THE STATE HOSPITALS BOARD FOR SCOTLAND

ADULT SUPPORT AND PROTECTION POLICY
AND
OPERATIONAL GUIDANCE AND PROCEDURES

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Lead Author	Social Work Team Leader	
Contributing Authors	Child and Adult Protection Forum	
	Social Work	
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REVIEW SUMMARY SHEET

No changes required to policy (evidence base checked)	☐

Changes required to policy (evidence base checked) ☒

Summary of changes within policy:

Changes to layout and flow of document.

Section 2: Legal Context - section expanded to include relevant legislation.

Section 5: Defining Adults at Risk – section expanded with clarity regarding the term 'unable'.

Section 6: Defining Harm – expanded to include guidance regarding professional judgement.

Section 18: West of Scotland Guidance – minor amendment to reflect updated membership of partnership

Operational Guidance Stage 1: Guidance section added in relation to Sharing Information and GDPR.

Operational Guidance Stage 2: Addition clarity given regarding 'duty to inquire'.

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1. Introduction

The Adult Support and Protection (Scotland) Act 2007 (the Act) was passed by the Scottish Parliament in February 2007. The Act is rights based legislation that makes new provisions intended to protect those adults who are unable to safeguard their own interests, such as those affected by disability, mental disorder, illness or physical or mental infirmity, who are at risk of harm or self harm, including neglect.

The Act consists of 5 parts which cover the following provisions:

- Part 1 of the Act deals with the protection of adults at risk of harm. The Act came into existence in October 2008.
- Parts 2, 3 and 4 of the Act aim to streamline and improve policy measures in existing legislation and include amendments to; the Adults with Incapacity (Scotland) Act 2000; the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Social Work (Scotland) Act 1968
- Part 5 is primarily concerned with procedural provisions to ensure that the Act operates as intended.

This document provides guidance and procedures to be followed in compliance with Part 1 of the Act.
Support and protection of adults at risk is the responsibility of all statutory, voluntary and private sectors with good communication and joint working key to the prevention of harm. It is therefore important that all staff, within The State Hospital (TSH), whatever their role and responsibilities, understand that preventing harm occurring and taking action to deal with it is a fundamental part of their day to day work.

The Act gives Councils, and in particular Social Work Resources, lead responsibility for inquiring and investigating into the circumstances of adults at risk who are or, who may be, being harmed When harm does occur, it needs to be dealt with quickly, effectively and in a way which is proportionate to the issues involved and which gives the adult concerned the opportunity to remain in control of their circumstances as far as practicable. The right of the adult to be heard throughout the adult protection process is integral to this policy.

The Act places an obligation on local Councils to establish multi-agency Adult Protection Committees (APCs) and provides a framework for how APCs should function. South Lanarkshire Council has established an Adult Protection Committee and multi agency procedures have been produced to reflect local arrangements across South Lanarkshire based on the West of Scotland Adult Protection Guidance. The introduction of the Public bodies (Joint Working) (Scotland) Act 2014 establishes partnership arrangements for the governance and oversight of health and social care services.

The West of Scotland Adult Protection Guidance gives an overview of the application of the Act and establishes a common operational procedure across the thirteen participating local authorities. This document provides TSH perspective to the South Lanarkshire multi agency operational guidance and procedures

This document is designed in two parts. Part 1 provides comprehensive information about the Act, adult harm, agencies' responsibilities and key partners. Appendix 1 provides a reference to Council Officer duties under the Act. Part 2 provides procedures for responding to allegations of harm. While staff are expected to work within a clear procedural framework this does not replace the need to exercise judgement in relation to the most appropriate response to specific circumstances.

This policy is based on best practice and will be revised on a regular basis to reflect our increasing understanding of the application of the Act and our experience of supporting and protecting adults at risk of harm within TSH. It should be read in conjunction with the Act and the accompanying Code of Practice.

2. Legal Context

The Act, the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003 are consistent with the Human Rights (Scotland) Act 1998 which provides a framework for decision making in relation to balancing rights with the need for intervention when situations of harm arise. Other legislation is equally important in the protection of adults at risk and may require to be referred to in the protection of adults including:

- Regulation of Care (Scotland) Act 2001
- Social Work (Scotland) Act 1968
- Human Rights Act 1998
- Data Protection Act.1998
- Regulation of Care (Scotland) Act 2001
- Community Care and Health (Scotland) Act 2002
- Mental Health (Scotland) Act 2015
- Protection of Vulnerable Groups (Scotland) Act 2007
- Public Health etc. (Scotland) Act 2008
- Sexual Offences (Scotland) Act 2009
- Offences (Aggravation by Prejudice) (Scotland) Act 2009
- Equalities Act 2010
- Domestic Abuse (Scotland) Act 2011
- Forced Marriage etc (Protection and Jurisdiction) (Scotland) Act 2011
- Human Trafficking and Exploitation (Scotland) Act 2015
- Victims and Witnesses (Scotland) Act 2014
- Anti-social behaviour, Crime and Policing Act 2014
- Children and Young Persons (Scotland) Act 2014
- Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (Part 2 – Duty of Candour & Part 3 – Ill-Treatment & Wilful Neglect)

3. Principles and Values

The Act includes a set of principles which must be taken into account when considering intervention in an adult at risk's life. These aim to ensure that any action taken is necessary and proportionate and strikes a balance between the adult's right to self determination and the prevention of harm to the adult with protection in the form of statutory orders when required.

The overarching principles in Section 1 of the Act underpin good practice and are similar to the principles contained in The Adults with Incapacity (Scotland) Act 2000 and The Mental Health (Care and Treatment) (Scotland) Act 2003.

Section 1 provides two general principles in relation to intervention:

1) It must provide benefit to the adult which could not reasonably be provided without intervening in the adult's affairs and
2) Is, of the range of options likely to fulfil the object of the intervention, the least restrictive to the adult's freedom

The above principles are further supported by a set of guiding principles in Section 2, which those performing functions under the Act must have regard to:

- The wishes and feelings of the adult at risk – both past and present
- The views of the adult's nearest relative, any primary carer, guardian or attorney, and any other known individuals with an interest in the adult's well-being or property
- The importance of the adult participating as fully as possible
- Providing the adult with the information and support necessary to enable them to do so including the use of an interpreter where required

- The adult is not, without justification, treated any less favourably than a person who is not an adult at risk in a comparable situation
- The importance of the adult's abilities, background and characteristics (age; sex; sexual orientation; religious persuasion; racial origin; ethnic group and cultural and linguistic heritage)

Within the high secure environment of TSH all staff additionally require to:

- Actively promote the empowerment and wellbeing of adults at risk of harm, through the services we provide
- Act in a way that supports the rights of the individual to lead an individual life based on self-determination and personal choice, which can sometimes involve risk, but to ensure that such risk is recognised and understood by all concerned, and minimised whenever possible
- Recognise people who are unable to safeguard their wellbeing or their assets
- Ensure that when the right to an independent lifestyle and choice is at risk the individual concerned receives appropriate help, including advice, protection and support from relevant agencies
- Ensure that the law and statutory requirements are known and used appropriately so that adults at risk of harm receive the protection of the law

4. Purpose of Part 1 of the Act

Part 1 of the Act introduces new measures to identify, support and protect adults who are vulnerable to being harmed whether as a result of their own or someone else's conduct, and fall into the category of 'adults at risk'. These measures include:

- Placing a duty on local Councils to make the necessary inquiries and investigations to establish whether or not further action is required to stop or prevent harm occurring and to protect the adult
- A requirement for specified public bodies to co-operate with local Councils and each other about adult protection investigations
- A range of Protection Orders including Assessment Orders, Removal Orders, Banning Orders and Interim Banning Orders
- The establishment of multi-agency Adult Protection Committees, within defined council areas

5. Defining Adults at Risk

Section 3(1) of the Act defines 'adults at risk 'as individuals, aged 16 years or over, who:

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

The first element of the above three point criteria relates to whether the adult is unable to safeguard their own well-being, property, rights, and other interests.

'Unable' is not further defined in the Act or guidance but is defined in the Oxford English Dictionary as 'Lacking the skills, means or opportunity to do something.'

A distinction should therefore be drawn, between an adult who lacks these skills and is unable to safeguard themselves, and one who is deemed to have the skills, means or opportunity to keep themselves safe, but chooses not to do so.

An inability to safeguard oneself is not the same as an adult not having capacity. An adult may be considered unwilling rather than unable to safeguard themselves and so may not be considered an adult at risk.

The presence of one particular condition does not automatically mean an adult is an 'adult at risk of harm'; someone may have a disability, be at risk of harm but be able to safeguard themselves. It is important to stress that all three elements of this definition must be met, or that there are grounds for believing all three elements may be met, for an adult to be deemed an adult at risk and for interventions to take place under the 2007 Act. It is the whole of an adult's particular circumstances that can combine to make them more vulnerable to harm than others.

It should be noted that the Act does not use the term 'vulnerable adults' in relation to those adults who come under this legislation. However, many adults who are potentially adults at risk of harm are vulnerable.

Factors which determine vulnerability may relate to personal characteristics and/or social and environmental issues and include:

- Lacking capacity to make decisions about their own safety
- Communication difficulties
- Dependency on others for personal care or support for daily living
- Low self-esteem
- Inappropriate or inadequate care
- Isolation and social exclusion
- Lack of access to information and support
- Susceptibility to manipulation by others

The likelihood of an adult who is vulnerable becoming an adult at risk relates to their ability to make and enact informed choices, free from influence or pressure, regarding protecting themselves from harm, neglect or exploitation.

6. Defining Harm

Section 53 of the Act defines harm as including all harmful conduct and, in particular:

- conduct which causes physical or 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

However, the Code of Practice is clear that these broad categories of harm, are not exhaustive and no category of harm is excluded simply because it is not explicitly listed in the Act.

While it is recognised it is not always possible to prevent all harm, there are a number of steps those working in Health and Social Care can take to reduce the risk of harm occurring. Staff should:

- Know what harm is
- Understand how it can happen
- Be alert to indicators of potential harmful situations
- Know the procedures for reporting concerns and poor practice
- Provide appropriate support through good assessment and care planning.

Section 3(2) of the Act states that an adult is at risk of harm if:

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

Harm may be caused by a single act; repeated or multiple acts or a failure to act. Where there is dependency there is a potential for acts of harm since harm takes place when an unequal relationship provides an opportunity to misuse power and control over another person.

Harm can occur in any setting where someone:

- Can tell another what to do
- Provides intimate personal care or activities of daily living
- Has status or credibility
- Meets essential material, social, or emotional needs

It can take place in any setting such as the adult's home, day centres, care homes, supported housing, hospitals or prisons.

Many acts of harm are criminal offences; consideration should always be given to reporting harm to the Police. If it is suspected a crime may have been committed the Police should always be informed. Practitioners need to inform family members or carers, where relevant, that they can contact the police independently, if they believe a criminal act has occurred within the adult's situation.

Professional judgement is important in deciding whether a situation constitutes harm. What constitutes harm within the Act can take many forms and evidence of harm may include a range of behaviours. Professional judgement should be based on sound knowledge of the factors which contribute to an assessment of whether harm exists. These include;

- The vulnerability of the adult
- The nature and extent of the behaviour
- The impact of the behaviour on the adult
- The likelihood of the behaviour continuing
- The likelihood of the behaviour escalating if left unchecked

As well as the actual behaviours impacting on the adult, assessment of the environment or context in which harm takes place is vital because exploitation, deception, misuse of authority or coercion may render the adult incapable of making his or her own decisions or disclosing harm even though they have capacity.

7. Serious Harm

The Act requires evidence of ***serious harm*** if a Protection Order is being sought. The Code of Practice contains no definition of ***serious harm***. There is no definition of 'serious harm' provided in the Act. Serious harm is the threshold that justifies compulsory intervention in an adult's life by the state. This can be a one off traumatic incident or event, but it could also be a number of single events or a build-up of concerns over a period of time.

What constitutes serious harm will be different for different adults. Professional judgement should be based on sound knowledge of the factors which contribute to an assessment of whether harm exists. When assessing harm and serious harm, areas that require to be taken into consideration are:

- Impact of harm on the adult's physical or mental health
- Injuries which are severe and/or life threatening
- The adult's perception
- Level of risk.
- The need for urgent action
- The frequency, consistency, and severity of harm

- The intent of the perpetrator
- History of harm
- The probable consequences of non-intervention

The seriousness or extent of harm is not always known at the point of referral; all allegations of harm should therefore be approached with an open mind and with the need to ensure appropriate action is taken to address concerns

8. Types of Harm

Physical Harm
This refers to non-accidental infliction of pain, injury or impairment. It includes hitting, kicking, pushing, shaking, scalding, pinching, punching, force feeding, misusing medication, rough handling, misuse of restraint, sustained exposure to heat or cold and withholding food or drink.

Emotional or Psychological Harm
This is behaviour which has a harmful effect on an adult's emotional health and development or any form of mental cruelty that results in mental distress. It includes the denial of basic human rights such as privacy and dignity or the right to make choices, isolation from others or from normal human activities and services or support networks, over-dependence on others to the detriment of the adult's well-being, emotional abuse, threats of harm or abandonment, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, shouting and withholding of affection.

Sexual Harm
This involves sexual activity where an adult cannot or does not give, or is pressured into giving, their consent. It includes incest, rape, indecent assault such as inappropriate touching, sexual harassment either verbal or physical, indecent exposure, displaying pornographic material and inappropriate sexual material and acts of gross indecency.

Financial Harm
This is the unauthorised use or appropriation of an adult's resources such as their property, financial assets or income. It includes theft, fraud, exploitation, undue pressure to share, provide or assign resources to another, misuse of legal or other arrangements such as Power of Attorney or Appointeeship for benefits.

Neglect and Acts of Omission
This is the failure to provide for the adult's basic needs. It includes withholding necessities such as adequate food, drink or medication; failing to allow access to appropriate health care, educational and social services; or ignoring medical or physical needs.

Neglect can be intentional or unintentional and the Act is intended to provide protection from both deliberate and unintentional harm. Neglect would be considered to be intentional if, for example, a carer wilfully refused to provide care or prevented an adult from receiving care, knowing that harm would result as a consequence.

Unintentional neglect could result, for example, from a carer failing to meet the needs of an adult because they do not understand the needs of the adult, or their own needs prevent them from caring appropriately for the adult or they are unaware of support services available.

Self Neglect
Self-neglect is a complex interplay between mental, physical, social and environmental factors. At one end of the spectrum self-neglect can be seen as a psycho-medical condition often associated with other mental disorder; at the other end it may be viewed as a social construct influenced by social, cultural and professional values based on value judgement. It is clear that all approaches to working with adults who self-neglect require consideration of factors both internal and external to the adult.

It may be difficult to understand and assess the psychological state of an adult who self-neglects but assessment of risk will include their ability and willingness to self care and perform other activities of daily living.

Self-neglect is largely reported as occurring in older people although it is also associated with mental ill health.

Differentiation between ability and willingness to care for oneself and capacity to understand the consequences of one's actions are important in determining the appropriate response to such adults.

There is evidence which suggests that professional judgement leads workers to conclude that self neglect is a 'lifestyle choice' rather than related to mental or physical impairment. This in turn can determine and influence the level of support and/or protection offered to the adult.

Interventions aimed at environmental conditions are rarely effective in their own right. Building good relationships is seen as key to maintaining contact with the self-neglecting adult, which may encourage the adult to agree to supports for daily living. This in turn may allow for opportunities to assess the adult's physical and mental health and capacity.

Self-Harm

The National Institute for Clinical Excellence (NICE) defines self-harm as 'self-poisoning or injury, irrespective of the apparent purpose of the act'. The Scottish Government Report 'Towards a Mentally Flourishing Scotland 2009 – 11 describes self-harm as a response to underlying emotional or psychological distress which can include feeling isolated, having a poor body image, economic or academic pressures, powerlessness and abuse or trauma.

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

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

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

Not all self-harming behaviours are deliberate acts which signal an intention to commit suicide. The level of suicidal intent may vary from completely absent, where self-harm is more about coping with difficult feelings, to extremely high where the intention was to die.

Inappropriate or Unauthorised Use of Restraint

Restraint is the use (or threat) of force to make an adult do something they are resisting or where the adult's freedom of movement is restricted whether they are resisting or not.

The Mental Welfare Commission for Scotland identifies the following types of restraint:

- Direct physical restraint through the actual or threatened laying on of hands to stop an adult from doing an intended action
- Direct mechanical restraint such as use of a restraining chair or straps for people who are mobile
- Locking doors and thereby restricting freedom to move about
- Technologically-based forms of restraint such as tagging, alarms and video surveillance
- The use of sedative or tranquilising drugs and covert medication purely to treat the symptoms of disturbed behaviour

- Restraint by default through the non-provision of mobility aids such as walking aids, wheelchairs or stair-lifts

Being restrained can be frightening for the adult and potentially can lead to injury to the adult and/or the carer/staff member if not appropriately managed. Appropriate use of restraint can be justified to prevent harm to a person as long as it is a proportionate response to actual or potential harm. However, unlawful use of restraint can constitute harm and all TSH staff working with adults with challenging behaviour must comply with the relevant policies and procedures on the use of restraint.

Institutional Harm
Harm within institutional settings refers to the systemic failure to provide a safe environment for residents or patients. It usually occurs where a culture of poor practice, inadequate management oversight, including supervision of staff and lack of training exists. It can occur in care homes, health settings and prisons.

Harm is more likely to happen in institutions with:

- Rigid routines and inflexible practice
- Poor management practice
- Inadequate staffing
- Poorly trained and supervised staff
- Poor care standards
- Lack of personalised care plans
- A closed culture

9. Young People

The Act defines an adult as a person aged 16 or over. This means that some young people may be an adult at risk of harm while already subject to other legislation such as The Children (Scotland) Act 1995 or Child Protection Procedures. This might be particularly relevant to young adult visitors to TSH.

10. Legal Considerations

Consent
In relation to adult capacity the assumption in law is that all adults have the capability to manage their own affairs until or unless they are recognised, in a court of law, as being incapable. Where an adult can make and act on decisions, he/she has capacity and no intervention can be imposed by outside agencies under the Act.

Under the Act all public agencies have a duty to report concerns about a person who is or may be an adult at risk of harm, to the Council. This is **not dependent on the adult's consent** although this is always preferable.

The Act makes a presumption that following referral, direct intervention by a Council Officer is reliant on the adult's consent. Consent is required for example, to visit and interview; undergo medical examination; attend meetings and agree to a protection plan. Without the adult's consent and cooperation there are clear limits on the level of support and/or protection which can be offered or provided to an adult at risk of harm.

The Adult Support and Protection Code of Practice suggests that a proactive approach to seeking consent to intervene should be taken to enable the adult to participate as fully as possible in the process. For example, the adult should be given reasonable opportunity and encouragement to answer questions whilst respecting their right not to. However, the Act gives Council Officers a range of powers which can be used in certain circumstances, even where consent has been withheld.

Section 10 allows for the examination of records such as health or financial records which is **not dependent on the adult's consent**. However, it is important to consider carefully the adult's right to confidentiality about such matters before requesting such information.

Section 35 provides that in relation to protection orders, where an adult has refused consent to an order, the Sheriff may ignore the refusal where they or the person seeking the order reasonably believes that:

- The adult at risk has been **unduly pressurised** to refuse consent, and
- That there are no steps which could reasonably be taken with the adult's consent which would protect the adult from the harm which the order or action is intended to prevent

Undue Pressure
Section 35(4) states that an adult at risk may be subject to **undue pressure** to refuse to consent if it appears that:

- Harm which the order or action is intended to prevent is being, or is likely to be inflicted by a person in whom the adult at risk has confidence and trust, and
- That the adult would consent if they did not have trust in that person

Undue pressure may also be applied by a person the adult is afraid of, such as a neighbour, carer, member of staff, family member, visitor or fellow patient. The significant issue is the relationship of confidence and trust between the adult and the person allegedly subjecting the adult to harm. This can also apply to a relationship between the adult and a non-harming person, providing a relationship of confidence and trust exists.

In such cases the Council Officer must provide evidence of undue pressure, how this has affected the relationship with the adult and the manner in which undue pressure has impacted upon the adult's safety and wellbeing or resulted in the adult's refusal to consent.

Where concerns regarding the adult's safety exist, and there are no grounds to believe that undue pressure exists, the Council Officer should advise the adult of their concerns and that there is a duty to record those concerns. The refusal of consent to intervene does not mean that inquiries cannot be pursued or that a risk assessment and/or a case conference cannot be held. In such cases, continuing contact via ongoing assessment and review processes should be maintained.

Support Needs
TSH is committed to ensuring that patients are able to engage meaningfully in the Adult Support and Protection process. Individually tailored care and treatment plans include specific arrangements in place to support patients with a sensory impairment and / or any other barrier to communication, including language, learning disability, to participate effectively.

Incapacity
The Act also applies to adults at risk of harm who lack capacity. Where it has been established that an adult at risk lacks capacity, the Act recommends that other legislation including the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care &Treatment) (Scotland) Act 2003 are considered in conjunction with the Act to protect the adult.

In these situations, discussion about the best way to support or protect the adult with incapacity should include the relevant Mental Health Officer and, if the adult is already subject to Guardianship, the Supervising Officer and Private Guardian, if appropriate.
The Act can offer a range of protective measures which compliment those of the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care &Treatment) (Scotland) Act 2003. These include:

- A duty on all public bodies to cooperate, including Police

- Examination of reports from a range of agencies
- Powers to visit, interview and apply for a Banning Order

These options can be used to protect an adult while an assessment of capacity is being undertaken or while an application for an appropriate order under the Adults with Incapacity (Scotland) Act 2000 is being progressed if deemed necessary.

Safeguarders
Section 41(6) gives a Sheriff the discretion to appoint a person to safeguard the interests of an adult at risk in any proceedings relating to an application for a protection order. This may be used, for example, to report on the issue of consent.

11. Information Sharing

South Lanarkshire Council, NHS Lanarkshire and Police Scotland are signatories to the Lanarkshire Information Sharing Protocol Obtaining Consent – Good Practice Guide. Reference should be made to this during inquiries and investigations in relation to sharing information with third parties.

In principle, consent should be sought from the adult at risk to share information prior to conducting an inquiry or investigation. However, this may not always be practicable and existing legislation allows information to be disclosed without consent, where such disclosure is required to protect the adult or is in the public interest.

Crime prevention, detection and prosecution may also provide legitimate grounds for disclosure. The person about whom information is disclosed should always be informed of the disclosure unless this is prejudicial to safety.

Under Section 5 of the Act there is a duty to cooperate with the council in inquiries and investigations.

The Act therefore requires staff within all public bodies to share information with the council regarding an adult at risk of harm.

Under Section 10 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 give records, or copies of records, to assist with a decision that action is required to protect the adult. It is a criminal offence to fail or refuse to comply with such a request without reasonable excuse.

Whilst confidentiality is important, it is not an absolute right.

Information should only be shared with those who need to know and if it is relevant to the particular concern identified. The amount of information shared should be proportionate to addressing that concern and should be recorded with due care and attention. Only health professionals can inspect health records.

12. Public Agencies Duty to Report

The Act confers responsibilities on all public agencies. Councils are the lead agency in relation to inquiring into situations of harm to an adult at risk and Social Work Service in TSH undertakes the role on behalf of the Council.

However, under Section 5 of the Act all public agencies including Health Boards have a duty, where they know or believe a person may be experiencing harm, to report that information to the Council for the area in which the adult is living at the time (Section 53). For all TSH patients, the council area is South Lanarkshire Council.

Public agencies including Health Boards also have a duty under Section 5 to cooperate with the Council and each other in relation to inquiries and investigations.

There is an expectation that a multi-agency and multi-disciplinary approach is taken to inquiries, investigations and training on Adult Support and Protection matters.

13. Allegations against Members of Staff

The procedure for responding to allegations made by an adult at risk against a staff member is the same whether this involves TSH staff, or social work staff, or an independent, voluntary or private agency.

Referrals concerning adults at risk who have been harmed by a staff member are subject to both adult protection procedures and the agency's disciplinary proceedings.

Social work staff are responsible for undertaking the adult protection inquiry. An adult at risk who makes allegations against their care staff should be responded to in the same way as any other such adult and the safety and security of the adult takes precedence over any other action.

It is not appropriate for social work staff to interview the staff member from another agency alleged to have harmed the adult as part of an adult protection inquiry/investigation.

The staff member's employing agency is responsible for investigating the allegation against their employee. This will include:

- Considering whether the staff member should be moved to another location
- If the decision is taken to move the staff member to another location considering whether there will be any further risk(s) to other patients
- Considering whether the staff member should be suspended
- Considering the need for police involvement where a crime may have been committed;
- Advising the staff member that an allegation has been made against him / her
- Disclosing the nature of the allegation to the staff member as directed by the Lead Nurse or other relevant line manager
- Initiating a fact finding exercise to determine the details of the alleged harm
- Deciding whether a disciplinary hearing is required
- Deciding on disciplinary actions
- Advising the relevant social work manager when TSH investigation is concluded

The procedure below should be followed for all allegations made by an adult at risk of harm against a staff member employed by South Lanarkshire Council:

- All allegations made against a staff member should be responded to immediately
- Details of the incident, including date, time and name of alleged harmer should be recorded accurately
- The allegation/information is brought to the attention of a senior manager immediately and reported to the Head of Service thereafter
- There should be discussion between the fieldwork/relevant social work manager for the adult and the Head of Service/Service Manager in conjunction with the Personnel Services manager to determine the appropriate action to be taken in accordance with the agreed procedures
- The Care Inspectorate should be advised of the allegation if appropriate and any planned action/s as appropriate
- All allegations against a staff member will be responded to through the council's disciplinary proceedings
- An adult protection inquiry must be undertaken in relation to the adult at risk; the outcome shared with senior managers and agreement reached as to the appropriate course of action in relation to both the adult and the alleged harmer

- A referral must be made to the police if it is thought a crime may have been committed
- The staff member should be advised an allegation has been made against him / her, but details of the allegation should not be disclosed
- Information received as a result of an adult protection inquiry may be shared with fact-finding officers, to avoid repeated questioning of the adult at risk
- It is essential for both the adult and the staff member that confidentiality is maintained in order not to prejudice the adult's safety, any council disciplinary proceedings or a potential court case

14. Council Duties and Powers

The Act sets out the duties and powers of Councils in relation to safeguarding adults at risk:

- 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 to protect the adult (Section 4)
- Co-operate with other Councils and other listed (or prescribed) bodies and office holders (Section 5)
- Have regard to the importance of the provision of appropriate services (including, in particular, independent advocacy services), where the Council considers that it needs to intervene in order to protect an adult at risk of harm (Section 6)
- Inform any adult interviewed that they may refuse to answer any question put to them (Section 8)
- Inform an adult believed to be at risk that they may refuse to consent to a medical examination (Section 9)
- Protect property owned or controlled by an adult who is removed from a place under a removal order. This may include moving property belonging to the adult from that place, where this is considered reasonably necessary in order to prevent the property from being lost or damaged. The council must ensure the property is returned to the adult concerned as soon as reasonably practicable after the relevant removal order ceases to have effect **(**Section 18)
- Visit a place at reasonable times only, state the object of the visit and produce evidence of authorisation to visit. Council Officers may not use force to facilitate, or during, a visit. However, a Sheriff or Justice of the Peace may authorise the police to use force (Sections 36 to 40)
- Set up an Adult Protection Committee to carry out various functions in relation to adult protection in its area, and to review procedures under the Act (Section 42)

The Council has powers to:

- Visit any place necessary to assist inquiries under (Section 4) and investigations under **(**Section 7)
- Interview, in private, any adult found at the place being visited (Section 8)
- Arrange for a medical examination of an adult known or believed to be at risk to be carried out by a health professional (Section 9)
- Request and examine health, financial and other records relating to an adult at risk (Section 10)
- Apply to the sheriff for the granting of a protection order. This may be an assessment order, a removal order a banning order or temporary banning order (Sections 11, 14, 19)

15. Council Officer

The Act refers to the staff member undertaking inquiries as the Council Officer. In South Lanarkshire a Council Officer is a qualified social worker or occupational therapist employed by the Council, who has 12 months experience of identifying, assessing and managing adults at risk and has undertaken appropriate Adult Protection training. Council Officers must be registered with the Scottish Social Services Council (SSSC) or Health Professions Council (HPC).

Council Officers must understand their responsibilities in relation to the inquiry and investigation process and any subsequent actions required. Referrals relating to alleged harm are given priority over other responsibilities and treated in accordance with the principles of the Act.

Section 7 of the Act allows for the Council Officer to be accompanied by another staff member from a public agency when undertaking a visit to an adult at risk of harm. Within TSH this will usually be another Council Officer or Social Worker/Team Leader.

16. Adult Protection Committee

The council is responsible for establishing an Adult Protection Committee (APC) with an Independent Chair. The APC must have representation from all public bodies and must provide a biennial report to the Scottish Government on its activities.

The principal remit of the Adult Protection Committee is to:

- Keep under review procedures and practices of public agencies
- Give information or advice in relation to safeguarding adults at risk
- Make arrangements to improve the skills and knowledge of staff;
- Improve cooperation between partners

The APC has representation from South Lanarkshire Council (Social Work, Corporate, Housing and Technical and Education Resources and Legal Services), NHS Lanarkshire, TSH, Q Division Strathclyde Police, the Procurator Fiscals Office, Carers Network and Advocacy agencies.

The Scottish Government has provided Guidance for Adult Protection Committees.

TSH and Child and Adult Protection Forum, which is chaired by the Director of Nursing and AHP, is responsible for submitting to the APC relevant data as agreed in the National Data Set on adult protection activity at TSH. Data is also submitted on the range and uptake of staff training on the Adult Support and Protection (Scotland) Act 2007.

17. Public Protection Chief Officers Group

The Adult Protection Committee reports to the Public Protection Chief Officers Group which consists of the South Lanarkshire Council Chief Executive, the Chief Executive NHS Lanarkshire, the Chief Executive for TSH, the Chief Superintendent for Police Scotland, the Authority Reporter for the Scottish Child Reporter Administration plus officers from their respective organisations. The Chief Officers Group meets on a quarterly basis.

18. West of Scotland Guidance

The West of Scotland Adult Protection Guidance gives an overview of the application of the Act across 13 West of Scotland Councils; Lanarkshire; Ayrshire and Arran and Greater Glasgow and Clyde Health Boards; The State Hospital Board for Scotland and Police Scotland. Its primary aim is to ensure consistency in intervention in relation to adults at risk of harm in the West of Scotland area.

The Guidance can be accessed via the South Lanarkshire Council web-site or the Social Work service in The State Hospital.

19. Key Partner Agencies

Police
Where inquiries suggest that a criminal offence may have been committed against an adult at risk, this must be reported to the police at the earliest opportunity. In the case of physical or sexual

harm, immediate referral to the police is essential. This is to ensure that the person receives appropriate medical attention and that vital evidence is not lost.

This does not remove responsibility from the Council to take immediate action to protect the adult at risk but any proposed action should be taken in consultation with the police.

The adult must be advised of the Council's duty to report a potential crime; this does not mean that the adult at risk, if he/she has capacity, is under an obligation to be interviewed by police. However, the potential risks of non-involvement of police in any situation should be explored with the adult. Social Work Resources staff must also be aware of the duty of care owed to other potential adults at risk, such as in care settings.

Police may conduct a criminal investigation into the adult's circumstances and with the Procurator Fiscal; make any subsequent decisions with regard to possible criminal proceedings under the legislation available to them.

Council Officer inquiries are likely to be placed on hold until any Police investigation has been concluded.

Police also have a range of duties and powers in relation to warrants and protection orders.

Within TSH, reference should also be made to the Protocol to be followed in the event of patients requesting police involvement.

Police Adult Protection HUB
The Police Scotland Adult Protection HUB is based within the Police Offices in Campbell Street, Hamilton.

Police Scotland has a Standard Operating Procedure for responding to adults at risk of harm.
Police Scotland can be contacted via 101 for the above purposes.

Health Boards
Section 9 of the Act allows a health professional to conduct a medical examination of an adult at risk of harm. A medical examination includes any physical, psychological or psychiatric assessment or examination. The examination can take place either at a place visited under Section 7 of the Act, or the premises where the adult has been taken under an assessment order granted under Section 11.

Section 9 (2) of the Act states that, the adult must be informed of their right to refuse to be examined before a medical examination is carried out. In an emergency and where consent cannot be obtained, doctors can provide medical treatment to anyone who needs it, provided that the treatment is necessary to save life or avoid significant deterioration in a patient's health. The adult's GP is the first point of contact. He/she will decide the most appropriate professional to undertake the examination.

Section 10 of the Act allows for examination of existing health records if this is required to establish whether further action is needed to protect the adult from harm. Health records can only be inspected by a health professional. In some cases, it may be sufficient for a health practitioner to provide a summary of the adult's health information along with any relevant documents or reports.

If a request for information is made at a time other than during a visit, it must be made in writing. If the requirement is transmitted electronically it will be treated as having been made in writing if it is received in a legible form and is capable of being used for subsequent reference.

The State Hospital
TSH has an Adult Protection Procedure for responding to patients who are also adults at risk of harm. Inquiries are responded to by the Social Work team within the Hospital. The Social Work Manager can be contacted on **01555 842146**.

Office of the Public Guardian
The Office of the Public Guardian is an independent body which was created by the Adults with Incapacity (Scotland) Act 2000. This Act gives the Public Guardian the powers to investigate concerns and take steps to safeguard the property and financial matters of an adult with incapacity, where it appears they are at risk of misuse or abuse.

Mental Welfare Commission for Scotland
The Mental Welfare Commission is an independent body which works to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder.

Advocacy Services
Section 6 of the Act places a duty on the Council to consider the provision of appropriate services, including independent advocacy, if there is a need to intervene in order to protect an adult at risk of harm. The definition of advocacy used in the Act is that given in Section 259(5) of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Adults with a mental disorder have the right to be offered advocacy support. Independent advocacy is provided by specialist organisations that do not provide any other services. Independent advocacy aims to help people by supporting them to express their own needs and make an informed decision. They will support adults to access information and explore and understand the options available to them.

Advocacy services may also provide support to a carer, service user or patient to alleviate stressful or conflict situations and the potential for harm, in particular where the adult has capacity and does not wish any protective action to be taken.

TSH has a dedicated Patient Advocacy Service (PAS) which should be contacted where appropriate in relation to all inquiries under the Act. The PAS does not provide support to carers.

Appropriate Adult
The role of the Appropriate Adult is to facilitate communication between a mentally disordered person and the police and, as far as possible, ensure understanding between the parties. Mental disorder is defined in the Mental Health (Care and Treatment) (Scotland) Act 2003 as any mental illness, personality disorder or learning disability however caused or manifested.

Appropriate Adults can be used in all categories of interview: witness, victim, suspect and accused. Appropriate Adults are expected to have experience in the field of mental health, learning disabilities, dementia and acquired brain injury.

It is the responsibility of the police to determine if someone is a mentally disordered person and to initiate access to the Appropriate Adult scheme.

In South Lanarkshire, Appropriate Adults are provided by Social Work Resources. Within The State Hospital the Appropriate Adult Scheme is coordinated during normal office hours by the Social Work Service based within the hospital. Outwith normal office hours inclusive of weekends and Public Holidays, this service is provided by the South Lanarkshire Emergency Social Work Service (ESWS) who will identify an Appropriate Adult if required. The ESWS can be contacted on 0303 123 1008.

Victim Support
Victim Support services may be appropriate if an adult has been subject to criminal activity. The South Lanarkshire Victim Support office is based at:

1st Floor, 4, Barrack Street, Hamilton, ML3 0DG. Telephone: 01698 301111.

Support for Vulnerable Witnesses
The Vulnerable Witnesses (Scotland) Act 2004 was extended in 2006 to include adult witnesses. This means that the special measures already available to support child witnesses can be used for the benefit of adults involved in court proceedings. Adults who can be considered for special measures include adults with mental disorder, including learning disability; communication difficulties; behavioural indicators and age and maturity conditions including old age and frailty.

Other more general factors which can be considered include situations where the adult is at risk of intimidation; has been subject to serious or repeated sexual offences; situations involving extreme or domestic violence or, where the accused is a significant family member or, the victim is dependent on the accused.

Special measures include the use of live television links; use of a screen in court; having a supporter present when giving evidence; taking prior statements as evidence (in criminal cases only). The use of special measures is decided by the court. Vulnerable Witnesses (Scotland) Act 2004

Carers
The Act (Section 2(c)) stresses the importance of the views of the adult's named person, nearest relative, primary carer and any guardian or attorney.

However, it will always be important to distinguish between the needs and perspectives of each person. There may be conflict between the needs of the adult and the named person or the carer due to differing perspectives and needs which will both require to be taken into account by council officers throughout the Adult Support and Protection process.

It may be that someone in a caring role or a guardian can cause harm intentionally or unintentionally, by using the power inappropriately, exerting undue pressure or they can be the victim of harm. There may be significant complexity in a relationship creating the potential for both parties to be both the victim and harmer at different times.

Considerable skill and patience will be needed, and information and assessments for both the carer and cared for person will need to be carefully considered in multi-agency meetings. Some carers may benefit from independent advocacy support, which will be independent from advocacy acting for the cared person.

20. Communication, Implementation, Monitoring and Review of Policy

This policy will be communicated to all stakeholders within The State Hospital via the intranet and through the staff bulletin. The Child and Adult Protection Forum will be responsible for the implementation and monitoring of this policy and appropriate audits will be scheduled to monitor impact.

This policy will be reviewed every three years or earlier if required.

21. Format

The State Hospitals Board recognises the need to ensure all stakeholders are supported to understand information about how services are delivered. Based on what is proportionate and reasonable, we can provide information / documents in alternative formats and are happy to discuss with you the most practical and cost effective format suitable for your needs. Some of the services we are able to access include interpretation, translation, large print, Braille, tape recorded material, sign language, use of plain English / images.

If you require information in another format, please contact the Person Centred Improvement Lead on 01555 842072.

Stakeholder Engagement

Key Stakeholders	Consulted (Y/N)
Patients	Y
Staff	Y
TSH Board	Y
Carers	Y
Volunteers	Y

Appendix 1

Council Officer Quick Guide to the Adult Protection Process

Stage	Action	Responsibility	Timescale	Decisions/Outcome
1. Raising a concern	• deal with immediate needs/risks • report to line manager • record concerns • refer to Social Work Service • complete referral form. (AP1)	All staff	• if emergency immediately or same working day	• is emergency action required? • should Police be notified? Send AP1 to Social Work Service
2. Referral process	• clarify facts within AP1 referral form. • if staff implicated notify line manager	Team Leader/ Council Officer.	• if emergency immediately or within 24 hours	• refer to Social Work Team Leader or Social Work Manager • should Care Inspectorate be notified • should Police be notified • send AP1 to Council officer
3. Inquiry process	• clarify facts within referral • check social work/hospital records /other involved parties • liaise with health/ other involved agencies • contact/visit/interview adult – where appropriate and advise him of his rights. • discuss/plan with team leader/manager • consider advocacy services • complete AP1B	Council Officer/ other key workers Team Leader/ Manager	• physical or sexual harm immediately within 24 hours - other harm types five working days	• does the adult meet the 3 point criteria' • is a capacity assessment required • is an investigation required • should the Police be consulted • consider all protective legislation – AWI, ASP, MHCTA, Police powers etc • discuss outcome of AP inquiry with Team Leader/Manager • is referral to Advocacy required
4. Planning meeting process	• evaluate risk/needs/strengths/rights /outcomes • plan investigative interview of adult and relevant others • consider	Council Officer other key workers Team Leader/ Manager multi-agency partners	• if emergency immediately or five working days • four weekly Core Groups thereafter	• agree investigation plan – who, what, when, where • decide if protective measures to be put in place • consider all protective legislation – AWI, ASP, MHCTA,

Stage	Action	Responsibility	Timescale	Decisions/Outcome
	Advocacy services • consider Legal Services • consider interim protection plan • record multi agency outcome • Update social work records			Police powers etc • agree timescales
5. Investigation process	• briefed by Team Leader/manage r • investigative interview of adult and relevant others • debrief by Team Leader/Manage r • complete risk assessment (AP2)	Council Officer/s Team Leader/ Manager	• if emergency immediately or within *five working days of receipt of referral	• decide if multi-agency case conference required arrange multi-agency case conference Prepare and send invite list of attendees
6. Case Conference process	• share relevant multi agency information • evaluate risk assessment • agree multi-agency core group membership • agree Protection Plan • record and distribute decisions • Update social work records • arrange multi agency review date	Social Work Manager Team Leader Council Officer/s Agency partners	• within 20 working days from referral • three monthly thereafter	• does the adult meet the '3 point criteria' • is a protection plan required • is a protection order required • consider all protective legislation – AWI, ASP, MHCTA, Police powers etc. • is a multi agency review required
7. Protection planning process	• complete protection plan (AP3) • complete Adult Protection, protection planning SWiS plus screen	Council Officer/s Team leader/ Manager multi-agency core group members	• within two days following case conference • review four weekly	• does protection plan meet identified risks/ needs/ rights/ strengths/ outcomes • consider • contingency plan
8. Monitoring and reviewing process	• arrange core group meetings record meetings • review protection plan • re-evaluate risk/	Social Work Manager Team leader Council Officer/s multi agency partners	• within three months of initial or previous case conference	• does the adult meet the '3 point criteria' • is a protection plan required • is a protection order required

Stage	Action	Responsibility	Timescale	Decisions/Outcome
	needs/ strengths/ rights/ outcomes • arrange next multi agency review			• consider all protective legislation – AWI, ASP, MHCTA, Police powers etc. • is a multi agency review required
9. Closing and recording the adult protection process	Complete outstanding actions from review and update social work records in line with social work procedures.	Council Officer/s Team Leader/ Manager Social Work Manager	• within 10 days following decision	

THE STATE HOSPITALS BOARD FOR SCOTLAND

ADULT SUPPORT AND PROTECTION OPERATIONAL GUIDANCE AND PROCEDURES

Introduction

This procedure sets out the roles and responsibilities of Social Work and The State Hospital (TSH) Staff in relation to individuals who are 'adults at risk of harm' as defined by the Adult Support and Protection (Scotland) Act 2007 (the Act).

Support and protection of adults at risk is the responsibility of all statutory agencies, voluntary and private providers and good communication and joint working is key to the prevention of harm. It is therefore important that all staff at TSH, whatever their role and responsibilities, understand that preventing harm occurring and taking action to deal with it is a fundamental part of their day to day work.

The Act confers responsibilities on all public agencies. Councils are the lead agency in relation to inquiring into situations of harm to an adult at risk and Social Work Service undertakes that role on behalf of the Council.

Under Section 5 of the Act all TSH staff have a duty, where they know or believe a person may be experiencing harm, to report that information to the Social Work Service. All staff at the hospital including other relevant public agencies such as the police also have a duty to cooperate with each other in relation to inquiries and investigations under the Act.

Stage 1: Identification of an Adult at Risk of Harm

Definition of Adult at Risk

Section 3(1) of the Act defines adults at risk as individuals, aged 16 years or over, who:

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

All three of the above criteria must be met for an adult to be deemed at risk of harm.

Definition of Harm

The Act provides protection from both deliberate and unintentional harm such as:

- Financial and material
- Psychological and emotional
- Physical harm
- Sexual abuse
- Neglect including self neglect
- Domestic abuse

This should not be regarded as an exhaustive list and other forms of harm may be relevant to a particular adult's circumstances at a particular time as noted in the guidance.

Making a Referral to the Social Work Service

Anyone can make a referral under the terms of the Act, however within TSH referrals are most likely to come from the patient, the patient's family, advocacy staff, Complaints Officer, nursing staff, medical staff, allied professionals or social work staff.

Having identified an adult at risk of harm, staff should assess the seriousness of the situation and consider if the risk is immediate. If the adult is in immediate danger, the appropriate action or intervention should be taken in the first instance to remove the immediate risk. Staff should then:

- Report concern to line manager **(immediate)**

- Record concern/event in health record if appropriate **(immediate)**
- Complete a Datix report if appropriate. A prompt will be generated for the referrer to complete an AP1 Referral Form if they know or believe that an adult is at risk of harm and the three point criteria is met (see Stage 1 above)
- Send completed AP1 Referral Form to Social Work Service
- All referrals will be screened by the Social Work Team Leader/Social Work Manager and forwarded to the Social Worker/Council Officer

Whilst the adults' consent is not required to make the referral, where possible the adult should be informed of the referral and given an explanation of what actions may follow.

Sharing Information and General Data Protection Regulations
Where there is a concern about an adult at risk of harm or you are made aware of such a concern, agencies have a responsibility to share and exchange relevant information with other professionals. This should be done without delay (within 24 hours) and in line with local procedures.

All staff should be aware that their own agency will support them if they have shared personal information in these circumstances using their professional judgement. Existing legislation does not prevent the sharing and/or exchanging relevant information where it is believed there are concerns about the protection of adults at risk of harm. In addition, agencies are lawfully able to share confidential information where disclosure is necessary to protect the individual or another third party.

It is important that we are open and transparent and make people aware that we will share information when we suspect an adult is at risk of harm. It is also important that staff record any decisions to share, or not share, information and their reasons for doing so.

Stage 2: Referral and Screening

Telephone referrals from any staff members should be followed up within **24 hours** with a completed AP1 Referral Form. The referring staff member is responsible for completing the AP1 Referral Form. The completed AP1 Referral Form should also accompany any letters being referred onto the Social Work Service for further action under the Act.

Where the referral is generated directly by patients, family members or other members of the public the Social Work Service will complete the AP1 Referral Form in discussion with the referral source.

On receipt of an AP1 Referral Form the Social Work Team Leader/Social Work Manager will screen the referral and forward to the Council Officer who will determine whether or not the referral meets the criteria in terms of the definition of an adult at risk under the Act. Actions will include consideration of the following as appropriate:

- Social Work Records
- Discussion with referrer
- Discussion with hub Social Worker and Nursing Team Leader
- Referral history

In all cases an inquiry must be undertaken. Cases must be considered with an open mind without assuming that harm has, or has not, occurred. All referrals warrant a considered and measured response. Such referrals should be acted upon as a source of information that may or may not be used as evidence at a later stage.

Section 4 of the Act places a duty on councils to make inquiries about a person's well-being, property or financial affairs if it knows or believes that:

- The person is an adult at risk; and
- That it might need to intervene (under the Act or otherwise) in order to protect the person's well-being, property or financial affairs.

Inquiries under Section 4 of the Act will be carried out by Social Work services and should follow adult protection procedures. They may consul or work in partnership with other agencies to conduct inquiries. Other professionals such as the police, the Care Inspectorate or health professionals may be asked to assist.

The responsible line manager must decide if immediate action is required. A referral must be made if the person is or could be an adult at risk of harm. **Deciding whether the adult's circumstances meet the criteria of the Act is a matter of judgement**.

In the event that no further action will be taken, the patient (if appropriate) and referrer will be advised both verbally and in writing.

All referrals will be acknowledged in writing within **1 working day** from receipt of the completed AP1.

In the event that the referral suggests allegations against State Hospital staff, the Social Work Team Leader or Social Work Manager will alert and discuss with the Director of Nursing and AHP and forward to them a copy of the referral. The Director of Nursing and AHP will appoint a lead officer to advise the staff member that an allegation has been made and progress initial HR inquiries which would be conducted in parallel to any inquiry and investigation into the suspected or alleged harm.

Where the referral suggests allegations against Social Work Staff at the hospital, the Social Work Manager will be alerted. The Social Work Manager will discuss the referral with their line manager and the Personnel Manager within South Lanarkshire Council to agree the most appropriate way forward with possible recourse to a fact finding inquiry and/or investigation; the appropriate appointment of external officers to undertake these inquiries and investigations and agree any interim actions to be put in place under the Councils Disciplinary Procedures. The Social Work Manager will advise TSH Chief Executive, the Director of Nursing and AHP of the referral, action being taken and the outcome of the inquiries and investigations.

The Lead Nurse or Senior Charge Nurse must be made aware of all referrals arising from the respective hub, and confirmation provided by the Lead Nurse or Senior Charge Nurse of any requirement for disassociation or increased observation levels in relation to the adult at risk.

In the event that the available information suggests that a crime may have been committed, the Lead Nurse/Council Officer must alert the Police. If the Police indicate that an investigation will be undertaken, all inquiries in relation to the referral will be placed on hold until the police investigation has been concluded. This does not preclude any essential actions being taken, to ensure the patient's immediate safety and wellbeing whilst the police investigation is underway.

The patient also has the right to request police involvement. In these circumstances all inquiries in relation to the referral will be placed on hold until the police investigation has been concluded outwith any essential actions being taken to ensure the patient's immediate safety and wellbeing, whilst the police investigation is underway.

The patient has the right to an Appropriate Adult being present during any interview by Police Officers. The Social Work Service will provide an Appropriate Adult if required within normal working hours, The South Lanarkshire Council Emergency Social Work Service will provide an Appropriate Adult outwith normal working hours if required.

In those instances, where the referral originates from the Complaints Officer, the original complaint will be placed on hold by the Complaints Officer until the adult support and protection issues have

been addressed. The outcome of the adult support and protection inquiry and/ or investigation will be reported to the Complaints Officer alongside any remaining issues not appropriate to be addressed under the adult protection process for the Complaints Officer to progress as appropriate.

Where the referral relates to allegations around injuries sustained during restraint, the Social Work Team Leader or Social Work Manager will request a report from the PMVA Advisor /Instructor and a copy of the medical/nursing Post Physical Intervention assessment (PPI) including body map from the relevant senior clinical cover.

Stage 3: Inquiry

The Social Work Team Leader or Social Work Manager will allocate a worker to make the initial inquiries unless it is evident from the referral there are risks which warrant the involvement of a second worker.

A Council Officer **will** be the lead officer in all ASP inquiries and investigations. Council Officer Inquiries will include the following as appropriate:

- Consideration of previous referrals, complaints, Datix reports, disassociation history, PMVA history, social work, medical and nursing notes
- Interview with patient ensuring that the patient has the opportunity for advocacy representation
- Interview with any patients who may have information relevant to the inquiry ensuring that the patient has the opportunity for advocacy representation
- Discussion with RMO and Lead Nurse
- If the referral relates to restraint a copy of the post restraint report must be followed up, alongside a written report from a PMVA Advisor/Instructor
- Consideration of financial records / patients' funds records where the alleged harm relates to finances or property matters and discussion with The Office of the Public Guardian where relevant
- Consideration of any capacity issues and any actions required
- In the event of a Significant Incident as defined by the Mental Welfare Commission in their guidance on Notification of Significant Incidents, advise the Mental Welfare Commission
- Any other inquiries as appropriate
- Request for Medical Assessment as appropriate
- Request for examination of records as appropriate

Council Officers will not interview TSH staff if there is an allegation in relation to the conduct of any TSH staff member, but may make general inquiries within the ward in terms of the patient's presentation, safety and wellbeing.

It is good practice for the Council Officer to ask the adult whether they would wish another person to be present and or would wish advocacy representation at interview. The decision to interview in private will depend on the circumstances of each case but the Council Officer must ensure that any person thought to have caused harm to the adult, or who might apply undue pressure, **must not** be included in the interview. Council Officers should be aware that the presence of an alleged harmer, even in an adjacent room, can intimidate the adult and effectively stop the adult from discussing their concerns.

As adult protection interviews are not conducted jointly with police, interview notes will not be submitted in court as evidence and therefore a verbatim record of the interview is not required. However, care needs to be taken to ensure that relevant and appropriate information is recorded and is done so accurately to ensure the adult is not subject to repeat interviewing particularly if the harm leads to court proceedings. The record should also evidence the risks identified by the adult and include their views and opinions.

The Council Officer should ensure that the record of any interview undertaken is completed by the second officer as soon as possible after the interview and cross-checked for accuracy. It should be signed and dated by both officers.

The Council Officers will ensure that if the patient wishes, the patient's family member or carer will be notified of the referral.

The Council Officer will complete an AP1B report of their inquiries, normally within **4 working days** from receipt of the referral, and discuss the risks and how these are to be addressed with the Social Work Team Leader or Social Work Manager.

In the event that no further action will be taken, the patient and referrer will be advised both verbally and in writing, and consideration will be given to other options to address any other issues raised in the referral. The patients RMO, Lead Nurse and if appropriate, Advocacy and any carer if agreed by the adult will also be copied into the correspondence. The Mental Welfare Commission will be updated as appropriate if relevant. The Director of Nursing and AHP should be updated and where there are HR issues, the Social Work Team Leader or Social Work Manager should be advised of the outcome of any initial inquiries.

Where possible, depending on individual circumstances, all actions will normally be completed within **5 working days** from receipt of the referral.

Medical Examinations
Under Section 9 of the Act a Council Officer may request that a health professional conduct a medical examination in private, of an adult at risk of harm. A health professional includes a doctor, nurse or midwife.

A medical examination may be required for a number of reasons including:

- The adult's need for immediate medical treatment
- To provide evidence of harm to inform a criminal prosecution
- An application for an order to safeguard the adult
- The assess the adult's health needs
- To assess the adult's mental capacity

Situations where a medical examination should be considered include:

- The adult has a physical injury inflicted by another person
- The adult has an injury where the explanation is inconsistent with the injuries
- There is an allegation of sexual abuse and the assault may have left physical evidence
- The adult appears to have been subject to neglect or self-neglect
- The adult is ill or injured and no treatment has previously been sought

Section 9(2) of the Act states that the adult must be informed of their right to refuse a medical examination.

A request for a medical examination should be made through the adult's GP using the appropriate paperwork. If the adult is not registered with a GP advice should be sought from the patients RMO.

Examination of Records
Section 10 of the Act allows Council Officers to require any person holding health, financial or other records relating to an adult at risk to give the records, or copies of them to the Council Officer, in order to assist them to decide whether further action is needed to protect the adult at risk from harm.

Wherever possible the adult's consent should be obtained and consideration given to their right to confidentiality however this should not delay intervention under the Act.

This information should be requested in writing unless the urgency of the situation precludes this.

Records are defined as those held in audio, visual or other formats.

Health records may only be inspected by a health professional.

Stage 4: Planning Meeting

A planning meeting is held when an inquiry/investigation indicates that the subject is an adult at risk of harm and further investigation, assessment or information sharing is required in order to address the adult support and protection issues identified and agree the most appropriate way forward for any other outstanding matters. It should take place no more than **5 working days** following referral.

The purpose of the planning meeting is to:

- Decide how the further investigation, assessment or information sharing is to be undertaken and the most appropriate way forward
- Decide if an interim protection plan is required
- Set a date for an adult protection case conference if appropriate

Planning meetings are minuted and are chaired by the Social Work Team Leader or Social Work Manager. The AP1 and AP1B will be made available to those in attendance at the meeting. An agenda will be circulated beforehand and written invitations will be extended to all proposed attendees including:

- The RMO
- 2 Council Officers
- The Lead Nurse/SCN
- Key Worker
- Lead Officer if there are HR issues
- Advocacy if involved
- Police if involved
- Complaints Officer if involved
- PMVA Instructor if there is a restraint issue
- Finance Officer if there is a finance issue

Generally, a planning meeting should not include the patient, carer or family member or any member of staff against whom an allegation has been made as the meeting will involve sharing information which might prejudice any potential police investigation, disciplinary proceedings or a potential court case. The exception to this is where the adult has a guardian with relevant powers, unless the guardian is implicated in the alleged harm.

Within TSH the clinical team/formulation meetings often consider Adult Protection concerns, therefore this may preclude the need for a planning meeting being convened. On such occasions the Council Officer attending will update the team leader of the outcome, record the decisions and follow up actions required, as per the procedure.

Outcome of Planning Meeting
In the event that no further action will be taken under the Act, the patient and referrer will be advised both verbally and in writing by the Council Officer, and consideration will be given to other options to address any issues raised in the referral. The patients RMO, Lead Nurse and if appropriate, Advocacy and any carer if agreed by the adult will also be copied into the correspondence. The Mental Welfare Commission will be updated as appropriate if relevant. The

Director of Nursing and AHP should be updated and where there are HR issues, the Social Work Team Leader or Social Work Manager should be advised of the outcome of any inquiries.

All actions will normally be completed within **5 working days** from receipt of the referral.

If issues remain outstanding and an Interim protection plan is required, the contents of this should be agreed at the meeting inclusive of implementation dates and lead officers for all actions required. Following the meeting this information will be collated by the Council Officers following the format of the AP3 Adult Protection Plan and circulated to those in attendance at the meeting with a copy of the minutes of the meeting.

The Council Officers will commence an AP2 (Risk Assessment) which summarises the findings and views of the Council Officer and the adult in relation to past events and possible future actions.

Stage 5: Investigation

A case conference will be arranged when there is continued risk to the adult and the need for a protection plan has been identified. The function of the case conference is to evaluate the risk assessment by focussing on:

- The adult's views
- Views of carers, Guardian or Attorney (where appropriate)
- The chronology of significant events
- The specific risk to the adult
- The adult's capacity and/or consent to action
- The strengths/weaknesses in the current support arrangements
- Advocacy issues
- The threats to the adult's wellbeing
- If protective measures require to be sought

Case conferences will normally take place within **20 working days** from receipt of the referral however this time frame may be extended if more than one planning meeting has taken place beforehand.

Case conferences are minuted and are chaired by the Social Work Manager. An agenda will be circulated beforehand and written invitations will be extended to all proposed attendees including:

- The RMO
- The Lead Nurse/SCN
- 2 Council Officers
- Lead Officer if there are HR issues
- Local Authority MHO and/or social work representative
- South Lanarkshire Council Legal Services Representative
- Police, if appropriate
- Complaints Officer if appropriate
- PMVA /Advisor Instructor if appropriate
- Finance Officer, if appropriate
- The patient with advocacy representation as appropriate
- Family members or Carer, if appropriate and agreed by the patient
- Guardian unless the guardian is implicated in the alleged harm

Attendance at the case conference is at the discretion of the Chairperson. However, there may be occasions when consideration should be given to excluding someone such as the adult, their family/carers or others from part or all of the case conference. Exclusion is appropriate if there are substantive grounds to believe that the involvement of that person would undermine the case conference process and purpose.

It is also appropriate if information is being shared that refers to third parties' (or others) circumstances which would be inappropriate for those parties to be aware of because awareness of the information could be harmful to a criminal investigation, prosecution or apprehension of offenders, or where it would not be lawful to share the information with that person because of legislation or other laws such as the Human Rights Act 1998 and Data Protection Act 1998.

Where the adult, the adult's representative and carers/family members have been excluded throughout or for part of the case conference, it is the responsibility of the Chairperson to ensure that they are informed of the outcome. Care must be taken to ensure that a restricted minute only for the part of the case conference attended is provided in this instance.

Council Officers require to complete the Adult Protection 2 form (AP2) risk assessment document inclusive of a chronology of the incident prior to the case conference. A copy of the AP1, AP1B, AP2 and interim Adult Protection Plan 3 (AP3) will be available at the case conference

Stage 6: Case Conference

The Chairperson should clearly state the purpose of the case conference by;

- Confirming the reason for the case conference within the context of the appropriate legislation
- Confirming the need to share information while being mindful of confidentiality
- Confirming the potential need for restriction of information, for evidential reasons
- Outlining the case conference process
- If the AP1/2/3 have not been circulated prior to the case conference participants should be given time to read and digest the information.
- The Council Officer should be asked to speak to his/her report by summarising the salient information.
- Participants should be given the opportunity to ask questions, share information and raise issues of concern.
- The Chairperson should briefly summarise each contribution to ensure that the information has been properly understood and confirm the decisions of the meeting. This process should also facilitate minute-taking of the meeting.

Sharing Information
Whilst confidentiality is important, it is not an absolute right. Co-operation in sharing information is necessary to enable a council to undertake the required inquiries and investigations. Information should only be shared with those who need to know and only if it is relevant to the particular concern identified. The amount of information shared should be proportionate to addressing that concern.

If information has been disclosed during the conference which suggests that a crime may have been committed, this information must be passed to the police if they are not present. Case conference participants should be advised that any information which could be used as evidence in a future court case is confidential and should not be divulged to anyone else.

If there are disagreements about information shared there should be an attempt to resolve these during the case conference. However, it may be that some disagreements can only be acknowledged, in which case this should be clearly recorded in the minute.

Dissent
Any dissent or complaint occurring within the proceedings of the case conference must be recorded. If the dispute or complaint cannot be resolved within the case conference the Chairperson will refer the issue to Director of Nursing and the Adult/Older People, Social Work Service Manager in the first instance.

If a second case conference is to be held to address the concerns raised this should be done within **15 working days** of the recorded concerns. This meeting must be chaired by the Adult/Older People Service Manager.

Any agency, adult or their carers have the right of access to the complaints procedure should they disagree with any decision or outcome arising from the case conference. Complaints relating to procedural arrangements should be made via the council's complaints procedure.

Minuting
The Chairperson should ensure that the minute of the case conference is accurate, includes all decisions reached and that the protection plan, if required is accurate. The minute must be signed by the Chairperson as approved prior to being issued.

The minute and the protection plan should be circulated within **5 working days** from the date of the case conference. This information must be treated as confidential. The minute should only be given to those attending the meeting and exclude any part of the meeting where the recipient was excluded from the meeting.

Stage 7: Protection Planning

The protection plan (AP3) has been designed for use when a case conference has agreed that there is a risk of harm or serious harm and actions need to be taken to address it.

The Social Work Manager is responsible for ensuring that both the protection plan and contingency plan are discussed and agreed at the case conference. The Council Officer will record the plans on the AP3 paperwork and pass to the Social Work Manager for approval. The Social Work Manager will distribute the protection plan to the conference attendees within **2 working days** of the case conference. The Team Leader will approve the AP3 if the Social Work Manager is not available so as not to delay the process.

Following the case conference, the protection plan should be implemented immediately. The reason for any delay in providing services or support to the adult should be clearly recorded and consideration given to how best to support the adult in the interim.

A protection plan would normally be put in place with the adult's consent and cooperation. However, it is possible to consider proactive actions without the express consent of the adult. Agencies, under the duty to co-operate, for example, may be asked to take on a monitoring role on behalf of social work resources and to share relevant information on a regular basis.

For adults already in receipt of a support plan, amendments may be made to the plan aimed at reducing risks identified in the risk assessment. In this case the support plan should be referred to as the protection plan.

The protection plan should reflect the risks identified in the AP2 and include:

- Decisions
- Expected outcome of actions
- Timescales for actions
- Roles and responsibilities of each agency/staff member involved
- What supports may be required to protect the adult
- Whether a protection order is required
- A contingency plan should the protection arrangements break down
- The contribution of the adult (and/or their family) to protecting themselves

The protection plan should take into account the views of the adult at risk and significant others as well as the professionals involved. Good communication is key to ensuring that participants in the plan understand their roles and responsibilities in keeping the adult safe from harm.

A protection plan may include a decision to apply for a Guardianship order under the AWI Act.

A protection order such as an Assessment order or a Removal order may be appropriate if the adult has refused a visit or health assessment. Alternatively, a protection order in the form of a Banning order may be appropriate in order to keep the adult safe from others.

Core Group
The Core Groups remit is to review need and risk and ensure that the protection plans agreed outcomes are being met. The Council Officer is responsible for the continued monitoring of the protection plan.

Where it has been identified that urgent action is required, the Social Work Manager must agree to any changes to the protection plan. The changes will be ratified retrospectively at the next case conference/review case conference (which depending on the situation, may need to be held sooner).

In most cases there will be a core group of staff from public and independent services who are contributing to the plan via provision of support and/or services who will take the actions forward.

The core group is chaired by the Social Work Team Leader and the professionals involved should meet every **four weeks**.

Outcome of Case Conference
In many instances the primary output from the case conference will be an AP3 Adult Protection Plan, which will provide detail in relation to the following:

- Identification of risk/harm issues
- Agreed measures to minimise risk/harm measures such as disassociation, observation levels, ward transfer etc.
- Identification of persons responsible for each action
- Agree timescales
- Agree date for protection plan review
- Agree date for review case conference within **20 working days** from initial case conference

Other potential outcomes arising from the case conference include:

- Application for Place of safety Order
- Application for an Assessment Order
- Application for a Banning Order or Temporary Banning Order
- Variation to Care & Treatment Plan
- Application to vary status under MH Act
- Application for welfare and/or financial powers under AWI legislation.
- No further action

In the event that no further action will be taken under the Act, the patient and referrer will be advised both verbally and in writing, and consideration will be given to other options to address any issues raised in the referral. The patients RMO, Lead Nurse and if appropriate, Advocacy and any carer if agreed by the adult will also be copied into the correspondence. The Mental Welfare Commission will be updated as appropriate if relevant. The Director of Nursing and AHP should be updated and where there are HR issues, the Social Work Team Leader or Social Work Manager should be advised of the progress of the inquiry and its conclusion.

Where ongoing action is required a similar notification process will be undertaken to ensure that the patient, the patients RMO, Lead Nurse and, if appropriate, Advocacy and any carer if agreed by the patient will also be copied into the correspondence to ensure that they are aware of and

understand the ongoing interventions and the reasons for these interventions. The Mental Welfare Commission will also be updated as appropriate if relevant. The and Director of Nursing and AHP should be updated and where there are HR issues, the social work Team Leader or Social Work Manager should be updated on the progress of the inquiry and its conclusion

Protection Order
Where a decision has been made at a case conference to progress with an application for a Protection Order, Council Officers must work closely with South Lanarkshire Council Legal Services, who will make the relevant application to the Sheriff Court on behalf of the Council,

Part 1 of the Act allows a Council to apply to the Sheriff for a Protection Order. This can take one of 3 forms:

- Assessment Order
- Removal Order
- Banning or Temporary Banning Order.

The Sheriff may grant such an order only if satisfied that certain criterion is met. Because any Protection Order under the Act represents a serious intervention in an adult's life, a Sheriff must be satisfied that an adult is at risk of ***serious*** harm, before granting any such order.

Assessment Order:
This allows a Council Officer to take a person named in the Order from a place visited by the Officer in the course of their investigations to conduct a private interview or a health professional to conduct a private interview or medical examination. An application for an Assessment Order can only be made where this action is required to establish whether the person is an adult at risk, and if so, to establish whether further action is required to protect them from harm. An Assessment Order will only be necessary where it would not be possible to carry out a private interview or medical examination within the place being visited. Assessment Orders are valid for up to 7 days.

Removal Order:
This authorises a Council Officer to remove an adult at risk to a specified place where there is a likelihood of serious harm if they are not removed. This type of order may be varied or recalled by the Sheriff where this is justified by a change in facts or circumstance of the case. Removal Orders are effective up to a maximum of 7 days.

Banning Order:
This bans the subject of the order from being in a specified place, for up to 6 months. It can only be granted where an adult at risk is being or is likely to be seriously harmed by another person and the Sheriff is satisfied that banning the subject of the order from the place will better safeguard the adult at risk than their removal from that place. A Temporary Banning Order can be granted by a Sheriff pending the determination of a Banning Order.

When these measures might be used
Part 1 of the Act makes provision for the purposes of protecting adults as risk of harm. It is anticipated that Protection Orders will be used sparingly.

In most situations, and in line with the guiding principles of the Act, other less restrictive measures will be sufficient to protect the person concerned. However, in those circumstances where firmer action is required, this legislation puts in place sufficiently robust provisions to ensure those who need protection can have it.

The fact that Council Officers will be given powers to visit and make inquiries where it is believed an adult may be at risk should allow early intervention where necessary, with the emphasis on prevention of harm. By virtue of the power to get through the door for the initial visit, it may become clear that other legislation is more appropriate for particular situations, for example, measures

under the Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Care and Treatment) (Scotland) Act 2003

Stage 8: Monitoring and Review.

Unless the decision of the case conference is for no further action, review case conferences must be held on a **monthly** basis to review the content of the protection plan and to consider any other issues which may require to be addressed. This process would continue until the protection plan is no longer required and no further action is required under the Act by any relevant parties.

Stage 9: Closing and Recording the Adult Protection Process

Closing
The adult protection process can end at any time if it is agreed that an inquiry, investigation or a protection plan is not or is no longer required. This should be a shared decision with all relevant agencies involved as well as the adult.

Closing the process should include:

- Ensuring all agreed actions have been taken and the outcome recorded
- Completing all records to the agreed standard – AP1; AP1B; AP2; AP3
- If the case is to be closed the adult is made aware of this and knows who to contact if the need arises in the future
- Agencies are aware that they should alert Social Work Service to any concerns they may have in the future

Recording
Recording adult protection activity involves keeping records updated and minutes of meetings. It may also include copies of AP1, AP1B, AP2 and AP3 forms, assessments or reports and correspondence in paper form.

It is essential that Council Officers, Team Leaders and Social Work Manager involved in the ASP process, ensure that all ASP are recorded on a timeous basis and reflect the journey of the adult through the adult support and protection process

Good recording of information throughout the adult protection process is essential. Records should be evidence based, accurate and up to date. All staff should ensure that recording takes place as soon after each event as possible and in line with the revised South Lanarkshire Council's case recording procedure.

The purpose of case recording in adult protection cases is to provide a written account of:

- Concerns expressed by the adult or others regarding the safety of the adult
- The adult's views, feelings and wishes in respect of their safety
- Evidence of the council's responses to those concerns
- Evidence of the actions undertaken by the council, the adult and partners
- Evidence of the outcome of actions undertaken
- Records may be lodged in Court

Chronology
Each adult protection case record should include a chronology of significant events. Recording of actions relating to the adult protection inquiry /investigation process should be recorded as significant events:

- The inquiry
- Planning meetings

- Investigations
- Case conferences and review case conferences
- Completion of a protection plan
- Application/granting of protection orders
- Core group meetings