preferences of the person or group they are engaging with.</td><td>Dignity is undermined. Repeated incidents/ patterns of similar concerns. Risk can/cannot be managed appropriately with current professional oversight or universal services. Incidents or behaviours cause some harm or disadvantage to the person or group affected by discrimination, or create a risk of harm or disadvantage if not addressed.

• A person is excluded from a social or professional opportunity because of their protected characteristic, or a policy or practice unintentionally disadvantages a certain group of people.
• A person is subjected to microaggressions or subtle forms of discrimination, such as being ignored, interrupted, or patronised, because of their protected characteristic.
• A person is exposed to stereotypes or prejudices that negatively affect their self-esteem, identity, or belonging.</td><td>Widespread, consistent ill treatment. Incidents or behaviours that cause significant harm or disadvantage to the person or group affected by discrimination, or that create a high risk of harm or disadvantage if not addressed.

• A person is subjected to harassment, bullying, or violence because of their protected characteristic, or a culture or climate of fear, hostility, or intimidation is created or tolerated.
• A person is denied access to essential services, resources, or rights because of their protected characteristic, or a system or structure perpetuates inequality and oppression of a certain group of people.</td></tr>
<tr><td>Actions/Outcomes to consider at every stage.</td><td colspan="2">Awareness-raising and education on diversity and inclusion, challenging stereotypes and biases, providing feedback and guidance, and promoting positive interactions and relationships.

Providing support and advocacy to the person or group affected by discrimination, investigating and resolving complaints and grievances, reviewing and revising policies and practices, and implementing changes and improvements.</td><td>Make an ASP Referral. If there is an indication a criminal act has occurred, the police MUST be contacted. Immediate safety plans must be implemented. Provide protection and safety to the person or group affected by discrimination; take disciplinary or legal action against the perpetrators; challenge and transform systems and structures. Consider also Actions / Outcomes as identified for Low and Medium Risk.</td></tr>
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Significant harm or risk of harm</td></tr>
<tr><td>SELF-NEGLECT
When a person is living in a way that puts their health/safety or wellbeing at risk.
- Lack of self-care (threatens personal health and safety) including neglect for personal hygiene, health or surroundings
- Inability to avoid harm as a result of self-neglect
- Failure to seek help or access services to meet care needs
- Inability or unwillingness to manage one’s personal affairs</td><td>A concern about an adult who is beginning to show signs and symptoms of self-neglect. There is no/low risk or impact to self or others Risks can be managed by current professional oversight or universal services The person is not at risk of losing their place within the community

• Property neglected but all services/ appliances work
• Some evidence of hoarding – no impact on health/safety
• Non-compliant with support but no impact on health/safety/wellbeing</td><td>There is medium risk and some impact to self/others

• Some signs of disengagement with professionals
• Indication of lack of insight
• Lack of essential amenities/food provision
• Collecting a large number of animals in inappropriate conditions
• Increasing unsanitary conditions Non-compliance with medication – medium risk to health and wellbeing
• Property neglected, evidence of hoarding beginning to impact on health/safety
• Animals in property are impacting on the environment with risk to health.</td><td>Behaviour poses risk to self and others. Health & wellbeing is impacted significantly without intervention.

• Living in squalid or unsanitary conditions
• There is extensive structural deterioration/ damage in the property causing risk to life
• Refusal of health/medical treatment that will have a significant impact on health/ wellbeing
• High level of clutter/hoarding impacting on health and wellbeing, including fire hazard
• Ongoing lack of care to the extent that health and wellbeing deteriorate significantly resulting in, e.g. dehydration, malnutrition, loss of independence
• Individual has no access to support
• The individual is not accepting any support or any plans to improve the situation.</td></tr>
<tr><td>Actions/Outcomes to consider at every stage.</td><td colspan="2">• Assessment by service/professional of concern. Engage person -building relationships, understanding trauma to support individual to make improvements. Self determination. Recognition of root causes of self-neglect and available supports
• Onward referrals for support, including Environmental Health, Fire Service.
• Refer to local Self-neglect guidance. Multiagency meeting to discuss concerns.
• Refer to Self Neglect & Hoarding Guidance & Clutter Rating Tool</td><td>Make an ASP Referral. Immediate safety plans must be implemented.

Consider also Actions / Outcomes as identified for Low and Medium Risk</td></tr>
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	Low risk **No impact**	**Medium risk** **Some harm or risk of harm**	**High risk** **Significant harm or risk of harm**
SELF- HARM **When a person intentionally or unknowingly physically harms themself putting their health/safety or wellbeing at risk.** May manifest in various forms e.g. self-injury (such as cuts or burn marks), use / abuse of drugs / alcohol, eating disorder, or simply not looking after emotional or physical needs.	There is no/low risk or impact to self or others The self-harm has little or no impact on the person's physical or mental health or pain management. The individual in engaging well and the risks are being reduced. Risks can be managed by current professional oversight or universal services	The self-harm has a notable impact on the person's physical or mental health or pain management. Risks are not able to be effectively managed by current professional oversight or universal services There is no evidence or knowledge of a care plan that acknowledges and is aware of related self harm behaviours • Where harm has escalated in frequency and intensity. • Where behaviours have changed to more high risk and/or the adult has reduced or stopped engagement in their care plan.	The self-harm has a notable impact on the person's physical or mental health or pain management. Risks are not able to be effectively managed by current professional oversight or universal services Despite any level of engagement, the care plan is not reducing risk and significant concerns remain. • Misadventure that may lead to death or severe injury.
Actions/Outcomes to consider at every stage.	Referral to services – GP and mental health services. Consider Multiagency meeting to discuss concerns, consider the risk and support the adult. Support to the individual - safety planning, crisis services. Consider referral to Mental Health services where there is a change in frequency or intensity of the self harming behaviour.		**Make an ASP Referral**. Immediate safety plans must be implemented. Consider also Actions / Outcomes as identified for Low and Medium Risk

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Type of harm	Non-Reportable	Requires Consultation	Reportable
	Low risk No impact	Medium risk Some harm or risk of harm	High risk Significant harm or risk of harm
***DOMESTIC ABUSE** **A pattern of controlling, coercive or violent behaviour(physical, verbal, sexual, psychological or financial) which takes place in the context of an intimate relationship involving current or ex-partners, with the aim of gaining power and control over the victim. May be perpetrated in a family home, in the community or online.**	The overall impact on well-being and autonomy is minimal. • A single, isolated episode of verbal disagreement or minor conflict without a history of violence. • Instances of isolated or less severe coercive control tactics that do not appear to be part of a pattern of abuse. • Both parties contribute to the conflict, with no clear pattern of one person leveraging power and control within the relationship.	Causes distress to the victim, impacting their independence, decision-making and physical and emotional well-being. • Ongoing patterns of verbal or emotional abuse causing distress to the victim (even if this doesn't escalate to physical violence). • Occasional minor physical altercations not resulting in serious injury. • Intermittent instances of control tactics, such as isolation, monitoring, and threats.	Profound impact on the victim's physical safety, ability to make choices, maintain relationships, and overall autonomy. • A pattern of abuse escalating in severity, frequency, or both. • The victim has sustained severe physical harm requiring medical attention. • Previous incidents involving weapons, strangulation, or attempts to cause serious physical harm. • A pattern of escalating coercive control tactics, including severe isolation, constant surveillance/contact, interference with medication, preventing access to care needs.
Actions/Outcomes to consider at every stage.	• Conduct a risk assessment with Domestic Abuse, Stalking, Harassment and Honour-Based Violence Assessment (DASH Risk Assessment) and develop safety plan with individual. • Consider referral to Multi-Agency Risk Assessment Conference (MARAC). Contact Police Scotland, at MARACGrampian@scotland.police.uk or by calling 101. If concerns relate to a current partner consider submitting Disclosure Scheme for Domestic Abuse Scotland application (DSDAS) • Discuss referral to specialist domestic abuse service or seek advice as a professional from relevant support service: - Local support services for Aberdeen City can be found here. - Local support services for Aberdeenshire can be found here: Domestic abuse services and support - Aberdeenshire Council - Information on gender based violence and local contact in Moray can be found here: https://morayprotects.co.uk/about/ending-gender-based-violence/ • Provide support to access medical care or report to Police, respecting the choices of the individual		**Make an ASP Referral**. Immediate safety plans must be implemented. Referral to MARAC. Where an individual is at immediate risk you must contact the Police. If the person is not in immediate danger, it is recommended you have a discussion with them before taking any further action, being mindful of possible service generated risk. Consider also Actions / Outcomes as identified for Low and Medium Risk

OFFICIAL

APPENDIX 3

GRAMPIAN ADULT SUPPORT AND PROTECTION REPORTING FORM

	Please return this form by **secure** email to:	To discuss, please call:
Aberdeen City	AdultProtectionUnit@aberdeencity.gov.uk	0800 731 5520
Aberdeenshire	adultprotectionnetwork@aberdeenshire.gov.uk	01467 533100
Moray	accesscareteam@moray.gov.uk	01343 563999

If there is a need for immediate action to protect the adult, this should be addressed prior to completing this form. If there is immediate danger to you or the adult, do not hesitate to call 999.

If a crime is known or suspected to have been committed, this should be reported to Police Scotland – telephone 101.

If your concern relates to a child contact should be made to the appropriate child protection services.

This form should be used if you know or believe that an adult is at risk of harm under ASP legislation. If you are unsure and wish to discuss your concern prior to making a referral, please contact the area where the adult currently is (see contact details above). It is not your responsibility to confirm that the adult meets the three-point criteria; it is enough that you believe them to meet the criteria to warrant an ASP referral.

Please refer to the Grampian Thresholds Good Practice Guide for further information on reporting and other support that can be provided to the adults that you are concerned about.

Complete the form as fully as possible, but don't allow a lack of information to delay a referral.

APPENDIX 3

<table>
<tr><th colspan="4">ADULTS DETAILS</th></tr>
<tr><td>Name</td><td></td><td rowspan="3">Home Address</td><td rowspan="3"></td></tr>
<tr><td>Date of Birth</td><td></td></tr>
<tr><td>If known, CHI or CareFirst Number</td><td></td></tr>
<tr><td>Email address</td><td></td><td>Current Address (if different)</td><td></td></tr>
<tr><td>Ethnicity</td><td></td><td>Telephone Number</td><td></td></tr>
<tr><td>Does the adult have a known illness, disability, infirmity or any other reason that makes them more vulnerable to harm?</td><td colspan="3"></td></tr>
</table>

<table>
<tr><th colspan="2">DETAILS OF CONCERN</th></tr>
<tr><td>What concerns do you have that led you to making an Adult Protection Referral today?

(what harm is occurring, why is the adult vulnerable and why do you feel they are not able to safeguard with their current support)</td><td></td></tr>
<tr><td>Has anything been tried or is planned</td><td></td></tr>
</table>

APPENDIX 3

to make the adult safer and if so, what?			
Given what you know about the adult, what could be done to help			
If a crime is suspected, has Police Scotland been contacted?	Yes ☐	No ☐	Not Required ☐
If yes, please provide Crime Reference Number			

COMMUNICATION / CONSENT /CAPACITY		
Do you have concerns about the adult's ability to understand and communicate?	Yes ☐	No ☐
If yes, please provide details		
Where possible and practicable, **you should discuss your concerns with the adult and make them aware of your intent to refer under adult support and protection. Consent is not 'required' but is best practice; you have a Duty to report concerns regardless.**		
Is the adult aware of this referral	Yes ☐	No ☐
What are the adults' thoughts/feelings about your concerns?		
If the adult does not have capacity, have you discussed the making of this referral with any other relevant person? What are their views?		

DETAILS OF PERSON MAKING THE REFERRAL			
Your Name		Date	

APPENDIX 3

Contact Details (preferred method)	
Your Relationship or Job Title	
Please complete one of the sections below to best describe the relationship you have to the adult being referred.	
Non-professional	Choose an item.
Council	Choose an item.
Health	Choose an item.
Third Sector	Choose an item.
Other	Please state

Other significant people involved with the adult (details of the perpetrator if known, any person providing support, including any proxies. professional or non-professional)		
Name	Relationship	Contact Details (if known)

APPENDIX 3

Additional Information	
Is there any other information that you feel it is important for us to know	

Dataset questions – to support national reporting please answer the last two questions			
In your opinion, which of the following harms is the adult experiencing (please tick any that apply)			
Physical	☐	Sexual	☐
Psychological/Emotional	☐	Financial/Material	☐
Neglect/Acts of Omission	☐	Discriminatory	☐
Self-Harm	☐	Self-Neglect	☐
Domestic Abuse	☐	Other (please specify)	
In your opinion, which vulnerabilities impacts the adults ability to safeguard (please tick any that apply)			
Dementia	☐	Mental Health (excl. dementia)	☐
Learning Disability	☐	Physical Disability	☐
Infirmity/frailty due to age	☐	Substance misuse/addiction	☐
Other (please specify)			

APPENDIX 3

What happens next?

Any report that an adult may be at risk of harm, including anonymous concerns reported to the council, will be taken seriously. The Council has a duty to make inquiries regarding an alleged incident of harm. Other professionals may be involved, for example: Police; Care Inspectorate; NHS and they must fully co-operate.

Appropriate feedback will be given to those making referrals. The timing and nature of the feedback will be in line with data protection legislation.

Feedback – Tell us you experience of competing this form to support continuous improvement		
Did this form allow you tell us effectively about your concern for the adult?	Yes ☐	No ☐
Do you have any suggestion for improving this form?		

ADULTS AT RISK OF HARM

INFORMATION SHARING PROTOCOL BETWEEN

ABERDEEN CITY COUNCIL, ABERDEENSHIRE COUNCIL, MORAY COUNCIL, NHS GRAMPIAN, POLICE SCOTLAND, OFFICE OF THE PUBLIC GUARDIAN (SCOTLAND), SCOTTISH AMBULANCE SERVICE AND SCOTTISH FIRE AND RESCUE SERVICE.

Data Sharing Protocol Version	Date Amendments Made	Author
VO.1	17/11/2010	Inga Heyman
VO.2	28/02/11	J Anderson
VO.3	28 /04/11	J Anderson
V0.4	23/06/11	Iain Gray
V0.5	02/09/11	J Anderson
V0.6	25/01/12	J Anderson
V0.7	01/09/17	Alan Thomson
V0.8	13/04/18	Alan Thomson
V0.9	04/10/21	Helen Cannings (incorporating feedback from all Partnership Organisations)
V10	16/02/22	Helen Cannings (incorporating changes required by Scottish Ambulance Service)
V11	22/8/23	Deirdre Nicolson (incorporating feedback from all Partnership Organisations)

CONTENTS

PROTOCOL

1.0 PARTNERSHIP ORGANISATIONS

2.0 PURPOSE AND SCOPE

3.0 LEGAL BASIS FOR SHARING INFORMATION (AND FOR MAKING AND KEEPING RECORDS ABOUT DISCLOSURE DECISIONS)

4.0 CONFIDENTIALITY

5.0 WHAT TO SHARE?

6.0 RESTRICTIONS ON THE USE OF INFORMATION

7.0 ROLES AND RESPONSIBILITIES

8.0 PROCESSES FOR SHARING INFORMATION

9.0 SECURITY, RETENTION AND DISPOSAL

10.0 WITHDRAWAL FROM THE PROTOCOL

11.0 COUNTERPARTS

12.0 SIGNATORIES

SCHEDULE TO PROTOCOL

Part 1 GRAMPIAN ADULT SUPPORT AND PROTECTION REPORTING FORM

Part 2 PROCESS MAP FOR SHARING ADULT SUPPORT AND PROTECTION INFORMATION

1.0 PARTNERSHIPS ORGANISATIONS

1.1 This protocol is between the following organisations:

ABERDEEN CITY COUNCIL, a local authority constituted under the Local Government etc. (Scotland) Act 1994 and having its principal place of business at the Town House, Broad Street, Aberdeen, AB10 1AQ (hereinafter referred to as "ACC");

ABERDEENSHIRE COUNCIL, a local authority constituted under the Local Government etc (Scotland) Act 1994 and having its principal place of business at Woodhill House, Westburn Road, Aberdeen, AB16 5GB (hereinafter referred to as "Aberdeenshire");

MORAY COUNCIL, a local authority constituted under the Local Government etc (Scotland) Act 1994 and having its principal place of business at the Council Offices, High Street, Elgin, **Moray,** IV30 1BX (hereinafter referred to as "Moray");

GRAMPIAN HEALTH BOARD (also known as NHS Grampian) a body corporate established under the National Health Service (Scotland) Act 1978 (as amended) and having its principal place of business at Summerfield House, Eday Road, Aberdeen, AB15 6RE (hereinafter referred to as NHSG);

POLICE SCOTLAND, a police force constituted by the Police and Fire Reform (Scotland) Act 2012, and having its principal place of business at Police Scotland Headquarters, PO Box 21184, Alloa, FK10 9DE (hereinafter referred to as Police);

OFFICE OF THE PUBLIC GUARDIAN (SCOTLAND), headed by the Public Guardian an official constituted under the Adults with Incapacity (Scotland) Act 2000 and having its place of business at Hadrian House, Callendar Business Park, Callendar Road, Falkirk, FK1 1XR (hereinafter referred to OPG);

SCOTTISH AMBULANCE SERVICE, a Special Health Board established under the National Health Service (Scotland) Act 1978 (as amended by the Scottish Ambulance Service Board Order 1999) and having its principal place of business at Gyle Square, 1 South Gyle Crescent, Edinburgh, EH12 9EB (hereinafter referred to as SAS); and

SCOTTISH FIRE AND RESCUE SERVICE, a body corporate constituted under the Fire (Scotland) Act 2005 (as amended) and having its principal place of business at, Westburn Drive, Cambuslang, G72 7NA (hereinafter referred to as SFRS)

The above organisations will be hereafter referred to as *'the Partnership Organisations'*.

2.0 PURPOSE AND SCOPE

2.1 We all have a responsibility, individually and collectively, to protect vulnerable people in our communities. This cuts across all aspects of private life and professional business. Supporting individuals at risk of harm is best done through collaboration and with a sense of community responsibility.

2.2 This Protocol sets out the arrangements agreed by the Partnership Organisations in respect of sharing information about adults who are known, or suspected to be, at risk of harm, otherwise known as "Adults at Risk".

2.3 The Partnership Organisations consider that the sharing of information, as set out in this Protocol, is necessary to enable the Partnership Organisations to effectively carry out their duties or exercise their powers under The Adult Support & Protection

(Scotland) Act 2007 ("the 2007 Act"), or where a Partnership Organisation does not have an explicit duty, to effectively play an appropriate role as enabled by the 2007 Act.

2.4 For the purposes of this Protocol, an "Adult at Risk" is defined as an adult aged 16 years or older who meets the criteria below:

- is unable to safeguard their own well-being, property, rights or other interests, and
- is at risk of harm, and
- because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected[1].

2.5 For the purposes of this Protocol the definition of "harm" is that defined in section 53 of the 2007 Act, namely; "All harmful conduct and, in particular, includes:

- conduct which causes physical harm,
- conduct which causes psychological harm (for example: causing fear, alarm or distress),
- unlawful conduct which appropriates or adversely effects property, rights or interests (for example: theft, fraud, embezzlement or extortion),
- conduct which causes self-harm".

2.6 The 2007 Act places a number of duties on the Councils to:

- make inquiries to establish whether action is required, where it is known or believed that an adult is at risk of harm and that intervention may be necessary – this may be either with or without the use of investigatory powers;
- co-operate with other Councils and other bodies (including but not limited to the other Partnership Organisations under this Protocol);
- inform the adult that they may refuse to answer any question put to them or may refuse to consent to a medical examination;
- request examination of health, financial or other records relating to the individual;
- visit the adult at risk at reasonable times;
- have regard to the importance of the provision of appropriate services, where the Council considers that it needs to intervene in order to protect an adult at risk of harm;
- protect property owned or controlled by an adult who is removed from a place under a removal order;
- set up an Adult Protection Committee to carry out various functions in relation to adult protection in its area.

2.7 If more than one Council is involved with the care of an adult, because the adult lives in a different place from their home address, the Council in whose area the adult lives shall lead any investigation. In terms of the duties in 2.3 above, it may be necessary for the lead Council to work with the Council in whose area the home address is.

2.8 Section 5 of the 2007 Act places a duty on other bodies (including the Police, NHS (including the Scottish Ambulance Service), Office of the Public Guardian and other public bodies) to:

- co-operate with a Council making inquiries to establish whether action is

[1] Section 1(3) of the Adult Support and Protection (Scotland) Act 2007

required where it is known or believed that an adult may be at risk

- to co-operate with each other, where such co-operation is likely to enable or assist the council making those inquiries, and
- to make a referral or report to a local authority when they believe an adult is at risk of harm.

2.9 The Scottish Government has recommended in the Adult Support and Protection Code of Practice that all relevant stakeholders participate, and although not specifically named by section 5 of the 2007 Act, the Scottish Fire and Rescue Service can legitimately share information under the UK GDPR and Data Protection Act 2018 (Data Protection legislation). The Scottish Fire and Rescue Service may become involved with adults whom they know or believe as being at risk, and may therefore have cause to refer people to the lead Council, and as such have a direct part to play in protecting people from risk of harm.

2.10 The Partnership Organisations agree that sharing information under this Protocol in the context of adults at risk may be required for any one of the following purposes:

- An initial alert
- an initial referral discussion
- an adult protection meeting
- an investigation being conducted
- a case conference
- ongoing support as defined in an Adult Protection Plan
- participation in appropriate quality assurance, review, learning, debriefing and inspection processes

3.0 THE LEGAL BASIS FOR SHARING INFORMATION (AND FOR MAKING AND KEEPING RECORDS ABOUT DISCLOSURE DECISIONS)

3.1 Each Partnership Organisation confirms that it is a sole Data Controller and shall ensure that it processes information fairly, lawfully and in a transparent manner in accordance with the Data Protection legislation.

3.2 Data Protection legislation regulates the handling of Personal Data. Personal Data can only be processed (in this case, shared, or records made about disclosure decisions), if an Article 6 legal basis of the UK GDPR is met. Special Category Personal Data can only be processed if an additional legal basis at Article 9 is also met and an appropriate condition for processing under DPA 2018 has been identified. Data relating to criminal convictions can only be processed under the circumstances outlined in Article 10 of the UK GDPR, and if an appropriate condition for processing under DPA 2018 has been identified.

3.3 The Councils will share information under the following legal bases:

- processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller (Art. 6(1)(e))
- processing is necessary for compliance with a legal obligation to which the controller is subject (Art. 6(1)(c))
- where information shared is special category personal data, or personal data relating to criminal convictions, the processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or

treatment or the management of health or social care systems and services (Art. 9(2)(h) and DPA 2018 Schedule 1, Part 1, Paragraph 2 and Art. 10 and DPA 2018 Schedule 1, Part 1 Paragraph 2)

The basis in law for this is the Adult Support and Protection (Scotland) Act 2007.

3.4 NHS Grampian and Scottish Ambulance Service will share information under the following legal bases:

- processing is necessary for compliance with a legal obligation to which the controller is subject (Art. 6(1)(c))
- where information shared is special category personal data, or personal data relating to criminal convictions, the processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services (Art. 9(2)(h) and DPA 2018 Schedule 1, Part 1, Paragraph 2 and Art. 10 and DPA 2018 Schedule 1, Part 1 Paragraph 2)

The basis in law for this is the Adult Support and Protection (Scotland) Act 2007.

3.5 Police Scotland and the Office of the Public Guardian will share information under the following legal bases:

- processing is necessary for compliance with a legal obligation to which the controller is subject (Art. 6(1)(c))
- where information shared is special category personal data, or personal data relating to criminal convictions, the processing is necessary for reasons of substantial public interest and is necessary for the safeguarding of children and individuals at risk (Art 9 (2) (g) and DPA 2018 Schedule 1, Part 2, Paragraph 18(1)) and Art 10 and DPA 2018 Schedule 1, Part 2, Paragraph 18(1))

The basis in law for this is the Adult Support and Protection (Scotland) Act 2007.

3.6 Scottish Fire and Rescue Service will share information under the following legal bases:

- processing is necessary for the performance of a task carried out in the public interest (Art. 6(1)(e))
- processing is necessary in order to protect the vital interests of the data subject or of another natural person (Art. 6(1)(d))
- where information shared is special category personal data, or personal data relating to criminal convictions, the processing is necessary to protect the vital interests of the data subject or of another natural person where the data subject is physically or legally incapable of giving consent; (Art. 9(2)(c)) and DPA 2018 Schedule 1, Part 2, Paragraph 18(1)) and Art 10 and DPA 2018 Schedule 1, Part 2, Paragraph 18(1))
- where information shared is special category personal data, or personal data relation to criminal convictions the processing is necessary for reasons of substantial public interest ((Art. 9(2)(g)) and is necessary for the safeguarding of children and individuals at risk (DPA 2018 Sch. 1, Part 2, Paragraph 18(1))

The basis in law for this is the Adult Support and Protection (Scotland) Act 2007.

4.0 CONFIDENTIALITY

4.1 Partnership Organisations, in addition to their responsibilities as Controllers under Data Protection legislation, will generally owe a common law duty of confidentiality to individuals about whom information is shared under this Protocol.

4.2 Partnership Organisations recognise that confidentiality is not an absolute right, and it will not always be appropriate to consult with individuals prior to sharing information under this Protocol.

4.3 Partnership Organisations recognise that clients have the right to be informed as to how information about them is used.

4.4 Partnership Organisations will have reference to the Grampian Interagency Procedures for Adult Support and Protection, as well as any specific guidance provided by their individual organisations or applicable regulatory bodies in relation to their obligations of confidentiality and consultation, when sharing information under this Protocol.

5.0 WHAT TO SHARE?

5.1 The following information will be shared between the Partnership Organisations:

Proportionate and relevant information necessary:

- to make an initial alert in relation to an Adult at Risk
- to make inquiries with or without the use of investigatory powers
- for an initial referral discussion
- for an effective adult protection meeting
- for an effective case conference and review case conference
- for the ongoing support of an individual as defined in an Adult Support Plan
- for the participation in appropriate quality assurance, review, learning, debriefing and inspection processes

5.2 Partnership Organisations should contact the lead Council if the organisation has concerns and/or believes that the adult is known, or is suspected, to be at risk of harm. For the purposes of an initial alert, the Partnership Organisations have agreed that the information contained within the form attached in Part 1 of the Schedule to this protocol comprises proportionate, relevant necessary information.

5.3 Where a Council Officer has determined that a person is, or is suspected to be, an adult at risk of harm, the officer may request information from any Partnership Organisation(s), or other organisations not party to this Protocol in accordance with sections 4 and 10 of the 2007 Act. When making such a request, the Council Officer should consider what information will be reasonably required for the support and protection of that adult.

5.4 In the event of uncertainty as to the relevance of information, the person holding the information should seek advice from their line manager and/or their lead officer for adult or public protection before deciding whether or not to share information.

5.5 The decision about what information to share with a Partnership Organisation will often depend on the particular inquiries the Council makes or the involvement of other Partnership Organisations with an adult. However, any information which is to be shared should be lawful, proportionate, adequate and necessary for the purposes listed in section 5.1 of this Protocol.

5.6 Partnership Organisations shall ensure that the information shared is accurate. Where any Partnership Organisation becomes aware of inaccuracies in information, they will notify the other Partnership Organisation.

6.0 RESTRICTIONS ON THE USE OF INFORMATION

6.1 By signing this Protocol, Partnership Organisations confirm that their use and disclosure of personal information under this Protocol will be done in accordance with Data Protection legislation, the common law duty of confidentiality and human rights law.

6.2 Information disclosed under this Protocol may be disclosed, or a secondary use made of that information by third parties, where any Partnership Organisation is obliged to disclose such information as a result of a Court Order, or because the recipient of such information has a statutory duty obliging such disclosure. Each Partnership Organisation shall notify the originator of the information of any third-party disclosure it is required to make in terms of this paragraph.

6.3 Other than under the conditions outlined at 6.2, above, any information disclosed under this Protocol must not be disclosed by any Partnership Organisation to any Third Party, or used for any incompatible purpose without the written consent of the Partnership Organisation(s) that provided the information.

6.4 Individuals have the right to make Subject Access Requests. Individuals may also request rectification, erasure, objections or restrictions in relation to the processing of their personal data. Partnership Organisations agree that the responsibility for responding to these requests shall rest on the Partnership Organisation who has received the request. Each Partnership Organisation confirms it has procedures in place to inform any recipient Partner Organisations if it:

- rectifies any data it has shared with them
- erases any data it has shared with them
- restricts any data it has shared with them

and will ensure these procedures are followed where relevant. Each Recipient Partnership Organisation will be individually responsible for addressing its own obligations to rectify, erase or restrict data as relevant when it is notified of a rectification, erasure or restriction by another Partner Organisation.

6.5 Partnership Organisations agree to notify other relevant Partnership Organisations of any Subject Access Requests received, as soon as is reasonably possible, and give relevant Partnership Organisations the opportunity to make representations regarding disclosures and /or exemptions. The final decision on disclosure, or the application of exemptions, will rest with the Partnership Organisation who received the request.

6.6 Partnership Organisations agree, when given notification of any relevant Subject Access Request received as outlined at 6.4 above, to respond promptly with any representations regarding disclosures and /or exemptions, or, where a Partnership Organisation has no representations to make, to confirm this fact.

7.0 ROLES AND RESPONSIBILITIES

7.1 Each Partnership Organisation should identify a point of contact who will have responsibility for compliance with this Protocol within their organisation. This should also be the person to participate in the annual review of the Protocol and act as a contact if there are any issues with the same.

7.2 The following individuals are the Point of Contacts in relation to this protocol:

POST	PARTNERSHIP ORG.	TELEPHONE NUMBER	EMAIL ADDRESS
Detective Inspector, NE Concern Hub	Police Scotland	01224 01224 301010	NorthEastConcernHub@scotland.police.uk
Lead Social Work Officer, Health and Social Care Partnership	Aberdeen City Council	01224 264085	APSW@aberdeencity.gov.uk
Chief Officer, Health and Social Care Partnership	Aberdeenshire Council	01467 533100	adultprotectionnetwork@aberdeenshire.gov.uk
Head of Adult Health and Social Care	Moray Council	01343 567127	AdultProtection@moray.gov.uk
Adult Support & Protection Lead	NHS Grampian	0345 456 6000	gram.publicprotection@nhs.scot
Public Guardian	Office of the Public Guardian (Scotland)	01324 678323	OPG@scotcourts.gov.uk
Head of Public Protection	Scottish Ambulance Service	07881 356376	sas.publicprotection@nhs.scot
Prevention and Protection Manager	Scottish Fire and Rescue Service	01224 728600	N.ABMPreventionandProtection@firescotland.gov.uk

7.3 Aberdeen City Council shall have responsibility for reviewing the Protocol and making any amendments to the Protocol which are deemed necessary by the Partnership Organisations. The review will take place annually and shall be led by a Council Officer in Aberdeen City Health and Social Care Partnership.

7.4 Each Partnership Organisation shall be responsible for ensuring their staff understand their responsibilities under this Protocol.

8.0 PROCESSES FOR SHARING INFORMATION

Making Referrals

8.1 Referrals to Councils can be made by using the Councils' dedicated online reporting form. It is recognised that some Partnership Organisations make use of internal forms for reporting, which will be used to make referrals to Councils. Where necessary, including where Partnership Organisations make use of internal reporting forms, referrals can also be made by telephone, secure email, in person, or by recorded first class post. Referrals from Police Scotland will be made using the iVPD system. Referrals from SAS will use the SAS National Vulnerable Person Reporting Form. SFRS will use their own template AP1 form for referrals.

Sharing Information via Telephone

8.2 Where it is necessary for Partnership Organisations to share information under this Protocol by telephone, Partnership Organisations will ensure appropriate verification checks are undertaken prior to any information being disclosed by telephone, to ensure that information is only disclosed to an appropriate individual

8.3 Where a Partnership Organisation considers it necessary to request disclosure of information by telephone, it will comply with reasonable steps requested by the disclosing Partnership Organisation to ensure the appropriate verification of requester identity and security of the disclosure.

8.4 For incoming telephone calls, verification will include establishing the identity of the caller – including a Police Rank/ Number/ Role in Partnership Organisation. Verification may also include requesting that an email be sent from the Partnership Organisation's corporate email system confirming the job title(s) of the requester(s), the requirement for telephone disclosure and the relevant organisational telephone number to be used for the disclosure.

8.5 Where a Partnership Organisation has assessed that it is appropriate to disclose information by telephone, information should be disclosed on a separate returned telephone call made to a recognised telephone number belonging to the Partnership Organisation – this is important in order to confirm the stated identity of the caller. A telephone number may be confirmed to belong to the Partnership Organisation by going via the Organisation's published switchboard number or using a number confirmed via an email sent from the Partnership Organisation's corporate email system.

8.6 Concerns may also be brought to a Partnership Organisation's attention from members of the public. Where possible officers should follow relevant steps to verify the identity of a caller bringing a concern to their attention, noting that there may be circumstances where a caller wishes to remain anonymous.

Sharing Information via Email

8.7 Email correspondence is permitted from a secure email to a receiving secure email. Partnership Organisations will use approved corporate email systems only for sharing information under this Protocol. Each Partnership Organisation will follow its own policies and procedures in relation to the safe and secure use of email.

Hand Delivering Information

8.8 Sometimes it may be appropriate to hand deliver information in person. Where the intention is to hand deliver information, the covering envelope should be addressed to a named officer in the Partnership Organisation. The name and role of the person the envelope has been handed to must be obtained and recorded, along with time and date of delivery. Envelopes used should be sufficiently robust, and if necessary double enveloped.

Posting Information

8.9 If the information is to be sent by post, this should be by way of first-class Special Delivery post so that it is traceable. Envelopes used should be sufficiently robust, and if necessary double enveloped. Partnership Organisations should follow any organisational policies and procedures in place for posting special category personal data. The covering envelope should be addressed to a named officer in the Partnership Organisation.

No use permitted of fax

8.10 Fax shall not be used for sharing information under this Protocol as its security cannot be guaranteed.

Meetings

8.11 Information may also be shared by officers or professionals from Partnership Organisations at multi agency meetings, such as at an adult protection meeting, case conference or Inter-agency Referral Discussion.

Use of approved video conferencing platforms: no recordings and no use of chat function.

8.12 Where such meetings are held virtually, Partnership Organisations will use approved organisational video conferencing platforms only. Chat functionality shall not be used to share information. Recordings will not be made of these meetings.

Record keeping of decisions to disclose and decisions not to disclose

8.13 When a decision has been made by a Partnership Organisation to share information, a record of the disclosure will be kept by that organisation, which shall include:

- the information disclosed
- person (including role and organisation) to whom the disclosure was made
- date of the disclosure
- reason for the disclosure
- the lawful basis for the disclosure
- how the information was disclosed (including, where appropriate, verification checks)
- signature of person making the disclosure, where appropriate
- whether disclosure was made with or without consulting the adult, and where a disclosure has been made without the adult being informed the reasons for this
- whether the disclosure was made with or without the knowledge of the adult, and where a disclosure has been made without the adult's knowledge, the reasons for this

8.14 When a decision has been made by a Partnership Organisation not to share information, a record of the decision not to disclose information will be kept by that Partnership Organisation, which shall include:

- the information requested
- the person (including role and organisation) making the request
- the reason for refusal
- the name and role of the person who took the decision to refuse the request.

8.15 The process for sharing information is summarised in the chart in Part 2 of the Schedule to this Protocol.

8.16 Partnership Organisations recognise that record keeping in respect of sharing (or decisions not to share) under this Protocol is a necessary part of demonstrating the effective and accountable undertaking of their respective duties in relation to Adult Support and Protection and as such, consider the legal basis for the creation and appropriate retention of these records to be as outlined at Section 3 of this Protocol.

9.0 SECURITY, RETENTION AND DISPOSAL

9.1 Partnership Organisations undertake to store information securely, in accordance with their organisational policies relating to Information Security, Data Protection and Records Management.

9.2 Partnership Organisations undertake to ensure that their staff members are appropriately trained to handle and process the information in accordance with this Protocol.

9.3 Partnership Organisations shall ensure that instances or alleged instances of unauthorised access or use of information shared under this Protocol will be investigated and managed in accordance with relevant organisational policies.

9.4 Partnership Organisations shall retain and dispose of information shared under this Protocol in accordance with their organisational retention schedules, and policies and procedures relating to the secure disposal of information.

9.5 Partnership Organisations shall ensure that records kept of decisions to share or not to share information (in accordance with sections 8.12 and 8.13 above) are retained in accordance with their organisational retention schedules, and policies and procedures relating to the secure disposal of information.

10.0 WITHDRAWAL FROM THE PROTOCOL

10.1 Any Partnership Organisation may withdraw from this Protocol on giving one month written notice to the others of their intention to do so.

10.2 This Protocol may be varied only by the written agreement of all of the Partnership Organisations.

10.3 This Protocol shall terminate on the execution by the Partnership Organisations (or their successors) and coming into force of another protocol on sharing personal data which is expressly stated to supersede this Protocol.

11.0 COUNTERPARTS

11.1 This Protocol may be executed in any number of counterparts and by each of the Partnership Organisations on separate counterparts, all as permitted by The Legal Writings (Counterparts and Delivery) (Scotland) Act 2015.

11.2 If executed in counterparts:

- this Protocol will not take effect until each of the counterparts had been delivered; and
- each counterpart will be held as undelivered until the parties agree a date on which the counterparts are to be treated as delivered; and
- the date of delivery of this Protocol will be the last date of signature by the Partnership Organisations.

12.0 SIGNATORIES

12.1 By signing this Protocol, all signatories accept responsibility for its execution and agree to ensure the staff are trained so that requests for information and the process of sharing itself is sufficient to meet the purposes of this Protocol.

On behalf of **Aberdeen City Council** by

Signed..
(Authorised Signatory)
Name
Position
Date

On behalf of **Aberdeenshire Council** by

Signed...
(Authorised Signatory)
Name
Position
Date

On behalf of **The Moray Council** by

Signed...
(Authorised Signatory)
Name
Position
Date

On behalf of **Grampian Health Board** by

Signed………………………………
(Authorised Signatory)
Name
Position
Date

On behalf of **Police Scotland** by

Signed…………………………………
(Authorised Signatory)
Name
Position
Date

On behalf of **Office of the Public Guardian (Scotland)** by

Signed…………………………………
(Authorised Signatory)
Name
Position
Date

On behalf of Scottish Ambulance Service by

Signed…………………………………
(Authorised Signatory)
Name
Position
Date

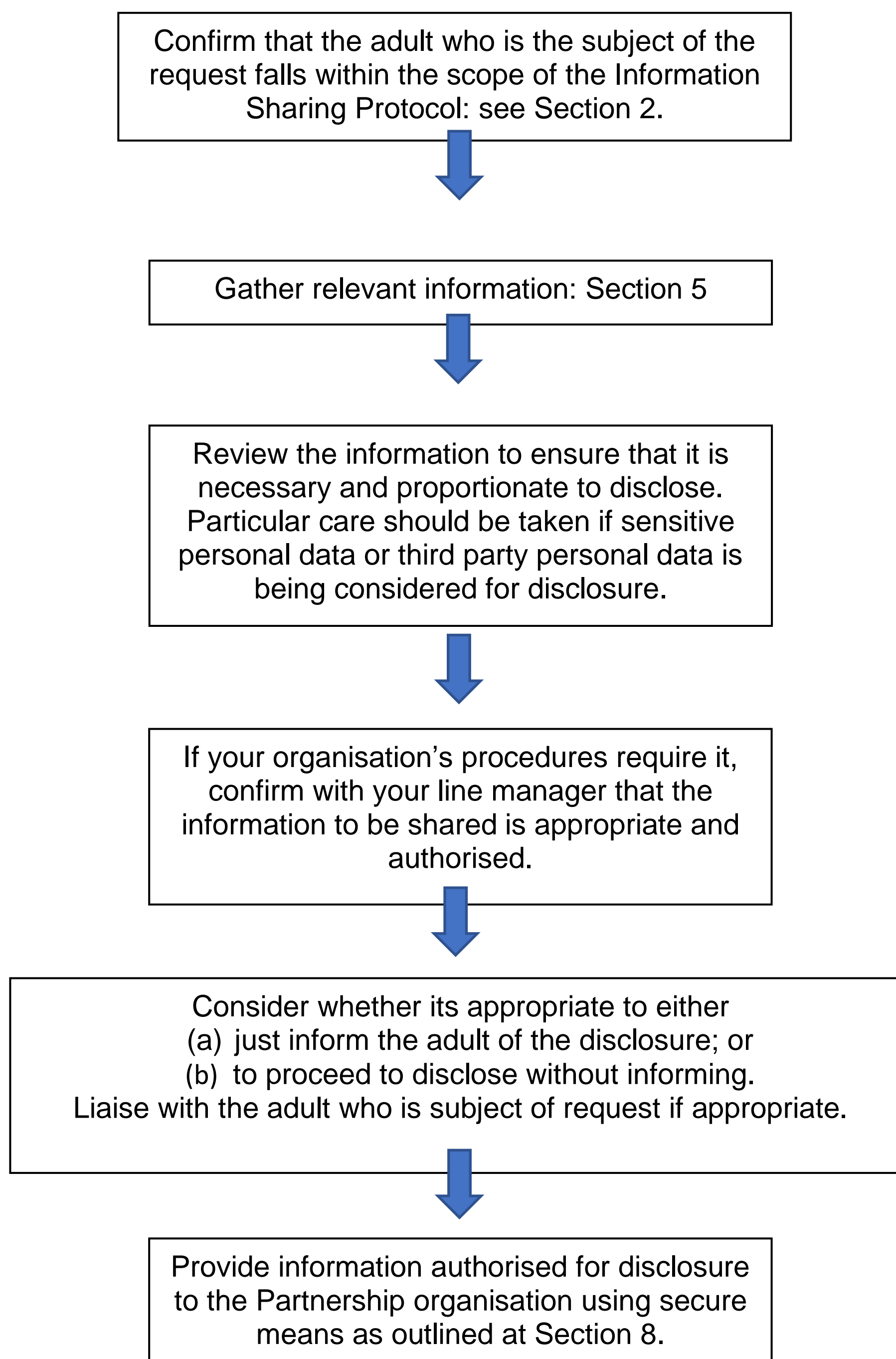
On behalf of **Scottish Fire and Rescue Services** by

Signed…………………………………

(Authorised Signatory)
Name
Position
Date

SCHEDULE: PART 2

PROCESS MAP FOR SHARING ADULT SUPPORT AND PROTECTION INFORMATION



Throughout the process - record details of your decisions about the information request . Keep records about decisions to share and decisions not to share information. Include all the details outlined at Section 8 about each request and disclosure decision.

APPENDIX 5

Grampian Interagency Procedure

for Large Scale Investigations of Adults at Risk of Harm in Managed Care Settings

First Issued:	JANUARY 2014
Date of Review:	JANUARY 2015

APPENDIX 5

CONTENTS

1. DEFINITIONS / SCOPE 3

2. INTRODUCTION 4

3. INITIAL REFERRAL DISCUSSION / IMMEDIATE SAFETY ISSUES 5

4. LARGE SCALE INVESTIGATION PLANNING MEETING 8

5. LARGE SCALE INVESTIGATION 11

6. LARGE SCALE INVESTIGATION OUTCOME MEETING 13

7. LARGE SCALE INVESTIGATION REVIEW MEETING 15

8. APPENDIX A 17

- Large Scale Investigation Planning Meeting Agenda
- Large Scale Investigation Outcome Meeting Agenda
- Large Scale Investigation Review Meeting Agenda

9. APPENDIX B 20

- Process Flowchart

APPENDIX 5

Interagency Procedure for Large Scale Investigations of Adults at Risk of Harm

1. DEFINITIONS / SCOPE

Definition of a Large-Scale Investigation

A Large-Scale Investigation is a multi-agency response to circumstances where there may be two or more adults at risk of harm where the source of harm is the same.

Purpose of Procedure

This procedure has been created to:

- Provide a standardised approach to carrying out a Large-Scale Investigation for all professions consistent with current evidence of best practice.
- Offer a framework for an alternative process to holding large numbers of individual Adult Support and Protection Inquiries and ensure that there is adequate overview / co-ordination where a number of agencies have key roles to play.
- Clarify partner agencies' responsibilities for involvement Large Scale Investigations in Grampian.

Scope

This procedure potentially???_applies to all adults at risk of harm, as defined by the Adult Support and Protection (Scotland) Act 2007

For the purpose of clarity, this procedure does not replace, (nor is it a substitute for), local case review, Health and Safety and/or Fire Safety procedures and arrangements. This procedure is designed purely to support the multi-agency response to concerns about harm regarding multiple adults where the source of harm is the same.

Relevant Legislation

The following legislation is viewed as being relevant and/or related to this procedure:

- Adult Support and Protection (Scotland) Act 2007
- Public Services Reform (Scotland) Act 2010
- The Public Bodies (Joint Working) (Scotland) Act 2014

Relevant Procedures

The following agency/interagency procedures are viewed as being relevant and/or related to this document:

- Grampian Interagency Policy and Procedure for the Support and Protection of Adults at Risk of Harm?

APPENDIX 5

2. INTRODUCTION

2.1 The Adult Support & Protection (Scotland) Act 2007 (The Act) introduced a duty for councils to make inquiries where it is known or believed that an adult may be at risk of harm and where protective action may be required. The Act gives the Council the lead role in Adult Protection investigations.

2.2 This procedure has been agreed by Aberdeen City Council, Aberdeenshire Council, Moray Council, NHS Grampian and Police Scotland, which will be the key agencies involved in any investigation process involving managed care settings. It is designed to minimise risk to both service users and staff in any care setting.

Due to its statutory responsibilities for regulated care services, the Care Inspectorate participated in the development of this procedure. Whilst not directly involved in the creation of this procedure, Healthcare Improvement Scotland (HIS) and the Mental Welfare Commission have also been consulted in relation to the content herein.

2.3 Concerns about an adult at risk being harmed can be raised from many sources including:

- Family / friends making a complaint about standards of care
- Whistleblowing within an organisation
- Procurator Fiscal investigating a death
- Concerns raised from an admission to hospital
- Concerns highlighted via regulatory process

2.4 This guidance should not be read in isolation and should be viewed as a companion to the Act's code of practice and the Grampian Interagency Policy and Procedure for the Support and Protection of Adults at Risk of Harm.

3. INITIAL REFERRAL DISCUSSION / IMMEDIATE SAFETY ISSUES

3.1 When an adult protection report is received by one of the three local authority partners, it will initially be screened as per standard adult support and protection procedures. However, when the harm is noted to have occurred within a managed care setting, the local authority adult protection units/network will also consider whether there is potential that other adults are also experiencing harm or are at risk of harm.

3.2 If there is potential that there may be multiple adults at risk of harm, then an Initial Referral Discussion (IRD) must be initiated with relevant agencies.

3.3 At this stage of the IRD process, relevant notifications (proforma) to other appropriate agencies this would include should be made.

3.4 The agencies who may be notified include [please note this is not an exhaustive list]:

- The Care Inspectorate (for concerns relating to registered care settings)
- Police Scotland (for concerns where there is potential criminality – also see point

3.7)

- The Mental Welfare Commission (where the concerns relate to ill treatment, neglect or cruelty towards a person with a mental disorder)
- Healthcare Improvement Scotland (for concerns located within NHS care settings)
- Local Authority Contracts/Commissioning Team
- The Office of the Public Guardian
- LA who have clients impacted by source of harm
- Community Safety Partners

Brief mention of purpose of IRD

3.5 Following the IRD, any actions that are required to safeguard adults at immediate risk should be taken straight away and should not wait for further stages in the procedure. This reflects the position of the wider Grampian Interagency Policy and Procedure ?? which is clear that if an adult at risk is in immediate danger, action should be taken without delay to safeguard/protect that individual.

3.6 Potential immediate interventions could include [please note this is not an exhaustive list]:

- A suspension on admissions/referrals to the managed care setting
- Immediate Human Resources (HR) actions taken against particular members of staff involved with the managed care setting (e.g. precautionary suspension etc.). This would be the responsibility of the management of the managed care setting with advice from other agencies as appropriate.

Think of other example specifically relating to community.

- Immediate removal from the managed care setting of particularly at risk individuals

3.7 A caveat to points 3.5 and 3.6 is that if there is the potential for a criminal investigation as a result of the concerns raised, Police Scotland will give instruction/advice as to what actions/activities can or cannot be progressed. The general principle is that any criminal investigation must take primacy and not be compromised by other agencies' actions. However, this will always be balanced against the need for timely action to ensure the safety of any adults who are potentially at risk.

3.8 Following the Initial Referral Discussion if held, a multi-agency will make a decision as to how to proceed in regard to the concern raised. Normally, there will be one of three outcomes:

- There is to be No Further Action (NFA) under adult protection procedures. This would be the outcome if the adults involved did not meet the three point test under Adult Support and Protection (ASP) legislation, or the risk of harm that was reported was not present. NOTE: A decision of NFA in regard to Adult Protection does not in any way preclude other interventions occurring (e.g. Care Inspectorate regulatory activity; contract enforcement action etc.).

- Individual Adult Protection Investigations – where it is likely that there are ongoing adult protection concerns, however these would be best addressed via individual inquiries/investigations. In these circumstances, individual ASP inquiries/investigations would be progressed via the standard arrangements within the Grampian Interagency Policy and Procedure. This would be the outcome if the harm is thought to be limited in who it affects within the managed care setting and is felt to be best addressed on an individual basis.

APPENDIX 5

- Large Scale Investigation – Where it is likely that there are ongoing adult protection concerns AND those concerns are felt to impact upon multiple adults who are affect by the harm

- Enhanced monitoring with ASP oversight- where there are existing mechanisms in place to monitor and manage the risk an enhanced monitoring is required.

3.9 When the decision of the local authority is that there ARE ongoing adult protection concerns within the managed care setting AND that it impacts upon multiple residents, the next step would be to convene a Large Scale Investigation Planning Meeting.

3.10 The following are examples of when it would be best practice to convene a Large Scale Investigation Planning Meeting:

- Where care standards in a managed care setting have deteriorated to a level where there is a realistic risk of neglect occurring as a form of harm and this is likely to have a global impact on all service users.

- Where there are multiple victims not in one location but linked due to their association with a managed care setting: for example, a number of adults at risk in the community may be being systematically targeted by an employee of a care provider. A Large Scale Investigation Planning meeting would bring together key agencies to assist in any investigation and consider how to support the adults at risk.

- It may also be useful to convene a Large Scale Investigation Planning meeting in cases where multiple allegations are received from service users against other service users within a managed care setting. In these circumstances, however, experience indicates that proactively addressing the supervisory arrangements, and the management of aggressive or sexualised behaviour, can be much more effective.

4. LARGE SCALE INVESTIGATION PLANNING MEETING

4.1 The council will be the lead agency for arranging the Large Scale Investigation Planning Meeting and will appoint a Chair person who will have overall responsibility for arranging and conducting the meeting.

4.2 The Chairperson will identify the key agencies that are required to attend the meeting. Those attending should be of a sufficiently senior level to contribute to decision making and resource allocation if necessary.

The following should routinely be considered for invitation [note this is not an exhaustive list]:

- Representative from the Council's Adult Protection Unit/Network
- Council Communications Manager
- NHS Grampian Representative
- GP medical link to the managed care setting (if appropriate)
- Other Medical Practitioner linked to the managed care setting – **e.g. Geriatrician, Psychiatric Consultant etc.**
- Police Scotland Representative – via the Referral Unit based in Aberdeen
- Care Inspectorate relevant Manager (if a registered care setting/provider)
- Senior Manager of the managed care setting involved (though see point 4.4 below)

- Representative(s) from any other local authorities who are funding placements for a service user(s) within the managed care setting concerned.
- Council Contracts Team Manager
- Council Legal representation

4.3 If senior managers are invited, they may bring/delegate attendance to relevant managers involved in the investigation. However, the principle stated in point **4.2 remains – all attendees should have sufficient seniority to allow effective decision making to take place.**

4.4 It is important to involve the relevant senior manager of the managed care setting that is involved in the potential investigation throughout the process, where possible. However, there will be instances where notifying the managed care setting may not be appropriate, for example, due to risk of compromise to an investigation. A decision as to whether to exclude a representative from the managed care setting from the planning meeting will be taken by the Chairperson in consultation with relevant partners e.g. Police Scotland, Care Inspectorate etc.

4.5 The Chairperson of the planning meeting will use the set agenda contained within this procedure (see Appendix A) to frame the discussion.

4.6 The intention of the Large Scale Investigation Planning meeting will be to:

- Analyse information available and make a decision as to whether a Large Scale Investigation should be initiated under Adult Support and Protection Procedures, and/or through criminal investigation.

- Consider the nature and timing of any regulatory response being proposed by the Care Inspectorate to ensure that this does not interfere with any proposed or ongoing investigation.

- Consider/discuss any assessments/investigations already conducted at this time (from Social Work, Health, or Police).

- Consider information provided by all agencies which will include previous concerns / reports and complaints received by them.

- Consider / review whether a media strategy is required.

- Provide clarity in regard to parallel/joint investigation i.e. Police/Care Inspectorate/Council/NHS

- Identify key tasks to be undertaken; the persons who will undertake these tasks; and agreed timescales for completion. This will include any immediate protective measures for individuals (where not already addressed).

- Consider the need for any individual interventions which need to be undertaken for adults considered to be at particular risk (it may not be necessary to do this if concerns / protection issues are adequately addressed by the Large Scale Investigation Procedure).

- Agree how the relevant manager of the care home / care setting **/ service under investigation will be apprised of the situation and who is responsible for this (if not already informed).**

- Decide whether the relevant Contracts Manager needs to be advised of the decisions of the strategy meeting (if not in attendance)

4.7 Consider notification of other parties (if notifications have not already been made at an earlier part of the process) – for example Mental Welfare Commission, other local authorities, family/main carers. Where the concerns relate to potential criminal activity the meeting will ensure that:

- Any agreed action plan will focus on the immediate protective measures required, but that;

- The action plan will otherwise be primarily informed by the requirements of the Police to conduct a criminal investigation in liaison with the Procurator Fiscal

4.8 Any staffing/resource issues which may impede the progression of an investigation should be escalated to senior management within the relevant body for quick resolution.

4.9 The Large Scale Investigation Planning meeting should be minuted and a copy sent to all participants and those who were invited but were unable to attend. Minutes should be circulated within 14 days of the meeting being held.

5. LARGE SCALE INVESTIGATIONS

5.1 The first step when proceeding with a large scale investigation is the appointment of a Lead Council Officer who will be responsible for the overall coordination of the investigatory process. For the purposes of clarity, it should be stressed that there is no expectation on the Lead Council Officer to undertake the investigatory work alone; they will merely coordinate the overall process of investigation.

5.2 The Chair of the Large Scale Investigation Planning meeting will agree who will be appointed as Lead Council Officer. This officer will be an authorised Council Officer under the Adult Support and Protection (Scotland) Act 2007 and possess substantial adult protection fieldwork experience.

5.3 As allegations vary widely, it is impossible to detail all the steps which should be undertaken in any large scale investigation of potential harm.

5.4 Different situations will necessitate different levels of investigatory response. For example, in a situation where there have been concerns about standards of care within a registered care setting over a period of time, the majority of information may already be available, and the primary responsibility of the Lead Council Officer will be to address any gaps in knowledge and ensure collation of all known reports. Conversely, in situations where the allegation of harm is completely new to the statutory services, far more substantial direct investigation may be required – potentially including interviews with service users, staff, family members etc.

5.5 However, as per the Grampian Policy, in all investigatory work, the following points should be considered:

- It is essential that council staff involved in interviewing have all undergone specific training in investigating allegations of harm.

- The investigation should be carried out as sensitively as possible. The impact on the adults should always be considered and the adults' wishes must be taken into account. A balance must be reached between the need to protect the adults and

respecting their rights.

- The investigation should be undertaken as soon as possible, taking into account the impact on the adults in the managed care setting.
- Preliminary interviews may have to take place with the person who may have made the allegation, workers of support services etc. Checks should also be made on all available computer records/manual records and with other councils if appropriate. Care should be taken in the choice of venue and timing of the interviews with the adults, to ensure they are at ease etc. and that all necessary supports are available, e.g. interpreter, computer, loop system and symbols.
- All interviews related to the investigation must be carried out by a Council Officer and one other professional e.g. from Social Work/NHS/Police. It may also be necessary to include a member of support staff who knows the adults well. If required, appropriate assistance should be made available to address any identified communication need(s).
- Council staff must consider the provision of independent advocacy services when investigations occur.
- Those involved in the investigation should always meet beforehand, to discuss how to proceed, making sure that they are aware of all the facts to date, any background knowledge/information regarding the adults involved and any alleged perpetrator.

5.6 Once the investigatory process is concluded, the Lead Council Officer will be responsible for collating the information obtained ready for presentation to, and consideration at, an Adult Protection Large Scale Investigation Outcome Meeting.

6. LARGE SCALE INVESTIGATION OUTCOME MEETING

6.1 Following conclusion of the large scale investigation, the chairperson of the planning meeting will call a large scale investigation outcome meeting to allow for discussion/deliberation of the findings.

6.2 It would be considered good practice for the chairperson of the outcome meeting to be the same person who chaired the original planning meeting.

6.3 All those who were invited to the original planning meeting should also be invited to the outcome meeting. In addition, any other relevant parties who may contribute to effective decision making should also be invited. For example, if as part of a Large Scale Investigation it was found that skin care was a particular risk factor, a tissue viability specialist might be asked to attend the outcome meeting.

6.4 Representatives of the management of the managed care setting should normally be invited to attend the outcome meeting. Due to the nature of the discussions/deliberations, the staff of the managed care setting may be excluded from sections of the outcome meeting proceedings – this will be at the discretion of the chairperson.

6.5 The chairperson of the outcome meeting will use the set agenda contained within this procedure (see Appendix A) to frame the deliberations.

6.6 Overall, the purpose of the Large Scale Investigation Outcome Meeting will be to:

- Determine, based on the information obtained during the investigation and thereafter, if the service users within the managed care setting are 'adults at risk of harm' under the terms of the 2007 legislation. If this is the case, to THEN:

- Develop an appropriate action plan to address the concerns/risks.

6.7 By the end of the Large Scale Investigation Outcome Meeting, a decision should be reached as to the ongoing management of the concerns. This will result in an outcome of one of the following:

- NFA under the Large Scale Investigation procedure. This outcome would be selected if the service users within the managed care setting were no longer found to be at risk of harm.

- Adult Protection Action Plan. This outcome would be selected if the service users within the managed care setting remained at risk of harm. This plan may include actions to safeguard all individuals involved, but may also have specific actions for safeguarding, particularly at risk adults within the managed care setting.

6.8 If it is determined that there is an ongoing risk of harm to service users, then an action plan should be agreed at the outcome meeting which clearly sets out how the risks will be managed and addressed.

6.9 The action plan should be specific in regard to those responsible and timescales for implementation.

6.10 In addition, if an action plan has been agreed, then a date for review of the plan must be set at the outcome meeting.

6.11 The Large Scale Investigation Outcome meeting should be minuted and a copy sent to all participants and those who were invited but were unable to attend. The minutes should be circulated within 14 days of the meeting being held.

6.12 If the Large Scale Investigation process terminates at this point, the Chairperson may wish to consider whether a review of the work undertaken is necessary to ensure any learning for the future is taken forward.

7. LARGE SCALE INVESTIGATION REVIEW MEETING

7.1 Following a Large Scale Investigation Outcome Meeting, if an action plan is in place, its effectiveness must be reviewed.

7.2 This review will be conducted via the Large Scale Investigation Review Meeting.

7.3 It is good practice for the chairperson of the review meeting to be the same person who chaired the outcome meeting.

7.4 All those who were invited to the outcome meeting should also be invited to the review meeting. In addition, any other relevant parties who may contribute to effective decision making should also be invited.

APPENDIX 5

7.5 Representatives of the management of the managed care setting should normally be invited to attend the review meeting. Due to the nature of the discussions/deliberations, the staff of the managed care setting may be excluded from sections of the review meeting proceedings – this will be at the discretion of the chairperson.

7.6 The chairperson of the review meeting will use the set agenda contained within this procedure (see Appendix A) to frame the deliberations.

7.7 Overall, the purpose of the Large Scale Investigation Review Meeting will be to:

- Review the effectiveness of the current action plan in place to safeguard those adults involved with the managed care setting;

  AND

- Determine, (based on the information obtained during the meeting and elsewhere) if the adults within the managed care setting continue to be 'adults at risk of harm' under the terms of the 2007 legislation.

7.8 By the end of the Large Scale Investigation Review Meeting, a decision should be reached as to the ongoing management of the concerns. This will result in an outcome of one of the following:

- NFA under the Large Scale Investigation procedure. This outcome would be selected if the service users within the managed care setting were no longer found to be at risk of harm.

- Adult Protection Action Plan. This outcome would be selected if the service users within the managed care setting remained at risk of harm, despite the current action plan being in place. Resultantly, amendments/changes will likely be made to the action plan to address the ongoing risk.

7.9 If it is determined that there remains an ongoing risk of harm to service users, then a revised action plan should be agreed at the review meeting which clearly sets out how the ongoing risks will be addressed.

7.10 The revised action plan should be specific regarding those responsible and timescales for implementation.

7.11 In addition, if there remains ongoing risk, and a revised action plan has been agreed, then a date for an additional review of the plan should be set at the review meeting. This review would use the same agenda and procedures as the first review meeting.

7.12 Reviews of the action plan should continue until the risk of harm is reduced to an acceptable level.

7.13 The Large Scale Investigation Review meeting should be minuted and a copy sent to all participants and those who were invited but who were unable to attend. The minutes should be circulated within 14 days of the meeting being held.

7.14 When the Large Scale Investigation process terminates, the Chairperson may wish to consider whether a review of the work undertaken is necessary to ensure any learning for the future is carried forward.

APPENDIX 5

8. APPENDIX A

Large Scale Investigation Planning Meeting

Agenda

1. Introductions and apologies.

2. Recording arrangements.

3. Information currently available from each agency and any reports received.

4. Summary of concerns and current situation.

5. Decide if service users qualify as 'adults at risk of harm'.

   The Act defines an 'adult at risk' as a person aged 16 years or over who:

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

6. Is a large scale investigation required?

   A large scale investigation will normally be appropriate in situations where multiple service users are considered to be adults at risk of harm due to the same source of concerns.

7. Investigation planning

8. Any immediate actions that need to occur to safeguard service users

9. Consider any notification requirements to other agencies/organisations

APPENDIX 5

Large Scale Investigation Outcome Meeting

Agenda

1. Introduction and apologies

2. Purpose of outcome meeting

3. Discussion of findings from the investigation plus any additional reports received.

4. Clarify if the adults are at risk of harm - note any dissenting views.

   The Act defines an 'adult at risk' as a person aged 16 years or over who:

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

5. Consideration of actions required to protect the adults including application for adult protection orders or other legislation - note any dissenting views.

6. Adult protection plan agreed (include timescales and responsible officers)

7. Review arrangements

OFFICIAL

APPENDIX 5

Large Scale Investigation Outcome Review meeting

Agenda

1 Purpose of the Meeting

The purpose of the meeting is for participants to provide any information updates since the last meeting, identify any ongoing risks and review the Adult Protection Plan. A decision will also be taken as to whether ongoing Case Conference Management is required.

2 Agency Updates

Each agency should provide a brief summary of any updates/ changes in circumstances since the previous meeting. Particularly focus on any changes in risks which need to be accommodated/ investigated and or issues with the existing protection plan.

The views of the adults and any carers etc. as to the effectiveness of the Adult Protection Plan should be sought, along with any suggestions they have for reducing risk/ increasing safety.

3 Review of Adult Protection Plan

Tasks set at last meeting should be explicitly reviewed. What is working well? Or not so well? Are there any particular gaps? Any required changes or additions should be discussed and agreed here.

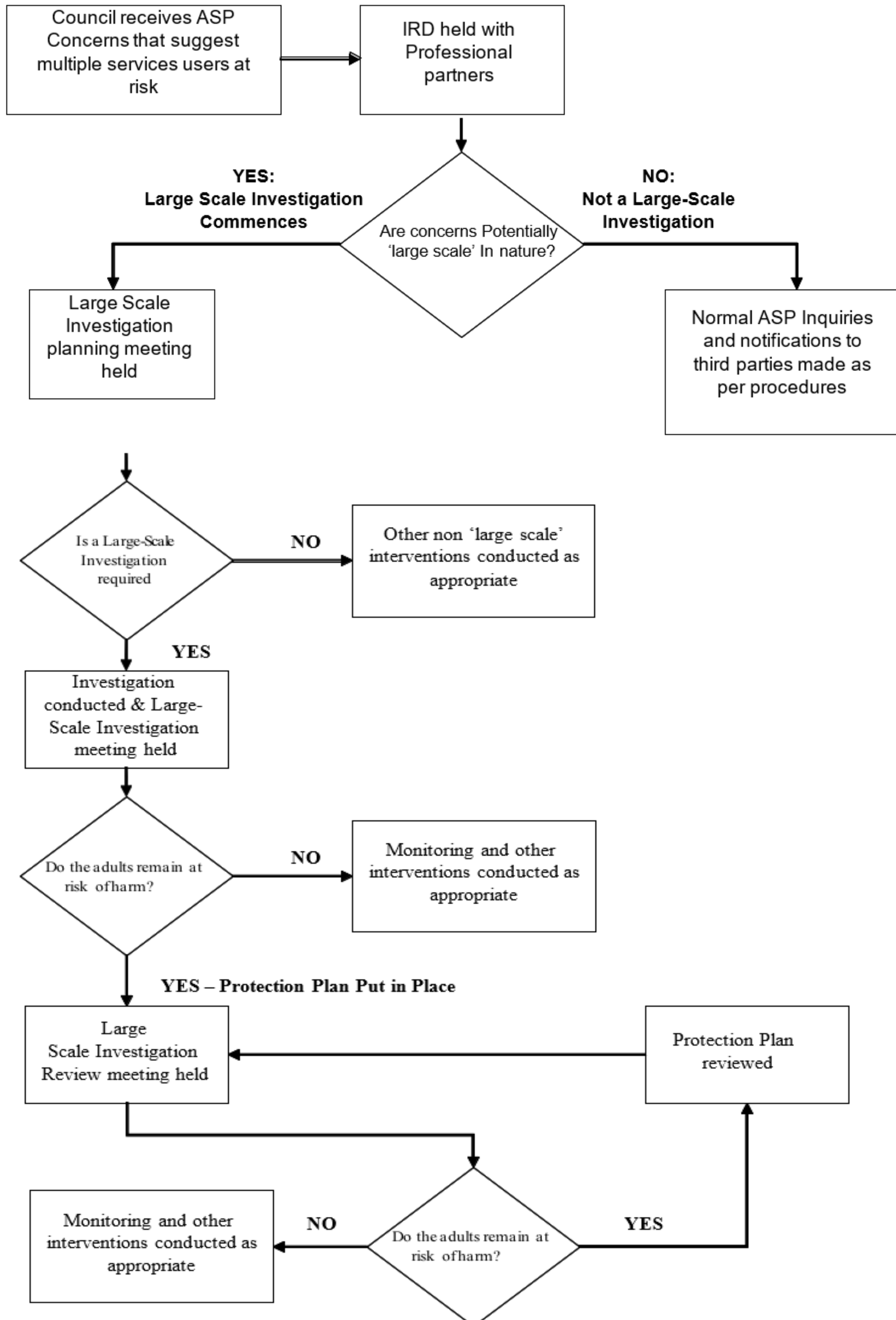
4 Arrangements for Monitoring/ Review

Either specify review date, with reasons, or that review will revert to normal procedures as no ongoing risk/ risk is managed acceptably

APPENDIX 5

9. APPENDIX B: PROCESS FLOWCHART

NOTE: The flowchart is designed to provide a simple graphical representation of the large-scale investigation process. It cannot cover all possible eventualities, and staff are advised to consult the whole procedure rather than rely on the diagram alone.



Grampian Multi-agency Escalation Process for Adult Support and Protection

Approvals:
This document was initially approved in Nov/Dec 2021 but subsequently it is reviewed and approved through Grampian Adult Protection procedures document.

Learning from Significant Case Reviews across Scotland has highlighted the need for practitioners and managers across all agencies to have a clear understanding about their responsibility for professional challenge and to know how to escalate concerns about decisions made where it relates to the safety of an adult.

This process aims to support positive resolution of professional difference between agencies working with adults at risk in Grampian. Professional differences are not, intrinsically, a negative thing when working in an area of such complexity as Adult Support and Protection. One of the key reasons for multiagency working in this area is the recognition and understanding that no single profession of professional will have the answer or solution in isolation. It should therefore be expected that, at times, professionals may see particular situations in different ways. What is most important, however, is that al professionals should feel comfortable with both challenging a particular view or opinion respectfully AND with accepting such challenges occurring.

Whilst there is clear evidence of good working relationships between partners, occasionally disagreements may arise which require timely resolution so as not to delay decision making. This process is specifically aimed at colleagues across all services and agencies in Grampian working with adults. It relates specifically to multi agency disagreement and does not cover disagreement within single agencies which should be addressed by agencies own escalation policy. This process does not apply to cases where there may be concerns about the behaviour or conduct of another professional that may impact on an adult's safety or wellbeing. In such cases, reference should be made to their agency's own protective processes.

When Dissent Occurs

Disagreements can arise in a number of areas, but are most likely to arise around thresholds, roles and responsibilities, the need for action and communication or service provision. Some examples may include:

- The referral does not appear to meet the eligibility criteria for assessment/support by a particular service.
- Where one professional disagrees with another around a particular course of action, such as closing involvement with an adult or proposed plans for support.
- Where one worker or agency considers that another worker or agency has not completed an agreed action for no acceptable or understood reason.
- Where one agency considers that the plan is inappropriate and that an adult's needs are not being best met by the current plan. This could include a disagreement that a particular agency does not feel it needs to be involved, but another does.
- Where a member of staff or an agency considers that the adult's needs cannot be met due to availability of appropriate service provision or challenges relating to professional difference

Key Principles

- Professionals will always acknowledge that the safety of the adult at risk is the paramount consideration in any professional disagreement even in the most challenging situations. Keeping the adult at the centre is essential in getting it right.

- Practitioners and managers across the multiagency workforce should be mindful of the risks in considering escalation and try to resolve difficulties quickly and openly. Professional disagreement is often reduced by clarity about roles and responsibilities and networking which enable problems to be shared and resolved through collaboration.

- Haringey Council in their escalation policy (revised after the death of child referred to as Baby P) suggest: "The best way of resolving difference is through discussion and where possible a face to face meeting between those concerned which will enable clear identification of the specific areas of difference and the desired outcomes for the child or young person. Email communication, whilst important, can be open to misinterpretation and should be avoided when making key decisions in challenging situations".

- Disagreement should be resolved at the lowest possible stage between the people who disagree but any worker who feels that a decision is unsafe should consult their manager or designated adult protection lead. It should be acknowledged that differences in status and / or experience may affect the confidence of some workers to pursue this unsupported.

The Staged Escalation Process

Stage 1

If professionals directly involved are unable to reach agreement about the way forward in an individual case, then they must escalate this to their manager and/or clinical supervisor. This manager/supervisor will then discuss with all relevant managers linked to the adult at that time what the areas of concern are and how they can be resolved.

Stage 2

If the concern continues about professional disagreement or service provision / availability then the Manager should refer the matter to the Adult Support and Protection Lead for their organisation. The Lead will then discuss the concern/disagreement with their relevant equivalent counterparts in the other organisations and seek a resolution. Timely feedback will be given to the professional who raised the concern.

Stage 3

In the extremely rare circumstance where no resolution can be reached, placing an adult at increased risk then it must be referred to the appropriate Senior member of staff (as per the table below) for discussion. If required, these staff will discuss with Chief Officers (via the Chief Officers Group) if concerns are significant enough to merit high level intervention.

APPENDIX 6 **OFFICIAL**

CONTACTS FOR ESCALATION STAGES

Stage 1 Escalation
Local line management and clinical supervisors.

Stage 2 Escalation – Adult Support and Protection Leads		
Organisation	**Job Title**	**Contact email**
Aberdeen City Council	Adult Protection Coordinator	APSW@aberdeencity.gov.uk [MARK "FAO: Adult Protection Coordinator"]
Aberdeenshire Council	Team Manager – Adult Protection Network	adultprotectionnetwork@aberdeenshire.gov.uk [MARK "FAO: Team Manager, APN"]
Moray Council	Consultant Practitioner, Adult Support and Protection	Adultprotection@moray.gov.uk [MARK "FAO: Consultant Practitioner, Adult Support and Protection Lead/Social Work
Police Scotland (across Grampian)	Detective Inspector, PPU	NorthEastPublicProtectionUnit@scotland.pnn.police.uk [MARK "FAO: Detective Inspector PPU"]
NHS Grampian (across Grampian)	Adult Public Protection Lead	Gram.publicprotection@nhs.scot [MARK "FAO: Adult Public Protection Lead"]

Stage 3 Escalation – Senior Management		
Organisation	**Job Title**	**Contact email**
Aberdeen City Council	Lead for Social Work	APSW@aberdeencity.gov.uk [MARK "FAO: Lead for Social Work"]
Aberdeenshire Council	Lead Social Worker	adultprotectionnetwork@aberdeenshire.gov.uk [MRK "FAO: Lead Social Worker"]
Moray Council	Chief Social Work Officer	jane.mackie@moray.gov.uk
Police Scotland (across Grampian)	Detective Chief Inspector, Public Protection Unit	NorthEastPublicProtectionUnit@scotland.pnn.police.uk [MARK "FAO: Detective Chief Inspector PPU"]
NHS Grampian	Director of Public Protection	Gram.publicprotection@nhs.scot [MARK: "FAO: Director of Public Protection"]

Adapted (with credit and thanks) from South Lanarkshire Child and Adult Protection Committee's "Joint Multi-Agency Transitions Guidance & Escalation Process for High Risk or Complex Cases"

GRAMPIAN MULTI-AGENCY IRD PROTOCOL

May 2023

Approvals:	
Aberdeen City Adult Protection Committee	24-04-2023
Aberdeenshire Adult Protection Committee	04-05-2023
Moray Adult Protection Committee	21-04-2023

Review Date	TO BE ALIGNED WITH GRAMPIAN ASP PROCEDURE REVIEW CYCLE

Responsibilities for review of this document:	
Lead Author/Co-ordinator	Kenneth O'Brien (Adult Public Protection Lead – NHS Grampian)

Revision History: (If there is no previous document please insert N/A into the boxes into the boxes in the top row of the table below).

Revision Date:	**Previous Revision Date:**	**Summary of Changes (Descriptive summary of the changes made)**	**Changes Marked * (Identify page numbers and section heading)**
February 2023	N/A	2.3 – Clarified only to be called if adult potentially meets ASP criteria; deleted reference to large scale investigations; general revisions to make IRD threshold for calling clearer. 2.4 – insertion to confirm that all core partners can request an IRD be called. 2.7 – insertion to clarify that other partners can be invited to IRD's in exceptional circumstances 3.4 – removed any mention of NHS staff setting date of IRD. 5.3 – edited to have Social Work set the date/time of the IRD. 5.8 – added clarifying statement on recording of 3rd party material in IRD Record	N/A
May 2023	N/A	At request of Aberdeenshire APC, "**Initial** Referral Discussion" included along with "**Inter-agency** Referral Discussion" to bring into full alignment with 2022 ASP Code of Practice. At request of Aberdeen City – adjusted references to "local authority social work" to either read as "H&SCP" or "Adult Social Work"	N/A

*Changes marked should detail the section(s) of the document that have been amended i.e. page number and section heading.

Contents

1. Introduction 4
2. Purpose of an IRD 5
3. IRD Process – Health Guidance 8
4. IRD Process – Police Guidance 10
5. IRD Process – Social Work Guidance 11

1. Introduction

1.1. Initial Referral Discussions (IRD's) – also known and referred to as Interagency Referral Discussions - have been long established in Child Protection and are a vital process to share information and make joint decisions. IRD's allow professionals to consider an adult support and protection report, share initial research and information, and then agree a response on a multi-agency basis.

1.2. All three Adult Protection Committees in Grampian agreed that IRD processes should be standardised on a Grampian-wide basis. As a result, this protocol was developed by Aberdeen City, Aberdeenshire and Moray Health and Social Care Partnerships in conjunction with Police Scotland and NHS Grampian.

1.3. The IRD, similar to the process in Child Protection, will be a telephone or virtual information gathering and decision-making forum. The core participants will be NHS Grampian, Police Scotland and the relevant social work team responsible for adult protection screening. The target should be for the IRD to occur within **48 hours** of the Referral being raised.

1.4. The introduction of this IRD protocol aims to improve multi-agency information sharing and joint decision making for adult support and protection throughout Grampian.

2. Purpose of an IRD

2.1. An IRD is not a case conference or a professionals meeting. Its purpose is to facilitate and support the sharing of relevant information to support **initial** decision making about an adult at risk and their circumstances.

2.2. An IRD should include, as part of the multi-agency discussions:

- Confirmation that immediate actions have been taken to make the adult safe in the short-term. [If not, an immediate protection plan should be agreed].
- Identification and sharing of relevant information, to determine if an ASP Investigation is required.
- Determination as to whether a police investigation is required, (if criminality is suspected).
- Agree a lead for any investigation and establish the involvement of other agencies.
- Consider what alternative (non-ASP) support and protective measures are required.
- Initial planning of an ASP Case Conference, pending any investigatory work being initiated.

2.3. An IRD should be considered where an adult potentially meets the 3 point criteria under the 2007 Act AND at least one of the following circumstances applies:

- There is need for immediate multi-agency safety planning and intervention prior to any investigatory activity commencing. [This is to determine the appropriate route for addressing the presenting issue.]

- The decision to proceed further under ASP procedures is considered 'borderline' and would benefit from multi-agency consideration to determine if ASP inquiries are required i.e. the three point criteria.

- The lead agency has received five distinct ASP reports for the same adult– triggering the need for multiagency consideration and review. OR locally, lead agencies wish to trigger a review due to locally agreed activity thresholds (high intensity user arrangements etc.)

2.4. For clarity, whilst Social Work are the lead agency for the handling and screening of ASP concerns (and will initiate the majority of IRD's), Police Scotland and NHS Grampian can also request that an IRD be called. This would be done via each organisations Single Point of Contact or ASP Lead contacting the lead agency with their request.

2.5. IRD's are also a legitimate mechanism to discuss situations where an adult has had 5 separate adult support and protection reports in a rolling two year period that have **not** resulted in any adult protection investigatory activity.

2.6. For the avoidance of doubt, this multiagency protocol governs IRD's related to individual adults at risk only. If it is believed that an ASP report relates to more than one individual where the origin of the harm is the same – this should be managed via the specific Large Scale Investigation IRD process as set out in the Grampian multiagency procedures and guidance.

2.7. As standard, attendees at an IRD will be the three core statutory partners (Health, Social Work, Police). Normally there will be one representative for each of the organisations as a whole. In exceptional circumstances, other agencies may be invited to an IRD if they have particular information or expertise that would aid deliberations. This could include housing colleagues, Scottish Fire and Rescue etc. Careful consideration must be given to expanding attendance at an IRD due to the sensitivity of the information being shared. Particular care must be taken when a representative is invited from an organisation that is not directly subject to the current Grampian Adult Support and Protection Information Sharing Protocol.

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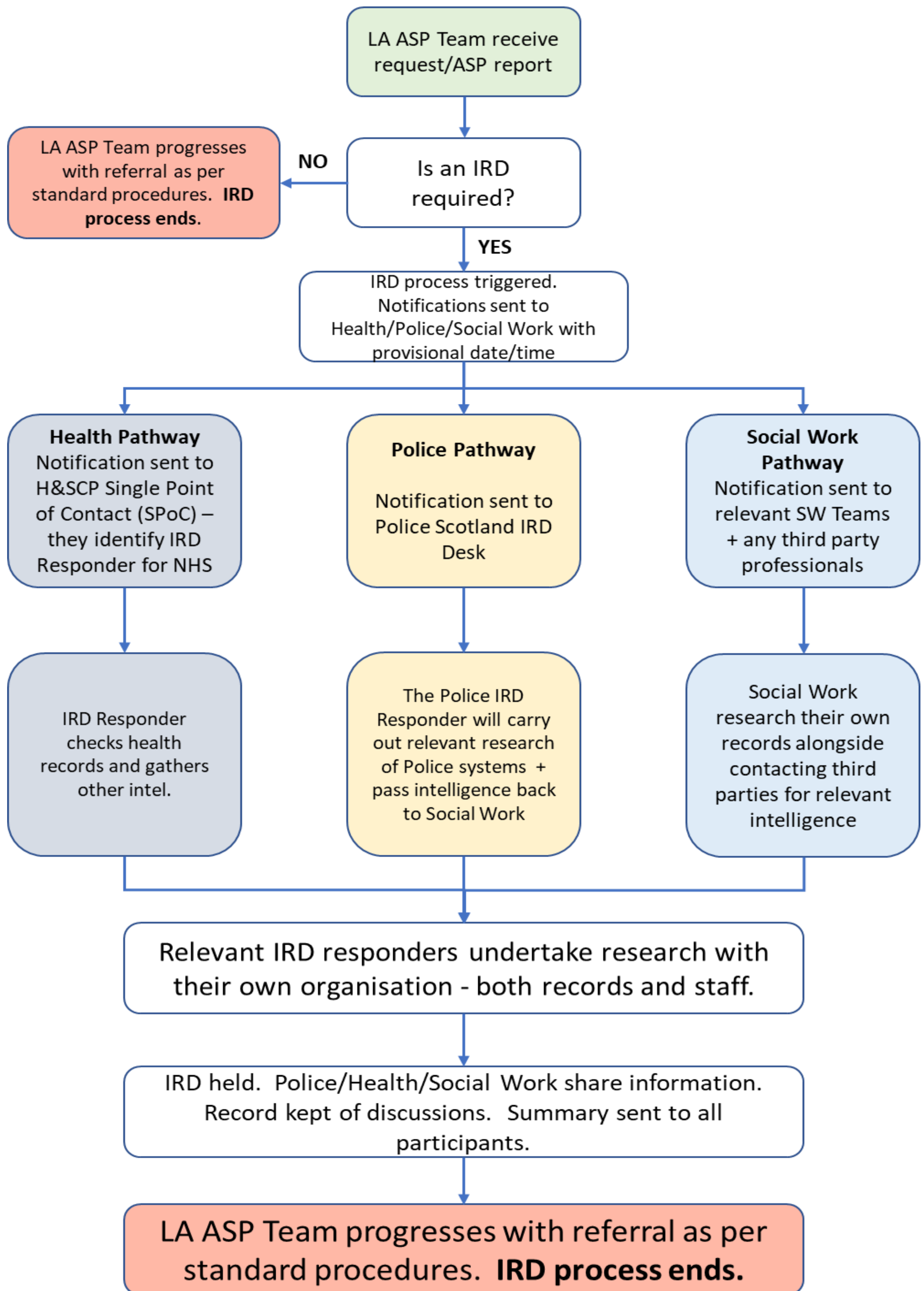

3. IRD Process – Health Guidance

3.1. Adult Social Work will contact the nominated Health Single Point of Contact (SPoC) within the relevant Health and Social Care Partnership.

3.2. The SPoC will check health records to ascertain if the potential adult at risk is known to any NHS professionals/teams. This could be community nursing teams, community psychiatric nurses, ward staff, allied health professionals, learning disability nursing, and integrated alcohol/drug service staff, amongst many others.

3.3. GP's will **not** be the default professional for attending IRD's – however may be the correct professional to attend if they have had significant involvement with the adult at risk, or are the only professional involved.

3.4. The SPoC will contact the relevant NHS professional and inform them that an IRD is required and give the details of the adult at risk. The professional identified by the SPoC will now be referred to as the **Health IRD Responder.** The IRD Responder will then inform the local authority social work department of their name and details.

3.5. If the SPoC is unable to source, for any reason, an appropriate IRD Responder, they should escalate to the local specialist ASP Nurse Practitioner or the NHS Grampian Public Protection Team immediately.

3.6. Adult Social Work will schedule the IRD and send joining instructions to the IRD Responder for the meeting. The IRD meeting will occur by telephone or virtual session and will last no longer than 20 minutes.

3.7. Prior to this meeting, the IRD Responder will have checked relevant health records to establish if there is any relevant information that supports the consideration of the adult support and protection report. The IRD Responder should also contact other health professionals who could have relevant information to inform the IRD.

3.8. The IRD Responder will participate in the IRD, sharing relevant health information and participate in discussions around next steps – ensuring the adult's health needs are fully considered.

3.9. The IRD Responder will record the IRD has happened in the adult's health records alongside the immediate outcome.

3.10. An IRD record will be provided by the local authority social work team to both the adult at risk's GP and the IRD Responder (if different). When received this should be added to the adult at risks health records.

IRD assessment tool – Health (this tool can be used by the IRD Responder to support the collection of health information; it is not a requirement)

Current or previous (last 2 years) health professionals providing a service to the Adult

Knowledge that would impact on the assessment that the adult has a mental or physical disability or impairment

Knowledge that would impact on the assessment that the adult is at risk of harm

Knowledge that would impact on the assessment that the adult is unable to protect themselves.

Any additional information

IRD Process – Police Guidance

3.11. The social work team will e-mail an IRD notification to IRDNorthEast@scotland.police.uk - following up with a phone call (01224-306918) in the case of urgent requests.

3.12. The IRD request will indicate

- The name and date of birth of the adult and other significant involved people
- The purpose of the request for information
- The requested time of the IRD teleconference

3.13. The Police Officer receiving the IRD request should nominate a named staff member to progress the IRD (**Police IRD Responder**). Any issues with this should be highlighted at this time.

3.14. The Police IRD Responder will carry out relevant research of Police systems with the information being available at IRD.

3.15. The presumption of Police attendance will be applied to all IRDs, however in certain circumstances where Police are unlikely to be required in the decision making process, it may be acceptable to share Police research with the lead agency and consult with them regarding the requirement for Police attendance. Unless agreed otherwise with the lead agency, Police will attend all IRDs.

3.16. The nominated Police Officer will take part in the teleconference, sharing relevant information and take part in discussion around next steps.

3.17. If a criminal investigation is required, discussion will occur about the impact on the ASP process. The Police IRD Responder will ensure any criminal investigation is undertaken timeously.

3.18. Police participation at an ASP IRD should be recorded via a VPD entry. This should document what information was shared and what actions will be taken as a result of the IRD.

3.19. In all cases a written IRD record will be provided by the social work lead agency within 24 hours.

3.20. If a Case Conference date is agreed, the Police IRD Responder will direct that invitations be sent via the Concern Hub as per existing arrangements for attendance to be facilitated.

4. IRD Process – Social Work

NOTE: Because the three separate Health and Social Care Partnerships in Grampian configure their adult support and protection operational activity differently – this section of the document captures the process in general terms only.

For further detail, please see each local authority area's own operational procedures.

4.1. Social Work will make the decision if an IRD is required and allocate a **Social Work IRD responder.**

4.2. Social Work sends IRD notification email to Health and Police.

4.3. The IRD notification template will indicate:

- The name and date of birth of the adult and other significant involved people.
- The reason an IRD is occurring.
- A provisional date and time for the IRD to occur.

4.4. The Social Work Team responsible for the IRD will check electronic files and contact any SW professional (currently involved – both community and acute services) to establish if there is any additional information held that supports the adult protection IRD process.

4.5. The Social Work Team will gather information from any other required professional or non-professional which would support the IRD discussion e.g. Care Inspectorate, Housing, Office of the Public Guardian, 3rd Sector organisation, carer.

4.6. The Social Work Team will send joining instructions to IRD participants for the IRD meeting. The IRD meeting will occur by telephone or virtual conference and will last no longer than 20 minutes.

4.7. The Social Work Team will facilitate the IRD, sharing relevant information and take part in discussion around next steps.

4.8. The IRD will:

- Confirm immediate actions have been taken to make the adult safe in the short-term - if this has not occurred, an immediate protection plan will be agreed.
- Identify and share relevant information, to determine if an ASP Investigation is required.
- Determine if a police investigation is required, if criminality is suspected.
- Establish what type of investigation is required (e.g. individual or large scale).
- Agree a lead for the investigation (ASP Investigation Lead) and establish involvement of other agencies.
- Agree a date for an Adult Protection Case Conference
- Decide what alternative (non-ASP) support and protective measures are required.
- Record the IRD in the adult's social work record. [This will document what information was shared and what actions will be taken as a result of the IRD.]

  NOTE: Any sensitive information (relevant criminal history, etc.) and 3rd party material (not related to the adult at risk) must only be recorded in the IRD Summary under 'Restricted Information'.

- Provide an IRD summary to health and police contacts. This will be provided within 24 hrs. of the IR

PLAN FOR ADULT PROTECTION INTERVIEW

Name of Adult:	**Date of Birth:**
	Carefirst Ref No.:
Address:	

Has referral information been fully shared amongst workers undertaking interview?	Yes/No
Have relevant agency checks been undertaken and information fully shared?	Yes/No
Are there grounds for immediate protection – if so, give brief details on how care will be arranged (e.g.; where, legal measures, contact, day-to-day arrangements, etc).	
Is the adult aware of referral?	Yes/No
If yes, what are their views?	
If no, how will they be made aware - who by and when?	
Does the Adult have capacity? (formal assessment)	Yes/No
If no, has permission been sought from the adults Legal Guardian	
Please note any known informal concerns about the adult's capacity?	
Has independent advocacy been considered?	
Are there any ethnic, religious or cultural issues that need to be taken into account?	
Is interviewing the adult the most appropriate next step or are other investigations more helpful e.g.: interview witnesses?	

APPENDIX 8 **OFFICIAL**

Interview Details

1	Location & Timing:
2	Who will lead? Who else will be present?
3	Special requirements (communication needs) – how will these be addressed?
4	Is a medical examination required (consider e.g., when, where, who consent, etc)?
6	Information sharing decisions? (How will the recorded information during the interview be shared between the interviewers, the adult and other agencies)
6	Who and how is it going to be recorded?

Further Investigation

1	Who will interview potential witnesses and when?
2	Actions relating to the alleged perpetrator.
3	Arrangements for review of this plan/decision-making from investigation:

Other Information/Considerations

Signed: ________________________________

APPENDIX 9 **OFFICIAL**

Adult Support and Protection Risk Assessment Matrix
(based on NHS Quality Improvement Scotland 2005)

CONSEQUENCES

Likelihood		**Negligible** e.g. minor injury, not requiring first aid. Reduced quality of patient/client experience.	**Minor** e.g. minor injury requiring first aid. Unsatisfactory patient/client experience but readily resolvable.	**Moderate** **e.g. Reportable incident (police). Significant injury requiring medical treatment/counselling** Unsatisfactory patient /client experience with effects lasting less than 1 week.	**Major** e.g. Major incident, long term incapacity requiring medical treatment /counselling. Unsatisfactory patient /client experience with effects lasting more than 1 week.	**Extreme** **e.g. Major permanent incapacity / death.** Continuing long term effects.
	X	**1**	**2**	**3**	**4**	**5**
Almost Certain Expected to occur frequently / in most circumstances – more likely to occur than not.	**5**	**5** MEDIUM	**10** HIGH	**15** HIGH	**20** VERY HIGH	**25** VERY HIGH
Likely Strong possibility that likely to occur – likely to occur.	**4**	**4** MEDIUM	**8** MEDIUM	**12** HIGH	**16** HIGH	**20** VERY HIGH
Possible May occur occasionally, has happened before on occasions – reasonable chance of occurring.	**3**	**3** LOW	**6** MEDIUM	**9** MEDIUM	**12** HIGH	**15** HIGH
Unlikely Not expected to happen, but definite possibility exists – unlikely to occur.	**2**	**2** LOW	**4** MEDIUM	**6** MEDIUM	**8** MEDIUM	**10** HIGH
Rare Can't believe this event would happen – will only happen in exceptional circumstances.	**1**	**1** LOW	**2** LOW	**3** LOW	**4** MEDIUM	**5** MEDIUM

NB – See Adult Support and Protection examples overleaf

Adult Support and Protection Risk Assessment Matrix

EXAMPLES OF POSSIBLE RISK

Negligible	Minor	Moderate	Major	Extreme
Inappropriate physical contact such as slap, punch, kick that does not lead to injury	Notable injury requiring first aid or medical attention	Significant but not permanent injury resulting from physical harm. More than one incident of physical harm.	Significant and long lasting /permanent injury.	Death, major permanent incapacity.
Financial exploitation having no impact on welfare.	Financial harm with minimal impact on personal welfare	Financial harm significantly impacting on personal welfare.	Depletion of funds to point where person is unable to meet their basic needs e.g. food, heating, housing etc.	
Omission of care with no impact.	Omission of care being provided resulting in distressed presentation by individual. (Continence pad not being changed)	Some level of neglect or lack of recognition of deterioration/need for support, causing pain, discomfort, distress or loss of independence.	Significant neglect requiring hospitalization or significant medical intervention.	Death. Major permanent incapacity.
Behavior which could be perceived as offensive with no impact on the person's psychological wellbeing.	Behavior which has minimal impact on psychological wellbeing.	Behavior which causes notable psychological harm.	Behavior which results in significant psychological harm and a short-term need for therapeutic /psychiatric intervention.	Long term trauma requiring intensive therapeutic /psychiatric intervention.
Inappropriate sexualized language used in presence of the person.	Inappropriate sexualized language directed at the person resulting in them feeling uncomfortable.	Non penetrative sexual harm with psychological impact.	Penetrative sexual abuse.	
	Risk to other vulnerable members of the community.			

<u>Context</u>

The above are meant as examples only. As part of the assessment, consideration should be given to whether the harm:

- is historical or current.
- is repetitive.
- has been the result of a power imbalance.
- has been carried out by a member of staff.

Consideration should also be given to the impact on the adult and how they perceive it.

GRAMPIAN ADULT PROTECTION COMMITTEES LEARNING REVIEW PROCEDURES

Approvals:	
Aberdeen City Adult Protection Committee	03/02/2023
Aberdeenshire Adult Protection Committee	21/03/2023
Moray Adult Protection Committee	17/02/2023

Review Date	May 2026

Responsibilities for review of this document:	
Lead Author/Co-ordinator	DCI Carron McKellar, Public Protection Unit, NE Div, Police Scotland

Revision History: (If there is no previous document please insert N/A into the boxes into the boxes in the top row of the table below).			
Revision Date:	**Previous Revision Date:**	**Summary of Changes (Descriptive summary of the changes made)**	**Changes Marked * (Identify page numbers and section heading)**
N/A			

*Changes marked should detail the section(s) of the document that have been amended i.e. page number and section heading.

This document replaces the Grampian Adult Protection Committees Serious Case Review and Case Review Protocol, June 2009 revised 2015. All copies of this document should be achieved/deleted according to your organisations retention policy.

Any queries regarding this procedure should be directed to: Annmarie.bruce@aberdeenshire.gov.uk

CONTENTS

		Page
	CONTEXT	4
1.	How are opportunities for learning / improving practice identified?	5
2.	Under which circumstances should a Learning Review be considered?	5
3.	What is the process for Learning Reviews?	6
4.	How should learning be disseminated and embedded and practice improvements made?	7
5.	How will the APC seek assurance that learning has been embedded, and practice / outcomes improved?	8
6.	What about cross authority and cross border considerations?	8

APPENDICES		
A.	Learning Review process	9
B.	Learning Review Notification Form	10
C.	Request for information	13
D.	APC Decision Notification Form	16
E.	Learning Review Report	21
F.	Implementation Plan	24

ADULT PROTECTION COMMITTEE (APC) LEARNING REVIEW PROCEDURES

CONTEXT

APC Functions and Responsibilities

The Adult Protection Committee (APC) is responsible for the commissioning and undertaking of reviews, development of learning and sharing of practice on the findings of a learning review.

The functions of the APC under the Adult Protection (Scotland) Act 2007 include:

- To make or assist in or encourage the making of arrangements for improving the skills and knowledge of officers or employees of local agencies who have responsibilities related to safeguarding of adults at risk.

Purpose of Framework

This paper sets out a framework for improving practice and embedding learning, by answering the following questions:

- How are opportunities for learning / improving practice identified?
- Under which circumstances should a Learning Review be considered?
- What is the process for Learning Reviews?
- How should learning be disseminated and embedded and practice improvements made?
- How will the APC seek assurance that learning has been embedded and that practice/outcomes have improved?
- What about cross authority and cross border considerations?

This document is aligned to the National Guidance for Adult Protection Committees Undertaking Learning Reviews and supports the recommended national process. It should be considered in line with this.

1. HOW ARE OPPORTUNITIES FOR LEARNING / IMPROVING PRACTICE IDENTIFIED?

Opportunities to share learning and improve practice may be identified in a number of ways including, but not limited to:

- As a result of regular or ad hoc Quality Assurance case file reviews, whether single or multi-agency;
- From the findings of audits or inspections (single or multi agency);
- As a result of complaints or feedback received, whether from, clients, carers or other services / agencies;
- Any time a worker from any organisation or service comes across an opportunity to improve practice; and,
- When serious incidents occur (please refer to section 2 regarding Learning Reviews).

Please note that opportunities for learning and improvements to practice will also arise from Learning Reviews originating in other areas. These will be considered by the Grampian Learning Review Sub Group and proposed learning highlighted to the APCs via Conveners and Lead Officers, for taking forward locally as appropriate and in line with this framework.

2. UNDER WHICH CIRCUMSTANCES SHOULD A LEARNING REVIEW BE CONSIDERED?

In line with the National Guidance for Adult Protection Committees Undertaking Learning Reviews, a Learning Review should seek to:

- Understand the full circumstances of the death of, or serious harm to, an adult;
- In a trauma-informed way, examine and assess the role of all relevant services, relating to both the adult and also, as appropriate, to relatives, carers or others who may be connected to the incident or events which led to the need for the review;
- Explore key practice issues and why they might have arisen, including identifying systematic issues. Consider the question of “How did the situation present itself to the practitioner at the time, and how did this lead to decisions and actions taken at the time?”
- Establish whether there are areas for development, how they are to be acted upon and what is expected to change as a result;
- Consider whether there are issues with the system and whether services should be reviewed or developed to address these
- Establish findings which will allow the APC to consider what recommendations need to be made to improve the quality of services.

Each APC has created a mandated sub-group whose function is to assess initial information and make recommendations to the APC regarding the need for a learning review”

3. WHAT IS THE PROCESS FOR LEARNING REVIEWS?

The three APCs in Grampian have agreed to adopt the National Guidance for Adult Protection Committees Undertaking Learning Reviews. This aims to:

- Identify the key features of a Learning Review;
- Clarify how a review is initiated and undertaken;
- Provide information regarding practitioner and first line manager and strategic manager events;
- Clarify the role of the Review Team and the Lead Reviewer;
- Highlights other review processes or investigations which require to be considered; and,
- Provide guidance regarding communication and media plans.

The National Guidance provides full details of the Learning Review process. Grampian APCs templates have been created in line with the national guidance to be used at each stage of the review process and are included in this document, along with a process map for Learning Reviews.

Administration

Any professional can submit a review notification. These must be submitted to the identified administrator and reports should be reviewed by their line manager before submission. It is preferable that a sub-committee member from the relevant agency also reviews the report prior to submission if possible.

The administrator contact details for each area are:

- **Aberdeen: APSW@aberdeencity.gov.uk**
- **Aberdeenshire: adultprotectionnetwork@aberdeenshire.gov.uk**
- **Moray: adultprotection@moray.gov.uk**

Once the initial notification has been received, a unique identifier will be raised and used in all subsequent documentation and communication by the sub-committee (this does not relate to the agency reports), i.e. Mr A, Ms B, etc. All notifications will be acknowledged, with confirmation sent to the referrer.

The administrator will send out requests to the relevant agencies for completion of an initial agency report ('Request for Information'). These should be completed within the defined timescale, normally within 14 days, and returned to the administrator who compiles the reports and forwards them to sub-committee members for consideration.

The reports will be discussed by the sub-committee at a meeting, ideally to be held within **14 days**. Should it be decided that the case concerned does not merit further review, the decision and rationale for this will be recorded and the Chair will present this to the APC for ratification.

Should a review be decided upon, the Terms of Reference and membership of the review team will be agreed, and a timescale provided for completion of the review. The terms of reference will also include the scope of the review and clarify the extent of it, i.e. whether a practitioner events and / or a senior manager event is required, and whether an individual / carer / family will be included.

In either case the Care Inspectorate will be notified as per the national guidance.

The Chair of the Review Team will provide verbal updates as required until the review is complete, whereupon the review report will be submitted to the APC for consideration along with the Review Team's recommendations and associated implementation plan. Once agreed, these will be presented to the Chief Officer's Group (COG) and, finally, the Care Inspectorate. The APC will be responsible for overseeing the progression of any implementation plan, which may include actions to be driven forward by the APC's other sub-committees or could include a Short Life Working Group.

It should be noted that any minute/notes of sub-committee meetings will not include any reference to personal or identifying information relating to any cases discussed.

4. HOW SHOULD LEARNING BE DISSEMINATED AND EMBEDDED AND PRACTICE IMPROVEMENTS MADE?

It may be helpful to consider the following questions when planning how to disseminate and embed learning and make improvements to practice (it may be necessary to apply these questions in relation to each separate area of improvement):

- What learning has been identified which gives rise to the need for change?
- What outcomes do we want to achieve?
- For whom are the identified areas relevant?
- What are the proposed strategies for improving systems and practice?
- How should the learning be addressed and disseminated?
- Do any changes need to be tested on a small scale, prior to roll-out?
- Do changes need to be made to policies / procedures / recording?
- How will we make sure the improvements are embedded into practice?

Learning can be addressed through several different means. Changes to multi-agency training or specific training may be deemed as appropriate; other options may include a single event or communication to practitioners, or the instigation of a short life working group to focus on a practitioner toolkit and longer term piece of work. The APC will consider the actions presented to it and facilitate any work as required.

The Implementation Plan template at *Appendix 6* should be used to present the actions required to address the learning identified in the review. It will be submitted to the APC for endorsement and the APC will be updated upon completion. It may be decided that further action through the APC's quality assurance processes will be required to evidence its effectiveness.

5. HOW WILL THE APC SEEK ASSURANCE THAT LEARNING HAS BEEN EMBEDDED, AND PRACTICE / OUTCOMES IMPROVED?

As referenced above, once the APC have received the completed Implementation Plan, consideration will be given to the incorporation of measures as relevant into the relevant quality assurance processes. This may include a focussed audit or thematic review as well as considered relevant data to gain assurance about the impact on practice and outcomes for the vulnerable individuals the partnership supports.

6. WHAT ABOUT CROSS AUTHORITY AND CROSS BORDER CONSIDERATIONS?

The undertaking of a Learning Review for one APC area may involve agencies and professionals from a different Local Authority, Health Board, Education or Police division. Other matters to consider include that the adult may have been/or is placed within another area from the commissioning authority. It is expected that the area which is hosting the adult is made aware of intent to progress to Learning Review at the earliest opportunity.

It is the responsibility of the considering APC to actively seek and discuss the potential for Learning Review and that an agreement for joint working is reached via the relevant committee, with the Convener of the APC making direct contact with the Convener of the other committee. Notification to the Chief Officers Group is expected as part of this process and any disagreement of dispute is managed by the Chief Officers Group and resolution found as early as possible. Should no resolution be reached, and the APC agrees to proceed to Learning Review then clear reference to the limitations and scope of the review should be documented within the findings and recommendations.

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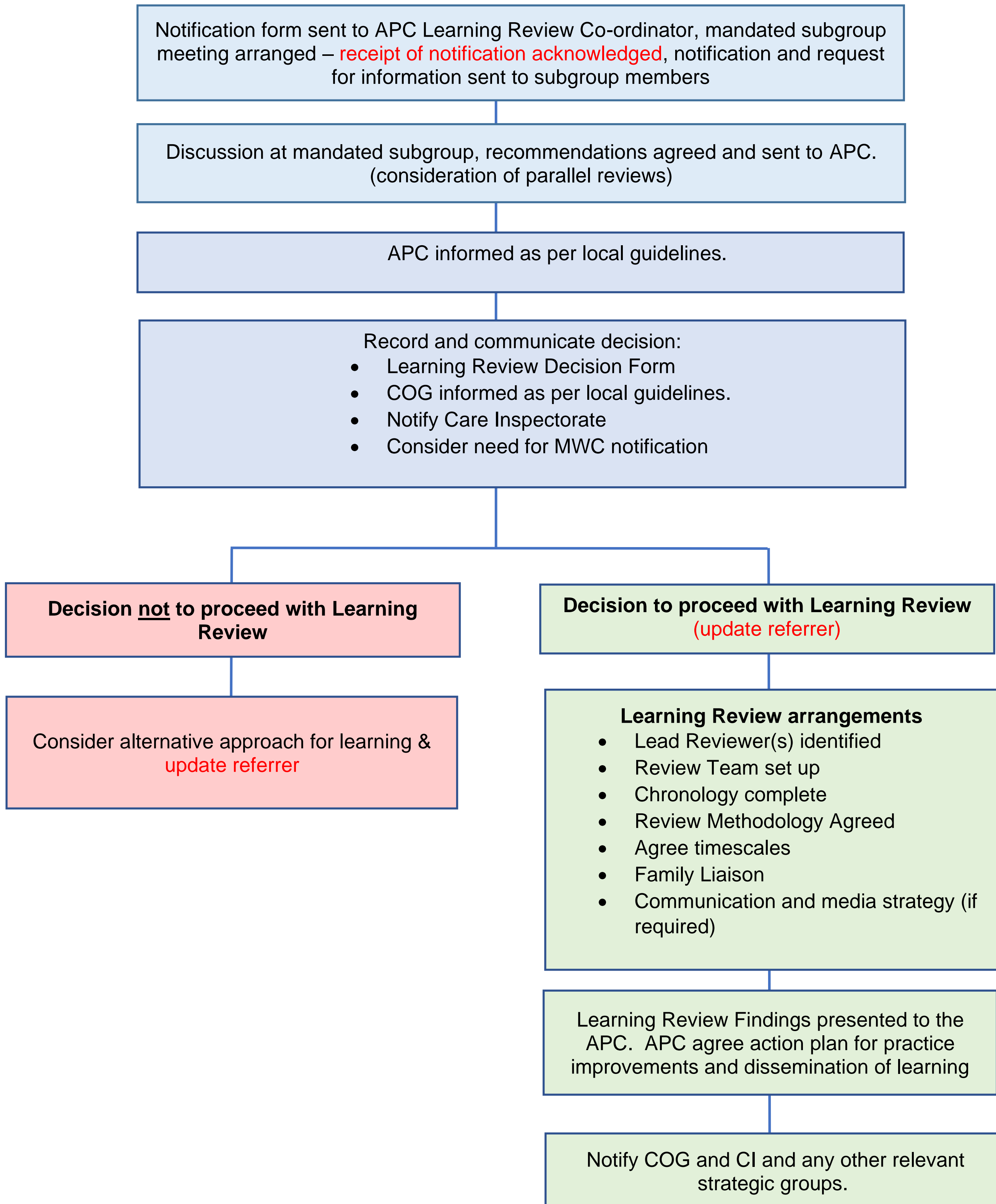
(APPENDIX A)

GRAMPIAN LEARNING REVIEW PROCESS



	Grampian Adult Protection Committees Learning Review Notification Form

Any agency with an interest in an adult's wellbeing or safety can raise a concern about a case which it is believed may meet the criteria for a Learning Review and submit a notification to the Adult Protection Committee (APC) using the Learning Review notification form.

This notification will be acknowledged and then responded to with the outcome of the APC's consideration of whether or not to proceed to a Learning Review. Criteria for undertaking a learning review.

An APC will undertake a Learning review in the following circumstances:

1. Where the adult is, or was, subject to adult support and protection processes and the incident or accumulation of incidents gives rise for reasonable cause for concern about how professionals and services worked together to protect the adult from harm, and one or more of the following apply:

(i) **The adult at risk of harm 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;
- the death is by alleged murder, culpable homicide, reckless conduct, or act of violence or

(ii) **The adult at risk of harm has not died but** is believed to have experienced serious abuse or neglect.

2. Where the adult who died or sustained serious harm was not subject to adult support and protection processes

(i) **When the findings of an inquiry or review by another organisation or court proceedings, or a referral from another organisation** gives rise to reasonable cause for concern about lack of involvement in relation to the Adult Support and Protection (Scotland) Act 2007 or;

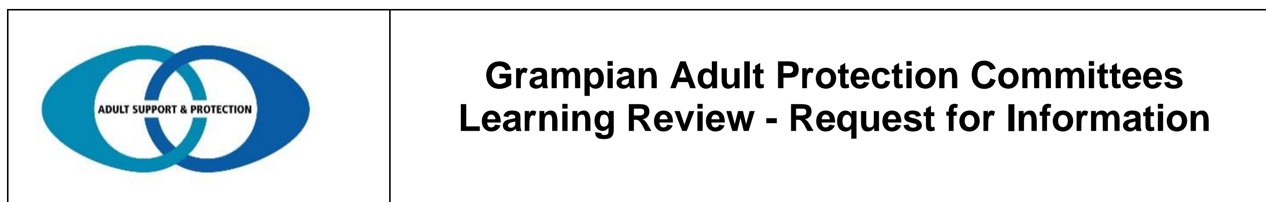
(ii) **The Adult Protection Committee determines** there may be learning to be gained through conducting a Learning Review.

Request from:	
Contact details:	
Agency:	
Date completed:	

Adult's Details	
Name:	
Date of birth:	
Date of death:	
Address:	

Gender:	
Ethnicity:	
Next of kin & address	
Any other Local Authorities involved:	
Is/was the adult subject of any statutory powers at time of concerns arising in relation to ASP, AWI or the MHCT?	
Were there concerns related to the adult's decision-making capacity? *(if yes, please provide details)*	
Contact details for any Guardian or Power of Attorney, if known	
Did the adult have an unpaid carer?	
Was the adult in receipt of support otherwise *(please provide details)*	
Criteria for Learning Review	
What grounds within the criteria do you consider apply for a Learning Review in this case?	
Immediate and general concerns	
Are there any immediate concerns? If yes: • **What are the immediate concerns and have these been passed to the relevant agency for consideration/ action?** • **What action has been taken (if known)?**	
Are there any general concerns identified during this process of notification? If yes: • **What are the general concerns and have these been passed to the relevant agency for consideration / action?** • **What action has been taken?**	
Summary of the case:	

Are other reviews, criminal investigations, or other statutory proceedings underway? If so, please give details.
Name of service/agency/individuals involved with the adult, with contact details (if known)



Grampian Adult Protection Committees Learning Review - Request for Information

A referral under the Grampian Learning Review Protocol has been made regarding the adult identified below. The first part of the process is to collate information in order that an interagency decision is made as how the referral should be progressed.

You are being asked to provide the local APC with the relevant information by completing Part B of this form, returning the form by email to the SCR Administrator **as soon as possible and in any case within 14 days.**

Please provide a brief account of your agency's contact with the adult named below, and provide your reflections on the key practice issues listed.

All reports reviewed will be acknowledged by the SCR Administrator.

Part A (For completion by SCR Administrator [*add name and email of person requesting info])*

Date sent:	
Date to be completed:	
APC area:	

Adult's name:	
Date of birth:	
Date of death (if applicable):	
Adult's address:	

Brief details of the immediate precipitating factors leading to the referral for consideration of a Learning Review

PART B

Summary of involvement with the adult: • What was your service involvement and considerations? • What was your service intervention? • What was the outcome of the intervention?

Relevant background history of the adult: • What were the vulnerabilities and protective factors of the adult • What were risks concerns regarding the adult
Key Practice Issues: Please provide information on: • Recognition and assessment of Risk and need in relation to the adult • Information sharing in this case • Strategies and actions to minimise harm • Timely and effective action taken • Multi-agency responses • Evidence of planning and reviewing • Quality of record keeping • Appropriate use of legal measures
Good Practice Identified
Please highlight any areas which may require further considerations for to enable practice improvements

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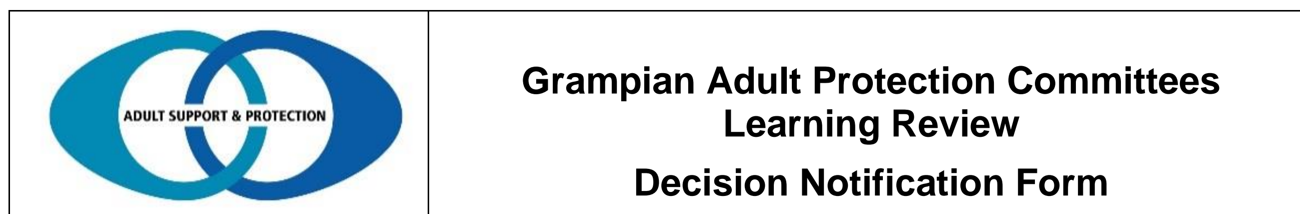
Parallel processes	
Are you aware of any current or planned reviews being undertaken for this case? If yes, please give details.	
Are you aware of any criminal proceedings associated with this case? If yes, please give details.	

Part B completed by:	
Name:	
Title:	
Agency:	
Email:	
Date:	



Grampian Adult Protection Committees Learning Review

Decision Notification Form

The notification form is to be completed at the point when a decision has been made to conduct a learning review, or to detail the reasons for not proceeding.

For the Care Inspectorate, Learning Review decision notifications should be submitted to: learning review decision notification.

A notification decision form is to be completed for all adults considered under the National Guidance for Adult Protection Committees Undertaking Learning reviews introduced on 26th May 2022.

For completion by representative of Adult Protection Committee or mandated sub-group.

Section 1

1.1	Date of notification
1.2	Name of the person submitting notification
1.3	Position
1.4	Email address
1.5	Telephone number
1.6	Adult Protection Committee area

Section 2: Adult's information

Note – only redacted information with no identifiable information

2.1	Adult identifier : (*For example: Adult D)*
2.2	Gender of adult :
2.3	Age of adult when Learning Review referral was made :
2.4	Primary type of harm • Financial • Psychological • Self-Harm • Physical • Sexual • Neglect • Self-Neglect

	• Institutional • Other *(please state)*
2.5	Any other applicable type of harm • Financial • Psychological • Self-Harm • Physical • Sexual • Neglect • Self-Neglect • Institutional • Other *(please state)*
2.6	What is/was the adult's ethnicity?
2.7	Primary case type • Alcohol or substance misuse • Dementia or cognitive impairment • Acquired brain injury • Learning disability • Mental health issues • Physical disability • Frail older • Sensory impairment • Other *(please state)*
2.8	Primary location of harm • Own home • Care home • Other private address • Sheltered housing or other supported accommodation • Independent hospital • NHS • Day centre • Public place • Not known • Other *(please state)*
2.9	Has the adult died?
2.9.1	If yes, please advise on date of death

2.10	Outline what is/was the nature of the adult's situation *Relevant background information including key risks and supports*
2.11	Was the adult referred under Adult Support and Protection (Scotland) Act 2007 during the time period being considered?
2.12	Was the adult supported under Adult Support and Protection (Scotland) Act 2007 during the time period being considered? *Support includes inquiry, investigation, case conference and protection planning*
2.12.1	If yes, please provide further details *This should include information about stages of the process and application of the three-point test/criteria*
2.13	Were there concerns related to the adult's decision-making capacity?
2.13.1	If yes, please provide further details
2.14	Was the adult subject to Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Care & Treatment) (Scotland) Act 2003 during the time period being considered?
2.14.1	If yes, please provide further details
2.15	Did the adult have an unpaid carer?
2.16	During the time period considered did the adult receive support that included a commissioned service?

2.16.1	Please select all type of services that apply: •

Section 3 – Decision making process

3.1	Date APC received the Notification Form for case to be considered
3.2	What are the locally agreed timescales for carrying out a Learning Review? (From referral to Learning Review decision)
3.3	What was the membership of the review group? *Name, organisation, and designation* •
3.4	Date of review group meeting
3.5	Options considered by review group *This may be in relation to immediate actions, or recommendations that precede any further case review processes.* •
3.6	Review group's recommendation and rationale to proceed or not to a Learning Review *Please provide a brief summary of the recommendations, and supporting rationale, made by the Review Group to the Adult Protection Committee* ***If a process other than a Learning Review is being pursued but meets the criteria for a Learning Review, please remember to forward a copy of this report to the Care Inspectorate and complete the outcome notification form*** •
3.7	Date of review group's recommendation
3.8	Date Adult Protection Committee notified of review group's recommendation

3.9	Note of discussion by Adult Protection Committee *Please provide a brief summary (perhaps in bullet point) of the discussion & resultant recommendation of the Adult Protection Committee regarding the findings of the review groups recommendations regarding a Learning Review, actions to be taken as an outcome, and recommendations to the Chief Officers Group* •
3.10	Adult Protection Committee's decision(s) and rationale
3.11	Date of Adult Protection Committee Decision(s)
3.12	Note of any comments by/discussion with Chief Officers *Please provide a brief summary of the discussion & resultant decision of the Chief Officer's Group regarding the findings of the Learning Review, and actions to be taken as an outcome – including whether there will be a full Learning Review.* •
3.13	Date of Chief Officers' final decision
3.14	If not proceeding to a Learning Review, any improvement actions identified and arrangements for oversight and implementation

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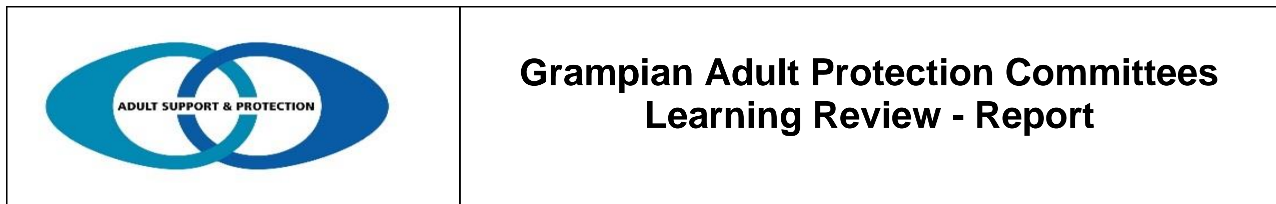
APPENDIX E



Grampian Adult Protection Committees Learning Review - Report

Core Data – Adult	
Adult's Identifier	
Age of Adult	
Gender	
Sexual Orientation *(if relevant)*	
Disability	
Health Needs *(incl. mental health)*	
Education	
Living Circumstances prior to incident	
Position in family / number of siblings	
Ethnicity	
Religion	
Marital status	
Substance use (if applicable)	
Previous trauma (childhood, domestic abuse, etc)	
Nature of injury / cause of death	
Legal status of adult	
Agencies / service involved	
Family / carer factors	
Age	
Health needs (incl. mental health)	
Disability	
Substance use (if applicable)	
Previous convictions (Y/N – if applicable)	
Childhood issues (if applicable)	
Domestic Abuse (if applicable)	
Ethnicity	

Religion	
Living circumstances	
Agencies involved	
Environmental Factors	
Financial issues	
Housing	
Support from extended family / community	

1. **INTRODUCTION**
   (include a brief synopsis of the circumstances which led to the review)

2. **THE REVIEW PROCESS**
   (include approach taken, engagement with the Review Team, details of records and compilation of any chronologies, details of reviews of records & compilation of chronologies, details of practitioner events/meetings and managers, details of family involvement)

3. **CIRCUMSTANCES**
   (include family background & circumstances, & agency involvement, a succinct chronology/timeline of significant events may be included)

4. **ANALYSIS**
   (include an assessment of the key circumstances of the case, any interventions offered & decisions made, identify key issues, the 'why' and the 'how' things have happened taking into consideration organisational culture, training & policies)

5. **PRACTICE & ORGANISATIONAL LEARNING**
   (highlight key learning points & how these were dealt with in relation to policies and procedures in place)

6. **EFFECTIVE PRACTICE**
   (identify areas of good practice)

7. **RECOMMENDATIONS**

8. **APPENDICES**
   (include review team, membership, terms of reference, files accessed/relevant documents, people interviewed)

Grampian Adult Protection Committees Learning Review – Implementation Plan

Learning Review Recommendation/s:

Identified Learning	Specific Actions to be taken (including Comms)	Stakeholders / staff groups affected	Desired Outcome	Action Lead	Timescales	Progress	How Impact will be measured