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| --- | --- | --- |
|  | **Content** | **Page** |
|  | [**Introduction**](#Intro)**:**  [Role of the Chief Officers’ Group.](#RoleofCOG)  [Structure of this document](#Structure) | **4** |
|  | **Preface** | **6** |
| [**Chapter 1**](#Chapter1) | **Legislative Context for Partnership Working**     * Guiding Principles from Human Rights Legislation. * Principles and Definitions of “Adult at Risk” * [Who is an ‘adult at risk’?](#whoisadultatrisk). * [Unable to safeguard or unwilling to safeguard](#unableunwilling)? * [What is “harm” and who may be considered “at risk”?](#whatisharm) * [Serious Harm.](#seriousharm) * [Types and Forms of harm](#typesofharm) * [Being more at risk of harm](#beingmoreatrisk) * [Particular Circumstances](#particularcircumstances) – [Trauma / Adverse Childhood Experiences /](#traumaaces) [Substance dependency, homelessness, and hoarding behaviour](#substancehomelesshoarding). * Transitions. | **8** |
| [**Chapter 2**](#chapter2)**:** | **Role of Partner Agencies -** Duty to refer and co-operate.   * [Information Sharing](#Informationsharing) * [Why do we need to share adult protection information?](#whydoweneeedtoshare) * [The “Four Referral Rs](#fourrs) * [Referrals](#referrals) * [Council’s duty to Inquire under 2007 Act (Section 4)](#dutytoinquire) * [Who can act as a Council Officer for the purposes of the Act?](#whocanbeaCO) * [Multi-agency working under the act.](#multiagencyworking) * [Police Scotland](#policescotland). * [Appropriate adults](#appropriateadult) * [Police Scotland Risk and Concern Management Hub.](#riskandconcernhub) * [Renfrewshire Community Safety Partnership Hub](#communitysafetyhub). * [Health.](#health) * [General Practices](#GPs). * [Healthcare Improvement Scotland](#HIS). * [Housing.](#Housing) * [The Scottish Fire and Rescue Service.](#SFRS) * [Scottish Society for Prevention Cruelty to Animals](#SSPCA). * [Scottish Ambulance Service.](#Ambulanceservice) * [Office of Public Guardian (OPG) (Scotland](#OPG)) * [Advocacy services](#Advocacy) * [Independent and third-sector providers and other organisations.](#thirdsectorproviders) * [Large Scale Investigations.](#LSI) * [Care Inspectorate.](#CareInspectorate) * [Mental Welfare Commission.](#MWC) * [Department of Work & Pensions (](#DWP)DWP (Department for Work and Pensions)) Escalation Process. * [Social Security Scotland.](#SSS) | **20** |
| **Chapter 3:** | [**Key**](#_Chapter_3_Key) **ASP Processes and multi-agency involvement.** | **36** |
| **Chapter 4:** | **Management of Professional / Organisational Disputes** | **60** |
| **Appendix 1** | **Adult Protection Referral Form** | **61** |
| **Appendix 2** | **Multi-agency Escalation of Risk Protocol** | **64** |
| **Appendix 3** | **Professional Concern / Outcome Resolution Form** | **68** |

**Introduction**

Since the introduction of The Adult Support and Protection (Scotland) Act 2007 during 2008, and publication by the Scottish Government of the Adult Support and Protection Code of Practice during 2014, there have been a number of policy, legislative and practice developments, both in the overall context of adult support and protection and in day-to-day activity. The revised version of the [Code of Practice, July 2022](https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2022/07/adult-support-protection-scotland-act-2007-code-practice-3/documents/adult-support-protection-scotland-act-2007-code-practice/adult-support-protection-scotland-act-2007-code-practice/govscot%3Adocument/adult-support-protection-scotland-act-2007-code-practice.pdf), aimed to capture these changes and has been referred to, to inform the development of these revised localised Adult Support & Protection Inter -agency Procedures and Guidance document.

Practice and policy expectations have also developed significantly over the past 12 years, with there now being a much greater appreciation of the breadth of work that can fall within the provisions of the Act, and of the implications this has for the work of Adult Protection Committees.

**Adult Protection Committees**, which are now firmly located within local public protection governance structures, duties and workings are outlined in [Section 42 (1) of the 2007 Act](https://www.legislation.gov.uk/asp/2007/10/section/42):

(a) to keep under review the procedures and practices of the public bodies and officeholders to which this section applies which relate to the safeguarding of adults at risk present in the council’s area (including, in particular, any such procedures and practices which involve co-operation between the council and other public bodies or officeholders to which this section applies),

(b) to give information or advice, or make proposals, to any public body and office holder to which this section applies on the exercise of functions which relate to the safeguarding of adults at risk present in the council’s area,

(c) to make, or assist in or encourage the making of, arrangements for improving the skills and knowledge of officers or employees of the public bodies and officeholders to which this section applies who have responsibilities relating to the safeguarding of adults at risk present in the council’s area,

(d) any other function relating to the safeguarding of adults at risk as the Scottish Ministers may by order specify.

**Role of the Chief Officers’ Group**

The [guidance for Adult Protection Committees](https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2022/07/adult-support-protection-scotland-act-2007-guidance-adult-protection-committees/documents/adult-support-protection-scotland-act-2007-guidance-adult-protection-committees/adult-support-protection-scotland-act-2007-guidance-adult-protection-committees/govscot%3Adocument/adult-support-protection-scotland-act-2007-guidance-adult-protection-committees.pdf) advises APCs will require to be given the authority by local agencies to be able to carry out their functions effectively; and will need lines of accountability to local councils, health boards and police.

The main forum for this is the Chief Officers Group, which are generally held quarterly, with a standing item for report(s) on Adult Protection activity and issues.

**Structure of this document:**

**Chapter 1** provides a legislative context; definitions and guiding principles to assist in identifying ‘harm’ and what is meant by an ‘adult at risk’.

**Chapter 2** outlines what will happen once an incident has been passed to the investigating agency’ and lays out the roles and responsibilities of each partner **agency** for working co-operatively in preventing or responding to harm to adults at risk.

**Chapter 3** describes how partner agencies might be involved in ASP processes.

**Chapter 4** provides a protocol for dealing with areas of disagreement between partner agencies.

**Preface**

There is now a growing appreciation that Adult Support and Protection can have direct relevance to a broader range of people than originally anticipated, including some people who have substance dependency problems or who are homeless. It can also potentially apply to people who may be being placed at risk, and whose human rights may be infringed, through inappropriate arrangements for their care.

*‘In 2021/22 there were an estimated 41,569 ASP referrals in Scotland where an adult is known or believed to be at risk, albeit an adult can be referred multiple times by different agencies. In 2021/22, the largest source of ASP referrals came from Police Scotland (28%), Social Work/Local authorities (17%) and from NHS/GP/Scottish Ambulance Service (15%). ASP referrals have been increasing: In 2019/20, there were 760 ASP referrals per 100,000 adults rising to 910 per 100,000 adults in 2021/22; an increase in estimated ASP referrals of around 20% over this two-year period’*.[[1]](#footnote-1)

Such figures indicate that [Adult Support and Protection is everyone’s business](https://www.iriss.org.uk/resources/reports/adult-support-and-protection-everyones-business) (see Iriss document, May 2023) with multi-agency working at the heart of an effective approach, providing the opportunity to make an important and growing contribution to the lives of adults at risk of harm, offering support as well as protection; preventing or reducing current or future harm.

This document has been produced on behalf of Renfrewshire Adult Protection Committee and aims to prevent such harm, wherever possible, but also to have agreed processes in place for dealing effectively and consistently with incidents of harm, through having a joint understanding across each agency of:

* The terminology used in adult support and protection.
* The principles of good practice in adult protection.
* The roles and responsibilities of all agencies in protecting adults that may be at risk of harm.
* Responding to reports of criminality.
* The duty of Public Bodies to cooperate.
* The links between Child, Adult and Public Protection.
* The lead role of Social Work in Adult Support & Protection
* The role of each council where cross-boundary issues arise.
* Standardise Procedural Forms (Appendix 1, 2, 3) which can be used by all agencies across Renfrewshire.
* The role of Chief Officers’ Group and Adult Protection Committee.
* An understanding of the legal basis for intervention.

While Social Work continues to take the lead role in Adult Support and Protection inquiries and use of investigatory powers, particularly through the responsibilities of the Council Officer, under the Renfrewshire Health & Social Care Partnership (RHSCP), all staff and managers are expected to play key roles in adult support & protection. This also applies to partners and agencies across the membership of Renfrewshire Adult Protection Committee.

There is a clear expectation that each of the ‘partner organisations’ within Renfrewshire produce and regularly review their own internal procedures to guide their staff in responding to incidents, and that these should be consistent with these multi-agency procedures.

**Definition**: By 'partner organisations’, we mean the group of partners who work together – operationally and strategically - to:

* receive all intimations of adult protect concerns.
* determine which concerns require investigative activity.
* determine actions required to make sure that adults at risk of harm are safe, protected, supported, involved, and consulted.
* and are responsible and accountable for the implementation of these actions.

**Chapter 1: Legislative Context for Partnership Working**

**Guiding Principles from Human Rights**

Human rights in Scotland are the subject of important legal safeguards, in particular as a result of the [Human Rights Act 1998](https://www.equalityhumanrights.com/en/human-rights/human-rights-act) and the [Scotland Act 1998](https://www.legislation.gov.uk/ukpga/1998/46/contents). These give domestic legal effect to internationally recognised rights and freedoms found in the [European Convention on Human Rights (ECHR)](https://www.equalityhumanrights.com/en/what-european-convention-human-rights#:~:text=The%20European%20Convention%20The%20European%20Convention%20on%20Human,the%20Protection%20of%20Human%20Rights%20and%20Fundamental%20Freedoms%E2%80%99.). For example, legislation passed by the Scottish Parliament is not law if it is incompatible with these “Convention rights.” More generally, it is unlawful for any public authority (including both central and local government) to act in a way that is incompatible with the Convention rights. It is therefore essential that all public bodies and practitioners ensure that they carry out their functions in a way that is ECHR-compatible.

Additionally, the Scottish Government has committed to incorporate four United Nations treaties into Scots law, as far as possible within devolved competence, including the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). This Convention promotes non-discriminatory, inclusive participation for all, with respect for the individual’s dignity and differences, reinforcing equal rights of people with disabilities. Incorporation of UNCRPD will place greater impetus on public bodies to remove barriers and support disabled people to fully participate in society.

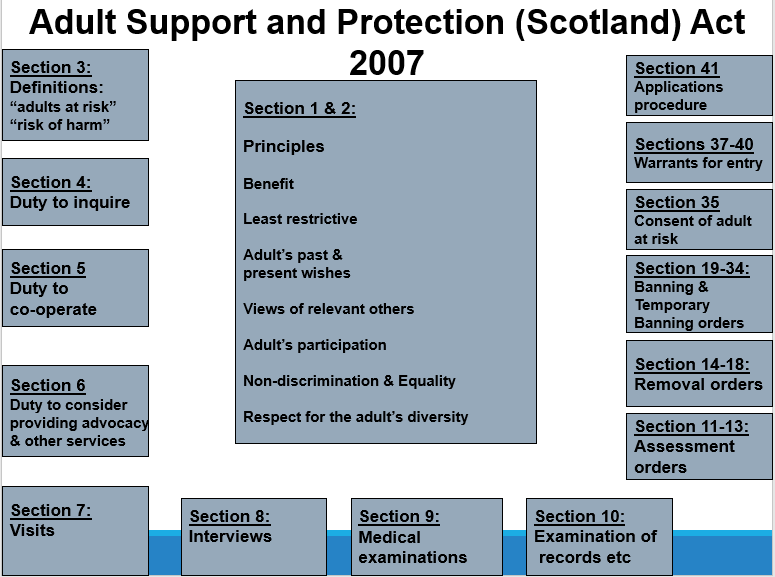
These domestic and international legal requirements are further reflected in the [Health and Social Care Standards,](https://hub.careinspectorate.com/media/2544/sg-health-and-social-care-standards.pdf) including in an overarching human rights outcome associated with the [National Performance Framework](https://nationalperformance.gov.scot/what-it). This establishes a shared vision for a Scotland in which “we respect, protect and fulfil human rights and live free from discrimination.”

The following principles and values should inform and guide the application of Adult Support and Protection procedures by the partner agencies:

* Each adult has a right to be protected from all forms of deliberate harm, neglect, and exploitation.
* The primary consideration at all stages will be the welfare and safety of the adult.
* Every effort should be made to enable the individual to express their wishes and make their own decisions to the best of their ability, recognising that such self-determination may well involve risk.
* Where it is necessary to override the wishes of the adult or make decisions on his/her behalf for their own safety (or the safety of others) this should be justifiable in terms of a proportionate and least disruptive response to clearly identified risks to the health and well-being of the person and in line with the existing legislative framework.

**Principles and Definitions of an “Adult at Risk” subject to the 2007 Act.**

**Image overview of sections of act-**



[The 2007 Act](https://www.legislation.gov.uk/asp/2007/10)provides measures to identify, and to provide support and protection for, those individuals who are at risk of harm or are being harmed, whether as a result of their own or someone else’s conduct. These measures include:

* S[ections 1 and 2](https://www.legislation.gov.uk/asp/2007/10/contents) of the Act and outlines the definitions of ‘adults at risk’ and ‘harm’ [(Sections 3 and 53 of the Act)](https://www.legislation.gov.uk/asp/2007/10/contents).
* **Section 2:** a set of principles which must be taken into account when performing functions under the Act.
* **Section 4:** placing a duty on Councils to make the necessary inquiries to establish whether or not an adult is at risk of harm and whether further action is required to protect the adult’s well-being, property, or financial affairs.
* **Section 5:** placing a duty on certain public bodies and office holders to cooperate in inquiries.
* **Section 6:** a duty to consider the provision of advocacy or other services after a decision has been made to intervene.
* **Section 7 & 8:** make visits,with right of entry**,** for the purpose of conducting interviews(section 8),as part of its inquiries**,** involving Council Officerswho have certain powers under the Act.
* **Section 9:** permitting, in certain circumstances, the medical examination of a person known or believed to be at risk of harm.
* **Section 10**: requiring access to records held by agencies in pursuance of an inquiry.
* a range of Protection Orders which are defined in the Act, namely:

▪ Assessment orders.

▪ Removal orders.

▪ Banning orders.

* **Section 18:** protect property owned or controlled by an adult who is removed from a place under a removal order (Section 18).
* **Section 42**: requiring the establishment of multi-agency Adult Protection Committees.

**Taking account of the principles of the 2007 Act**

Sections 1 and 2 sets out the general principles of the Act. These apply to any public body or office holder authorising any intervention in an adult’s affairs or carrying out a function under the Act in relation to an adult. For example, they apply to any Social Worker, Care Provider or Health Professional intervening or performing functions under the Act.

This means that the following persons are not bound by these principles: the adult; the adults nearest relative; the adult's primary carer; an independent advocate; the adult's legal representative; and any guardian or attorney of the adult. (These latter groups will, however, be bound either by their own codes of conduct and principles, or the principles of the legislation that resulted in their appointment).

The 2007 Act requires the principles to be applied when deciding which measure will be most suitable for meeting the needs of the individual. Any person or body taking a decision or action under the Act must be able to demonstrate that the principles in sections 1 and 2 have been applied.

The principles in section 1 require that any intervention in an adult’s affairs under the Act :

* (a) will provide **benefit** to the adult which could not reasonably be provided without intervening in the adult’s affairs, and
* (b) is, of the range of options likely to fulfil the object of the intervention, the **least restrictive** to the adult’s freedom.

The principles in section 2 require that any public body or office holder performing a function under the Act must have regard to the following:

The **general principles** in Section 1, and:

* **The wishes of the adult** - any public body or office holder performing a function or making a decision must have regard to the present and past wishes and feelings of the adult, where they are relevant to the exercise of the function, and as far as they can be ascertained. Efforts should be made to assist and facilitate communication using whatever method is appropriate to the needs of the individual. Where this communication support is not provided, reasons for this should be recorded clearly.
* **The views of others** – the views of the adult's nearest relative, primary carer, a guardian or attorney, and any other person who has an interest in the adult’s well-being or property, must be taken into account if such views are relevant. Cognisance, when weighing the merits of such views, must be taken of any possibility of **‘undue pressure**’[[2]](#footnote-2), or increase of risk, if the views of others are sought. It is important that the adult has the option to maintain existing family and social contacts, should they wish to do so.
* The Act seeks to **provide support** additional to that of existent networks. Thus, a person, who may be an adult at risk, might have neighbours, friends or other contacts who have an interest in their wellbeing and are willing to give support (noting the caveat that consideration should be given to whether **‘**[**undue pressure’**](#unduepressure) from those contacts is a suspected or known risk factor). Every effort should be made to ensure that action taken under the Act does not have an adverse effect on the adult’s relationships.
* The **importance of the adult participating as fully as possible** – the adult should be enabled to participate as fully as possible in any decisions being made. It is therefore essential that the adult is also provided with support and information to aid that participation, and in a way that is most likely to be understood by the adult. Any needs the adult may have for help with communication (for example, translation services or signing) should be met. Any unmet need should be recorded. Wherever practicable the adult should be kept fully informed at every stage of the process. This includes information about their right to refuse to participate.
* **The adult is not treated less favourably** – there is a need to ensure that the adult is not treated, without justification, any less favourably than the way in which a person who is not an ‘adult at risk’ would be treated in a comparable situation.
* **The adult’s abilities, background, and characteristics** – including the adult’s age, sex, sexual orientation, religious persuasion, racial origin, ethnic group, and cultural and linguistic heritage.

So as to more fully assess the abilities, background and characteristics of the adult, users of this document may find it helpful to consider the wider protected characteristics list and definitions set out in the [Equality Act 2010](https://renfrewshirecouncilgov-my.sharepoint.com/personal/frances_toland_renfrewshire_gov_uk/Documents/Desktop/egislation.gov.uk/ukpga/2010/15/contents) for the purposes of that Act

These principles should always be considered when decisions are required about action that may be taken to protect an adult.

However, there will be situations where their consideration produces potential conflicts, such as occasions when the adult at risk expresses a preference not to engage with any form of intervention, but the professionals involved believe that adult protection interventions would provide a benefit to them. In such circumstances, the expectation is that decision-making should take place on a multi-agency basis to enable full and complete discussion of potential protective actions, and the application of the principles set out above.

For the purpose of these principles, **making a decision not to act is still considered as making a decision. The reasons for taking this course of action should be recorded as a matter of good practice.**

[**Undue Pressure:**](#unduepressure)

Where the adult has decisional capacity and refuses consent/ engage, this should not automatically be a ‘no further action’ outcome. Further consideration must be given to the circumstances of the case, in discussion with relevant others, in order to ensure that issues of ‘undue pressure’ have been considered.

**Who is an ‘adult at risk’?**

The 2007 Act refers throughout to an ‘adult’.

[**Section 3(1)**](https://www.legislation.gov.uk/asp/2007/10/section/3)defines an ‘adult at risk’ as someone who meets all of the following three-point criteria:

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

**Note:** ‘It should be noted and strongly emphasised that the three-point criteria above make no reference to capacity. For the purposes of the Act, capacity should be considered on a contextual basis around a specific decision, and not restricted to an overall clinical judgement. It is recognised that, due to many factors in an individual’s life, capacity to make an authentic decision is a fluctuating concept. Thus, even if deemed to possess general capacity, attention must be paid to whether a person has clear decisional and executional ability (i.e., to both make and action decisions) to safeguard themselves in the specific context arising’[[3]](#footnote-3).

**Note**: the presence of a particular condition does not automatically mean an adult is an "adult at risk".

**Unable to safeguard or unwilling to safeguard?**

The first point of the three-point criteria set out in section 3(1) of the Act relates to whether the adult is **unable** to safeguard their own well-being, property, rights, or other interests.

As a result, a distinction may have to be made between an adult who lacks the skills and is therefore unable to safeguard themselves, and one who is deemed to have the power, ability, or authority to safeguard themselves, but who is apparently **unwilling** to do so.

* **‘Unable’** is not further defined in the Act but is defined in the Collins English Dictionary as “lacking the necessary power, ability, or authority (to do something); not able.”
* **‘Unwilling’** is defined in the Collins English Dictionary as “unfavourably inclined; reluctant.”

The latter may describe someone who is aware of the potential consequences but still makes a deliberate choice. **Unwilling** to safeguard themselves, rather than unable to safeguard themselves, may not be considered an adult at risk.

This distinction requires careful consideration. All adults who have capacity have the right to make their own choices about their lives and these choices should be respected if they are made freely.

However, for many people the effects of [trauma and/or adverse adult & childhood experiences](https://www.gov.scot/publications/adverse-childhood-experiences-aces/) may impact upon both their ability to make and action decisions, and the type of choices they appear to make. In this context it is reasonable to envisage situations in which these experiences, and the cumulative impact of them through life, may very well have rendered some people effectively unable, through reliable decision making or action, to safeguard themselves. Similar considerations apply to ‘[coercive control’](#coercivecontrol) or [‘undue pressure’](#unduepressure). In such situations the control exercised over a vulnerable person may also effectively render them unable to take or action decisions that would protect them from harm.

It is therefore important to understand the person’s decision-making processes. This should include an understanding of any factors which may have impacted upon them with the effect of impinging on, or detracting from, their ability to make, and action, free andinformed decisions to safeguard themselves. This could therefore mean that in these circumstances they should be regarded as unable to safeguard themselves.

It is also important to bear in mind that an inability to safeguard oneself is not the sameas anadult lacking mental capacity. For example, a person may have relevant mental capacity, but also have physical limitations that restrict their ability to implement actions to safeguard themselves. Capacity applies to both decisions making and the implementation of decisions. A person can have the capacity to make a particular decision but through illness or infirmity may not have the physical capacity to implement that decision.

Where an individual is deemed not to meet the three-point criteria or there exist factors or complexities that may be relevant to legislation other than the Act, thought should be given to other legislation which may provide alternative or additional pathways, e.g. the [Adults with Incapacity (Scotland) Act 2000](https://www.legislation.gov.uk/asp/2000/4/contents) or the [Mental Health (Care and Treatment) (Scotland) Act 2003.](https://www.legislation.gov.uk/asp/2003/13/contents)

**What is “harm” and who may be considered “at risk”?**

**Definition:** Coercive Control - A pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

To meet the second point of the three-point criteria the adult must be assessed as being at risk of harm. Section 3(2) of the 2007 Act defines an adult as being at risk of harm if:

* another person’s conduct is causing (or is likely to cause) the adult harm; or
* the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.

Adults can be at risk of harm in any setting, be it in their own home, in the wider community, or in a hospital setting. It must not be assumed that while a person is a patient in hospital that they are safe from harm from alleged perpetrators. A person also may be placed at risk through inappropriate arrangements for their care in a range of residential social or hospital care settings.

People who cause harm can include the adult themselves; members of their family; friends; neighbours; informal/ formal carers; fellow users of residential/ day services; fraudsters and members of the public; and strangers.

[Section 53](https://www.legislation.gov.uk/asp/2007/10/section/53) of the 2007 Act states that “harm” includes all harmful conduct and gives the following examples:

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

**Serious Harm**

There is no definition of ‘serious harm’ provided in the 2007 Act. Serious harm is the threshold that justifies compulsory intervention in an adult’s life by the state. This can be a singletraumatic incident or event, but it could also be a number of single events or a build-upof concerns over a period of time. What constitutes serious harm will be different for different adults (See [West of Scotland Inter-agency AS& P procedures](https://www.east-ayrshire.gov.uk/Resources/PDF/W/West-of-Scotland-Inter-Agency-ASP-Guidance.pdf), 2019, p.12).

When assessing harm, areas that require to be taken into consideration are:

* Impact of harm on the adult’s physical or mental health- including cumulative impact.
* Injuries which are severe and/or life threatening.
* The adult’s perception.
* Level of risk.
* The need for urgent action- imminence.
* The number, frequency, consistency, and severity of harm- escalation.
* The intent of the person causing the harm.
* History of harm- likelihood of recurrence & context.
* The probable consequences of non-intervention.

**Types and Forms of harm**

In general terms, behaviours that constitute harm to a person can be physical, sexual, psychological, financial, or a combination of these.

The harm can be accidental or intentional, as a result of self-neglect, neglect by a carer or caused by self-harm and/or suicidal behaviours. Other forms of harm can include domestic abuse, Gender-Based violence, forced marriage, female genital mutilation (FGM), human trafficking, stalking, scam trading and hate crime.

Some such cases will result in adults being identified as at risk of harm under the terms of the Act, but this will not always be the case.

The [Act Against Harm](https://www.actagainstharm.org/what-is-harm/) website provides further explanations of and possible signs of harm.

**Note:** The following list is not exhaustive, and no category of harm is excluded simply because it is not explicitly listed:

**Physical Harm** – including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions, deliberate fire-starting.

**Sexual Harm** – including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, could not consent, or was pressurised into consenting. Also, adults who may be at higher risk of sexual exploitation due to mental health problems, physical impairment or learning disabilities. Sexual harm includes:

* ‘contact’ harm – touch e.g., of breast, genitals, arms, mouth etc.; masturbation of either or both persons; penetration or attempted penetration of vagina, anus, mouth by penis, fingers or by other objects.
* ‘non-contact’ harm – looking, photography, indecent exposure, harassment, serious teasing, or innuendo.

**Psychological Harm** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.

**Financial or material harm** – Financial harm takes many forms including theft, fraud (e.g., doorstep scammers, scamming by post, over the phone, online or through a combination of these methods), pressure to hand or sign over property or money, misuse of property or welfare benefits, stopping someone getting their money or possessions, etc.

When considering whether financial harm is occurring, it is helpful to consider a person’s past behaviours and views, as this may offer insight to their current behaviours and highlight changes.

**Note:** Not all people subject to financial harm will be regarded as adults at risk, but the Act can be used to protect those people who are so regarded. In such cases, the potential for coercive control or [‘undue pressure’](#unduepressure) should be considered. *(See role of Public Guardian)*

**Neglect and acts of omission** -including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life such as medication, adequate nutrition, and heating.

**Multiple forms of harm**– may occur in an ongoing relationship, a service setting or to more than one person at a time. This makes it important to look beyond single incidents or breaches in standards, to underlying dynamics and patterns of harm. Any or all of these types of harm may be perpetrated either as a result of deliberate targeting of adults at risk or through negligence or ignorance. In some cases, it may result from an extreme level of stress on an informal carer – which may include aggressive or violent behaviour by the vulnerable adult towards the carer. In such cases a sensitive approach in supporting the carer has to be combined with a determination to deal with the harmful behaviour and prevent it recurring and placing the protection of the adult at risk at the forefront of intervention.

**Self-harm** – the adult at risk is engaging in behaviour which is causing (or likely to cause) self-harm. This is a broad term but will include people:

* injuring or poisoning themselves by scratching, cutting, or burning skin, by hitting themselves against objects, fire-setting or taking a drug overdose, or swallowing or putting other things inside themselves; suicidal ideation.
* less obvious forms, including unnecessary risks, developing an eating disorder (such as anorexia or bulimia), substance dependency (alcohol or drugs), or someone simply not looking after their own emotional or physical needs.

The category of self-harm could also include instances where the conduct of others is considered to be a cause of an adult at risk self-harming though there would be a clear link with Emotional Abuse.

If **Domestic Abuse** is a factor, consideration may also be given to the relevance of a Multi-agency Risk Assessment Conference (‘MARAC’), under Renfrewshire’s MARAC Operating Protocol (2021), in which information about domestic abuse victims at risk of the most serious levels of harm is shared on a multi-agency basis to inform a coordinated action plan.

* Note: ASP Legislation and Procedure takes precedence.



**Being more at risk of harm**

The third point of the criteria requires that because the adult is affected by disability, mentaldisorder, illness, or physical or mental infirmity they are more at risk to being harmed than adults who are not so affected.

Physical or mental infirmity are distinct from disability and mental disorder and are not defined in the Act. Infirmity is defined as a “physical or mental weakness.” Infirmity does not,therefore, necessarily rely upon a clinical diagnosis in the way that mental disorder or illness do.

**Note:** It is recognised that “infirmity” is a term that is no longer favoured when describingdisability**.** Having a particular condition or being a disabled person does not automatically mean someone is unable to safeguard their own wellbeing. “Illness” can apply to physical or mental health. The impact of illness on an individual’s ability to safeguardthemselves, and the extent to which it makes them more vulnerable to harm, must be considered. Depending upon the nature and trajectory of an illness, the assessment of this criterion of the three-point criteria may change over time.

**Note: Each of the three criteria must be met to enable intervention subject to the Act**.

**Impact of Personal Circumstances / Trauma Based Practice:**

Many people affected by trauma and adverse childhood experiences remain able to safeguard their own wellbeing. However, for some, the complexity, severity, and persistence of post traumatic reactions may impact to the extent that these individuals repeatedly take decisions that place them at risk of harm.

Examples of such adaptations can include: maintaining contact with an alleged harmer; use of drugs or alcohol; self-harm; [hoarding behaviour](https://www.nhs.uk/mental-health/conditions/hoarding-disorder/), and avoidance of places and people, including professional relationships and services, which may trigger reminders of prior traumatic experiences. In such circumstances, some people’s ability to take and action decisions about safeguarding themselves may effectively be compromised.

Professionals involved in the identification, support, and protection of adults at risk of harm may wish to make use of the resources provided by the [National Trauma Training Programme](https://www.nes.scot.nhs.uk/our-work/trauma-national-trauma-training-programme/).

It is essential to move from a position of looking at presenting issues in isolation and, instead, to see it in terms of relational causation and connection, i.e., a shift from the view that dependency causes self-neglect, to one that understands such dependency as an outward symptom or sign of deeper challenges and of self-neglect itself. As above, considerations of the impact of trauma on the individual’s ability to safeguard should be a thread throughout ASP activity.

It should be highlighted however,

* While Trauma informed practice is exclusively referenced within the Code of Practice, practitioners may wish to supplement reference to Trauma based Practice in their assessment work with reference to other academic Social Work Theories e.g., Psychosocial Development Theory, Systems Theory, Rational Choice Theory.
* It is essential that whatever approach is taken that there is a recognition that a welfare approach to social work/ social care does not always achieve the primary object of ASP which is Care and Protection. The requirement to protect may require an authoritarian, directive and or legislative approach to casework in the short to medium term or on occasion indefinitely.

**Transitions between Child Protection and Adult Support /Protection**

A short-term working group has been established and led by the Lead Officers of the Child and Adult Support and Protection Committees in order to progress this matter and report recommendations to the committees during 2024.Princpiples already established are as follows:

* The matter will be progressed in the best interests of the young adult aged 16 & 17.
* Continuity should be provided by Children’s services and the Child Protection procedures for those young adults presently subject to statutory childcare provision.
* Future procedures should be consistent with the proposed updates to Child Care legislation, specifically extending the remit of the statutory children’s services to include 16- & 17-year-olds which focuses on a welfare approach to intervention and support. Children (Care and Justice) (Scotland) Bill (SP Bill 22).

Where there are concerns that 16- and 17-year-olds may be at risk of harm, part of the Council’s inquiry process will involve a consideration of which legislative framework is best placed to support and protect the young adult.

**Chapter 2: Role of Partner Agencies.**

**Duty to refer and co-operate.**

**Information Sharing**

Supporting individuals at risk of harm is best achieved through collaboration and with a sense of community responsibility. This cuts across all aspects of private life and professional business.

Information sharing to support the operational processes of Adult Support and Protection, when an adult is known or believed to be at risk of harm, is justified and can be shared lawfully within the parameters of the Data Protection Act 2018 and the General Data Protection Regulation (GDPR), in keeping with the following principles:

**Necessary, proportionate, relevant, accurate, timely and secure:**ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up to date, is shared in a timely fashion, and is shared securely.

**Why do we need to share adult protection information****?**

Organisations need to share adult protection concerns with the right people at the right time to:

* prevent death or serious harm.
* coordinate effective and efficient responses.
* enable early interventions to prevent the escalation of risk.
* prevent abuse and harm that may increase the need for care and support.
* maintain and improve good practice in protecting adults.
* reveal patterns of harm that were previously undetected and that could identify others at risk of harm.
* identify low-level concerns that may reveal people at risk of harm.
* help people to access the right kind of support to reduce risk and promote wellbeing.
* help identify people who may pose a risk to others and, where possible, work to reduce offending behaviour.
* reduce organisational risk and protect reputation

(COP (code of practice), 2022, p.35)

**Note:** The General Data Protection Regulation (GDPR) is not a barrier to sharinginformationbut provides a framework to ensure that personal information about living persons is shared appropriately.

**Steps to Take:** **The “Four Referral Rs”:**

* **Recognise** – be aware of adult protection issues and how an adult at risk of harm may present. Consider trauma, undue pressure etc., and the adult’s ability to safeguard themselves.
* **Report** – where you have an internal adviser for adult protection report the matter to them, discuss with appropriate colleagues the need to make a referral but ensure this does not adversely delay referring.
* **Refer** – Refer the individual and their circumstances through your local adult protection referral process. Where the matter is urgent contact the relevant emergency services without delay.
* **Record** – use the individual’s record to note the issues that arose, the circumstances, the decisions made/actions you took, and the rationale for your actions.

You do not have to evidence that the three parts of criteria are met in order to make a **referral**. Your information may form part of a larger picture. The criteria are that you ‘know or believe’ an adult is at risk of harm.

**Note:** If there is imminent risk of danger or significant harm has happened contact the relevant Emergency Service- Police/Fire/Ambulance immediately and then make the ASP referral.

**Referrals**

Any referral suggesting that an adult may be at risk of harm, including anonymous referrals, will be considered without assuming that harm has, or has not, occurred.

A referral may be made to a council in several ways, but most usually will be either:

* by a referrer who uses an ASP notification process or referral form, or otherwise specifies that they are referring an adult they think may be in need of support or protection under the Act; or
* by a referrer who is raising a more general (welfare) concern, which is then escalated on receipt to be treated under Adult Support & Protection.

Note: As discussed above, the adult’s consent is not required for a referral to be made.

**Chapter 3 provides details for a referral.**

**Council’s duty to Inquire subject to the 2007 Act (Section 4)**

[Section 4 of the 2007 Act](https://www.legislation.gov.uk/asp/2007/10/section/4) 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.

**Social Work**

* Inquiries subject to Section 4 of the Act will be carried out by the Council's Social Work services and should follow Renfrewshire’s ASP Operational Guidance 2024
* Definition: *An inquiry is used to gather information to determine if the person meets the three-point criteria and if any action is required under to intervene.*
* Social Work will also have the overall lead responsibility, within RHSCP, when investigatory powers are required to be utilised under the act; and for coordinating the process of decision-taking and monitoring that may follow investigatory activity.
* Timescales for completion of Inquiries using Investigatory Powers is documented in the Renfrewshire Operational Procedures 2024.
* An inquiry does not need to be (but can be) undertaken by a Council Officer, which can include the collation and consideration of relevant material, including consideration of previous records relating to the individual, and seeking the views of other agencies and professionals (aka desktop inquiries).
* The timescales for completion of Inquires Without Use of Investigatory Powers is generally carried out within 5 working days of receiving referral.
* If desktop inquiries do not provide sufficient information to determine whether or not the adult is at risk, then further steps can be taken to allow for such a determination to be made.
* These actions relate to when there is a need to use Investigatory Powers**.** If these specific actions need to be taken, there is a requirement for a [Council Officer](#CouncilOfficer)to be involved.
* The 2007 Act enables a council to, through the offices of a Council Officer:
* to visit[(Section 7)](https://www.legislation.gov.uk/asp/2007/10/section/7) any place necessary to assist with inquiries under section 4. Council officers have rights of entry to places where adults are known or believed to be at risk of harm.
* may interview [(section 8),](https://www.legislation.gov.uk/asp/2007/10/section/8) in private, any adult found at the place being visited.
* may 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);](https://www.legislation.gov.uk/asp/2007/10/section/9)
* Health, financial and other records **r**elating to an adult at risk may be requested and examined [(section 10).](https://www.legislation.gov.uk/asp/2007/10/section/10) Notethat the Council Officer is empowered by the Act to identify, take, or copy medical records held by a service but having obtained them must ensure they are interpreted by a health professional.

The council can:

If**,** following inquiries, a Council Officer believes that action is required, the council canpetition the Sheriff Court for a protection order. The range of protection orders include:

* **assessment orders** (which may be to carry out an interview or medical examination of a person).
* **removal orders** (removal of an adult at risk).
* **banning orders or temporary banning orders** (banning of the person causing, or likely to cause, the harm from being in a specified place).

[(Section 11 to 34)](https://www.legislation.gov.uk/asp/2007/10/contents)

**Who can act as a Council Officer for the purposes of the Act?**

[Section 53 (1)](https://www.legislation.gov.uk/asp/2007/10/section/53) of the Act defines a council officer as an individual appointed by a council subject to [Section 64 of the Local Government (Scotland) Act 1973](https://www.legislation.gov.uk/ukpga/1973/65/section/64).

Scottish Ministers have made an order that prescribes that a council must not authorise a person to perform the functions of a Council Officer subject to sections 7 to 10 of the Act (investigative functions) unless the person:

* is registered in the part of the Scottish Social Services Council register maintained in respect of Social Workers or social service workers or is the subject of an equivalent registration.
* is registered as an Occupational Therapist in the register maintained under article 5(1) (establishment and maintenance of register) of the Health Professions Order 2001; or
* is a Nurse; and the person has at least 12 months' post qualifying experience of identifying, assessing, and managing adults at risk.

While different professionals as noted can become Council Officers they must be employed in posts within the Local Authority and have received the appropriate Council Officer training.

**Multi-agency working**

The council may consult and/or work in partnership with other agencies to conduct inquiries**.** Other professionals, such as Police Scotland, Scottish Fire & Rescue Service; the Care Inspectorate; health professionals, Housing, etc. may be asked to assist.

Partner agencies working within Renfrewshire have the following obligations placed on them subject to the 2007Act.

**Duty to co-operate (section 5)**

This section of the Act applies to:

* the Mental Welfare Commission for Scotland,
* the Care Inspectorate,
* the Office of the Public Guardian,
* all councils,
* Chief Constable of Police Scotland,
* the relevant Health Board, and
* any other public body or officeholder as the Scottish Ministers may by order specify.

The public bodies and officeholders to which this section applies must, in keeping with the proper exercise of their functions, co-operate with a council making inquiries subject tosection 4, and each other, where such co-operation is likely to enable or assist the council making those inquiries.

While it is not specified in the Act, a wide range of other services also contribute to the protection of adults at risk. These include:

* GP Practices, dentists, and pharmacists.
* Scottish Fire and Rescue Service.
* Agencies of the Scottish Government, e.g. The Scottish Prison Service; Social Security Scotland

* Where staff in named bodies have to report suspected cases of adults at risk of harm within their own organisations, they should be clear to whom they have a duty to report.
* The above services and agencies may all become involved with adults whom they know or believe as being at risk and may, therefore, have cause to refer people to the council, and as such have a direct part to play in protecting people from risk of harm.

[Section 49](https://www.legislation.gov.uk/asp/2007/10/section/49) of the 2007 Act provides that it is an offence to, without reasonable cause, prevent or obstruct any person from doing anything they are authorised or entitled to do under the Act (see Chapter 15 of this Code)

To emphasise, whilst the provisions of the Act are concerned with adults at risk of harm, public services and agencies are expected to make a referral, share information, co-operate with assisting inquiries, attend a Case Conference as required and, if relevant, provide services to support adults at risk of harm and support any other ASP-related activity, e.g. attend Core Group meeting.

**Police Scotland:**

* Police have a statutory duty subject to the 2007 Act to refer any adult who may be at risk of harm and to cooperate with council ‘duty to inquire’, in line with local policies and procedures. This means accurately recording any concerns under the category ‘Adult Concerns’ so that reports and relevant information can be shared with relevant partners.
* Police Scotland must be contacted in the first instance if staff know or believe a criminal act may have been committed and agreement made on how best to proceed.
* Where there has been a physical or sexual assault the Police must be consulted immediately, and any medical examination (other than emergency medical treatment) should be carried out under the direction of the Police.
* If there are immediate concerns for the safety of an adult (or child), Police Scotland have Powers of entry to a property, which is derived from common law. It broadly states that police are empowered to enter a house or other building without a warrant for the purposes of:
* protecting life and property.
* quelling an ongoing disturbance or disorder.
* assisting when hearing cries for help or of distress.
* close pursuit of a person who has committed or attempted to commit a serious crime.
* Police Scotland can enterand search premises where an invitation has been freely given by the occupant.
* Police Scotland have the lead role for investigating where the actual or suspected harm to an adult at risk is thought to have constituted a criminaloffence. It is not the responsibility of staff from any other agency to judge if a criminal act has occurred and they should err on the side of reporting and discussing with the Police who will decide if a criminal investigation is required. It is essential that non-Police Officers do not interfere with a criminal investigation.
* Police Scotland will investigate an alleged offence by gathering and preserving evidence. Staff from other agencies will have an important role in ensuring thatforensic evidence is not lost and that, if the risk of harm is significant and ongoing, the adult is protected and isolated from the person alleged to be causing harm, pending police intervention.
* Police Scotland will inform Social Work where they receive a report of a suspected offence or other concerns relating to an ‘adult at risk,’ whereupon it will be the responsibility of Social Work to co-ordinate the overall Inquiry activity.

Police Scotland have particular functions subject to the ASP Act (2007) in terms of accompanying a Council Officer to execute a [warrant for entry](https://www.legislation.gov.uk/asp/2007/10/section/37) subject to section 37 of the Act. The accompanying constable may use reasonable force where necessary to fulfil the object of the visit. This may include the constable opening places which are secured by a lock; it would therefore be expected that the council would take all reasonable steps to ensure the security of the person's premises and belongings if force has been required to enter the premises.

**Appropriate adults:**

Appropriate Adults provide communication support to vulnerable victims, witnesses, suspects and accused persons, aged 16 and over, during police investigations.

The role of the Appropriate Adult is to facilitate communication between a person with mental disorder and the police and, as far as is possible, ensure understanding by the individual.

It is recognised that not all individuals who may require Appropriate Adult support will have a formal diagnosis, nor may they be able or willing to share any diagnosis with the police. In circumstances where a diagnosis cannot be confirmed but it is clear that the individual cannot understand procedures or communicate effectively with the police, and that the cause of such difficulty is not solely because of substance use/intoxication, then Appropriate Adult support should be requested.

[Section 42 of the Criminal Justice (Scotland) Act 2016](https://www.legislation.gov.uk/asp/2016/1/section/42/enacted) places a duty on the police to ensure this type of support is provided during custody procedures, while the [Criminal Justice (Scotland) Act 2016 (Support for Vulnerable Persons) Regulations 2019](https://www.legislation.gov.uk/sdsi/2019/9780111043295/regulation/4) place a duty on local authorities to provide an Appropriate Adult when such a request is made by the police. The duty on the local authorities extends to requests made for support in relation to victims and witnesses, as well as to those made for support for suspects and accused persons. In addition to custody processes, Appropriate Adults can be used in any number of Police procedures, including interviews, the taking of witness statements, identification procedures, medical examinations, and property searches**.**



**Police Scotland Risk and Concern Management Hub**

K Division covers Renfrewshire and Inverclyde:

The role of the Risk and Concern Hub (R&CH) is to review and assess relevant information held on Police systems, compile reports, and share this and other information with internal and external partners in support of the Concern Hub functions associated with protecting adults and children at risk of harm.

The R&CH can share information under AS & P but, due to data sensitivity and management, any information has to be formally requested using their Information Sharing Request form and forwarded to the Hub.

Due to the official nature around data sharing, associated with this process, a copy of the form has not been included in this document.

The Risk and concern Hub also holds the remit for arranging Police representation at any relevant ASP meetings but only at the organisation stage. All invites and relevant documentation would go through the R&CH, and they would send it out to their local Community Policing Team, who would attend the meetings, present any relevant reports. The R&CH would collate and feedback the minutes etc.

**Renfrewshire Community Safety Partnership Hub:**

Renfrewshire Community Safety Hub is a community safety partnership resource in Mill Street, Paisley where relevant partners work and are tasked and deployed jointly to deliver effective and efficient services that protect vulnerable people and communities across Renfrewshire. The Hub includes Wardens, Mediation, Investigation and enforcement services, Public Space CCTV and civil contingencies. It co-ordinates the relevant activities of partners covered by this ISP to ensure that communities, businesses, residents, and individuals throughout Renfrewshire can go about their lives freely, safely and with confidence.

Renfrewshire Daily Tasking Process operates from the Community Safety Partnership Hub and reviews Police, Fire and other significant incidents or events over the previous 24-hour period. Information may be pro-actively disclosed to partners who attend the daily meetings where reasonable, appropriate, proportionate, and lawful to do so for effective and early intervention to tackle issues including antisocial behaviour, vulnerable adult, and child protection concerns, to safeguard and protect vulnerable individuals and communities.

Incidents are disposed to the most relevant partner for them to apply early intervention.

Renfrewshire Community Safety Partnership:[rcsp@renfrewshire.gov.uk](mailto:rcsp@renfrewshire.gov.uk)

**NHS / Health:**

Health staff working within Renfrewshire include practitioners employed by NHS Greater Glasgow and Clyde in primary care, and community learning disability, mental health and alcohol and drug recovery services as well as GPs and other specialist health services such as the Scottish Ambulance Service.

Health staff have a major role in preventing (as well as reporting) harm to adults at risk through an awareness of stress factors for those in caring roles, identifying the need for services and assisting the patient and family around self-protection.

Health staff may also have a role when a medical examination [(section 9)](https://www.legislation.gov.uk/asp/2007/10/section/9) is required as part of the inquiry, using investigatory powers, of an allegation of harm, where there is not a requirement for this to carried out by the Police.

Such an examination can only be carried out by a:

* GP
* nurse
* or midwife.

In most cases a health practitioner will encounter or suspect harm to an adult at risk by a relative or other person known to the adult either on NHS premises or within the community. All allegations of harm by non-employees should be immediately reported to Social Work and, if a criminal offence may have been committed, the Police.

There may however be instances where the alleged harmer is a health worker. Where the person alleged to have caused harm is a health worker, NHS Greater Glasgow and Clyde will take action independently, in line with its own internal procedures, to investigate allegations, where necessary take appropriate disciplinary action and take immediate steps to safeguard patients. Where the alleged harm might constitute a criminal offence, the Police will be notified by the relevant manager. In all cases, instances of alleged harm to an adult at risk by a worker should also be reported to Social Work to assess the ongoing risk to the adult and the need for any other protective action.

The Scottish Government has issued separate guidance to GPs- see below.

**General Practice:**

The Scottish Government published revised ASP [Guidance for General Practice](https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2022/07/adult-support-protection-scotland-act-2007-guidance-general-practice2/documents/adult-support-protection-scotland-act-2007-guidance-general-practice/adult-support-protection-scotland-act-2007-guidance-general-practice/govscot%3Adocument/adult-support-protection-scotland-act-2007-guidance-general-practice.pdf) in tandem with the revised Code of Practice, July 2022.This is intended to assist the involvement of General Practitioners and their staff (“General Practices”) in activities which arise from the Act and aid them to support their patients in achieving the best outcome.

It provides advice on how to make referrals and notes that:

* General Practices are well placed to identify adults at risk of harm and are a vital component in the multi-agency arrangements to support and protect where it is necessary.
* Adult Support and Protection applies to those with and without mental capacity.
* As with other referrers, evidence is not required that all elements of the three-point criteria are met in order to make a referral. Their information may form part of a larger picture. In this regard, it is ultimately the responsibility of the council or delegated agency to decide whether an adult meets the definition of an adult at risk of harm.
* General practices will be expected to co-operate with inquiries including with the [examination of records subject to Section 10 of the 2007 Act](https://www.legislation.gov.uk/asp/2007/10/section/10). This co-operation is based upon the Council’s knowledge or belief that that the person is at risk of harm. The purpose of providing the information is to assist the Council in determining whether or not the person is at risk, or later in the process to understand how to support and protect them from those risks.

[**Healthcare Improvement Scotland (HIS:**)](https://www.healthcareimprovementscotland.org/)

Healthcare Improvement Scotland currently has a similar scrutiny and improvement role to the Care Inspectorate for independent hospitals, voluntary hospices, and private psychiatric hospitals.

**Housing:**

* Housing Professionals, such as Housing Officers and Property Maintenance Teams, are in a key position to be able to identify indicators that an adult is/ believed to be at risk of harm; and make a referral to the council.
* Each housing situation will vary depending on the type of tenure. Tenants who are in social rented accommodation will generally have an allocated housing officer in the associated Local Authority or Housing Association.
* Additionally, as part of a ‘section 4 inquiry’ housing may be asked to contribute knowledge concerning the individual in question.
* For Specific concerns relating to Hoarding Behaviour, please refer to Renfrewshire’s Hoarding Behaviour Guide- link to document in chapter 1 under Particular Circumstances section.

**The** **Scottish Fire and Rescue Service:**

* The Scottish Fire and Rescue Service (“SFRS”) have a key role to play in keeping people safe from harm particularly in relation to fire safety. They are an important source of referrals regarding adults as a result of their fire safety advice activity and can identify some people who may be at risk of harm for other reasons.
* The SFRS has in place an ‘Adults at Risk of Harm’ procedure which provides staff with an awareness of adult protection issues and clear guidance on how to take the appropriate action.
* The SFRS, in its Fire Safety Enforcement capacity, will also conduct regular fire safety audits within registered care establishments and will refer any adult protection issues to Renfrewshire Health and Social Care Partnership.
* The SFRS can also conduct home visits, in conjunction with its partner agencies, when concerns exist around fire risk, pending other actions taken by other Lead Agencies.
* While a person’s consent to involve SFRS should always be sought, it may be necessary to override the person’s wishes if they, or others, are risk of serious injury or death if a fire occurs.

*To discuss a case or for partner agencies to make a referral; and for Home Fire Safety Advice Prevention & Protection, contact the ERRI Community Action Team - East Renfrewshire, Renfrewshire, and Inverclyde (ERRI).*

*ERRI Safety Centre, Canal Street, Paisley, PA1 2HQ*

*Tel: 0141 889 0022*

*Email:* [*w.erri.communityactionteam@firescotland.gov.uk*](mailto:w.erri.communityactionteam@firescotland.gov.uk)

**Scottish SPCA**

Evidence of animal hoarding/ harm should at any level be reported to the SSPCA as well as other relevant agencies.

**Scottish Ambulance Service (SAS):**

The Scottish Ambulance Service is designated a special health board for the whole of Scotland and is therefore included in the Section 5 duties as outlined above; it operates as an emergency service, and has contact with a wide range of people, many of whom may be adults at risk. The SAS, therefore, can be a source of information; potential referrer and, as with Scottish Fire and Rescue Service, can act as an early warning system for some people at risk of harm. There is scope for greater understanding of the role SAS can play and for greater engagement between the SAS and Adult Support and Protection at both local and national levels.

**Office of Public Guardian (OPG) (Scotland):**

In cases where there may be a misuse of proxy powers (Power of Attorney or Financial Guardianship), in addition to any immediate matters that they may be addressing, practitioners should be alert to the need to refer matters with a financial element to the Office of the Public Guardian (Scotland) - [(information and resources)](https://www.publicguardian-scotland.gov.uk/investigations/investigations-forms-and-publications) (“OPG”) for investigation. The OPG should be notified even if harm by the proxy was unintentional, and the risk was mitigated through actions taken by the proxy and/or via adult protection processes or intervention. This expectation applies to cases of financial guardianship and intervention, due to the OPG’s supervisory role over financial guardians and interveners.

If the person alleged to be causing harm has financial decision-making powers for more than one person, consideration should be given to possible financial harm risks to others. This could be in the person alleged to be causing harm role as attorney, guardian, intervener, Department of Work and Pensions appointee, or withdrawer as per the Access to Funds scheme within the [Adults with Incapacity (Scotland) Act 2000.](https://www.legislation.gov.uk/asp/2000/4/contents)

**OPG** [Investigation referral form-](https://www.publicguardian-scotland.gov.uk/docs/librariesprovider3/investigations/pdf-files/new-referral-form-june-2023pdf.pdf?sfvrsn=ed90bb46_2)

***Note:*** When Police Scotland, OPG or Care Inspectorate are involved:

Simultaneous inquiry activity (covered more in Chapter 3) - with or without use of investigatory powers- should never be used as a reason for failing to make an Adult Support & Protection referral, whenever an adult is known or believed to be an adult at risk.

All public bodies and officeholders named in the Act must make Adult Support & Protection referrals and co-operate with subsequent Adult Support & Protection inquiries, irrespective of their own specific functions under other legislation.

**Independent** **Advocacy services:**

Section 6 of the Act places a duty on the council, if it considers that it needs to intervene to protect an adult at risk of harm, after making inquiries under Section 4 of the Act, to have “regard to the importance of the provision of appropriate services (including, in particular, independent advocacy services) to the adult concerned”. Independent advocacy aims to ensure that a person’s voice is listened to, and their views taken into account; to support access to information; and to assist people to navigate systems.

The adult should be asked if they know about and would like advocacy support.

[You First Advocacy](http://youfirstadvocacy.org/about/) is an independent advocacy service to adults within Renfrewshire who are receiving health and social care services. Other advocacy services can be considered ads required/appropriate to specific cases.

*Input from independent advocacy services should always be considered when an intervention under the Act is being planned- e.g., use of Investigatory Powers; Case Conference; Protection Order being sought.*

**Independent and** **third-sector providers and other organisations:**

There will be a range of service providers and service user and carer organisations in the independent and third sectors, who will have a direct service provision role in relation to adults who may be at risk of harm.

Adults, who may be at risk of financial harm, may have dealings with a range of agencies including financial institutions such as banks, building societies, credit unions, post offices, Royal Mail and the Department of Work and Pensions. While independent organisations such as these do not have specific legal duties or powers under the Act.

The Council Officer, however, may require any person holding health, financial or other records relating to an individual, whom the officer knows or believes to be an adult at risk, to give the records, or copies of them, to the officer ([section 10 examination of records).](https://www.legislation.gov.uk/asp/2007/10/section/10)

Care Providers

* Have a responsibility to involve themselves with the Act, where appropriate, by making referrals, assisting inquiries and through the provision of services to assist people at risk of harm. These organisations should discuss and share with relevant statutory agencies information they may have about adults who may be at risk of harm.
* Renfrewshire Council’s Contracts and Commissioning team keep under review their contract agreements with the independent and third sector providers, to ensure that their services are consistent with the principles of the AS & P Act.
* Registered Care Services must separately notify the Care Inspectorate and the council’s contracts department using an e-notification referral system or by telephone when an allegation or evidence of harm is received which may involve one or more service users.

**Large Scale Investigations (LSI)**

An LSI may be required where there is reason to believe that adults who are service users of a care home, supported accommodation, an NHS hospital or other facility, or who receive services in their own home, may be at risk of harm due to another service user, a member of staff, some failing or deficit in the management regime, or in the environment of the establishment or service. See Procedures attached 2020.



Also, the Institute of Research & Innovation in Social Services (Iriss) developed an online resource to support better understanding of and practice in Large Scale Investigations

An LSI may also be indicated by the need to address structures or systems that lead to possible harm for all those under such structures. In such circumstances, this means that there is a belief that a particular service may be placing some or all of its residents or service users at risk of harm.

An LSI could be considered if one or more of the following applies:

* An adult protection referral is received that involves 2 or more adults living within or cared for by the same service.
* A referral is received regarding one adult, but the nature of the referral raises queries regarding the standard of care provided by a service.
* Where more than one perpetrator is suspected.
* Institutional harm is suspected.
* A whistle-blower has made serious allegations regarding a service.
* There are significant concerns regarding the quality of care provided and a service’s ability to improve. These concerns could come from a regulatory body such as the Care Inspectorate.
* An adult or adults are living independently within the community but are subject to harm from a perpetrator or group of perpetrators, or it is strongly suspected that more than one adult is subject to such harm.
* Concerns regarding an adult are raised following their admission to hospital or discharge. This may include concerns about a care service that are evidenced by an admission to hospital or concerns regarding an NHS service area.
* Concerns are raised via a complaint to the Care Inspectorate, NHS Board, or the local Council or Health and Social Care Partnership.
* Concerns are raised by General Practices, District Nurses, Dentists, Allied Health Professionals etc. who attend a service.

**Care Inspectorate:**

The Care Inspectorate has a duty to investigate complaints made in respect of the standards of care within registered establishments and one of its overriding objectives is to improve the protection afforded to adults at risk. It also has powers to enforce action legally if this is required. In many cases complaints received by the Care Inspectorate will not involve allegations of harm to specific service users and will relate more to instances of failing to meet care standards, poor practice, or negligence. There may, however, be some cases where harm is alleged and involves the welfare and safety of one or more individuals using the service. In such circumstances, the Inspectorate will report the concern to the Police and/or Social Work as appropriate, in order to establish the need for Adult Protection measures and to formulate a protection plan.

**The Mental Welfare Commission:**

The Mental Welfare Commission has specific powers under the Mental Health (Care & Treatment) (Scotland) Act 2003 in relation to the protection of patients and other people with a mental disorder who are subject to an order or direction under the Act. Where it believes that such a person may have been subject or exposed to ill-treatment, neglect, or lack of care the Commission may carry out an investigation and make recommendations for action.

The Commission’s power to investigate sits alongside the ‘duty to inquire’ placed on the local authority in similar cases where someone with a mental disorder is thought to be at risk. The Commission is also expected to exercise a protective function in respect of adults subject to Guardianship or Intervention orders under the Adults with Incapacity (Scotland) Act 2000 and to consult with both the Office of the Public Guardian and the local authority where appropriate in the exercise of such functions. The Commission also has a power to investigate where it feels that the local authority has not dealt appropriately with a complaint.

**Department of Work & Pensions (DWP) Escalation Process:**

The Department of Work and Pensions or Social Security Scotland can give a person financial decision-making power through the role of Appointee.

If the person alleged to be causing harm has financial decision-making powers, for the adult concerned or for more than one person, consideration should be given to discussing the possible financial harm with the relevant agency.

The DWP’s Advanced Customer Support Service should be used for DWP customers at immediate risk of harm, you should email- [acssl.escalationscotland@dwp.gov.uk](mailto:acssl.escalationscotland@dwp.gov.uk)

include the following information:

* The customer’s details.
* An overview of the situation and details of the risk to the customer.
* What steps have already been taken to resolve the problem.
* What action is required.

Although the S.5 Duty to Cooperate does not apply to the DWP, you should cite in the email that you are authorised as a Council Officer and are using your power at S.10 to request access to the adult’s records.

Normally the ACS Senior Leader for the DWP’s Scotland West area will provide support to resolve the issue.

Where the generic email process, to escalate an ongoing issue for an adult at risk of harm, has failed, contact the Advanced Customer Support Senior Leader for Renfrewshire.

**Social Security Scotland**

‘There is currently no referral process or role similar to that of the ACSSL in Social Security Scotland, so all queries should come through the main telephone number.

0800 182 2222 or alternative contact via link to [Webchat, phone or post - mygov.scot](https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.mygov.scot%2Fcontact-social-security-scotland&data=05%7C01%7Cfrances.toland%40renfrewshire.gov.uk%7Cd9b4fce98fc7400d926908dbc03fb98f%7Cca2953361aa64486b2b2cf7669625305%7C0%7C0%7C638315152155824177%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=KCLapN3W2iJ8T6SIqeEgnb8FKnydHCKrNzFgdv%2Fhx%2FI%3D&reserved=0)

Ask to speak with a member of the ‘Safeguarding Team.’

# **Chapter 3: Key ASP Processes and multi-agency involvement.**

**What do I do if I have concerns about possible harm to an adult at risk?**

As noted in Chapter 2, staff from all the partner agencies operating under these procedures have a responsibility to:

* be aware of harmful, oppressive, and poor care practice.
* report any concerns, suspicions, or evidence of harm they may observe or be advised of.
* co-operate with any investigation of harm to an adult at risk.

Chapter 1 of this guides should be consulted to assist in making a judgement as to whether the circumstances constitute harm or the potential for harm, and whether there is a need for action to be taken to support and protect the adult from the risk.

* Staff may witness harmful behaviour or a situation where there is a risk of harm occurring.
* In other cases, concerns may have concerns passed on to staff by a colleague, relative or friend of the adult, or a member of the public.
* The adult may disclose to a member of staff that he or she has been harmed or fears being harmed.

All Adult Support & Protection inquiries begin with a referral (Form AP1- see Appendix 1- or Police Referral form).

In Renfrewshire, if the referral form does not come via Adult Services Referral Team (ASeRT), it is a requirement that ASeRT are contacted immediately by the responsible manager to record the referral and allocate the case as per the operational guidance document (Renfrewshire ASP Operational Guidance and Procedures 2024)

Contact details for ASeRT:

Adult Services Referral Team

Tel: 0300 300 1380

Email: adultservicesreferral.sw@renfrewshire.gov.uk

**Are there any Children involved?**

All agencies have a responsibility to consider the needs of any child who may reside or have contact with an adult(s) involved in any form of harm. Agencies with concerns that relate to a child should also make a referral to Child Protection.

• Social Work General - 0300 300 1199

• Evenings and weekends - 0300 343 1505

**What if I need to take immediate action to protect the adult?**

In cases where the adult is thought to be in immediate danger, the staff member should call the relevant emergency service e.g. Ambulance, Police. The following is a brief checklist to guide staff where there is an opportunity to engage with the adult:

**DO**

* listen to the adult.
* offer reassurance and support whilst being clear to the adult that you may not be able to preserve the confidentiality of what you are told if they are at risk.
* ask simple non-leading questions to obtain the facts.
* make careful notes (including date and time).
* take precautions to preserve any forensic evidence, as the role of the Police in investigating crime should not be compromised.
* in the event of the person being injured make a note of the injuries.
* inform your line manager (or other Social Work manager) as soon as possible.

**DO NOT**

* dismiss the adult’s concerns or be judgmental.
* interview or investigate beyond what is essential to ascertain the basic facts.
* make promises that cannot be kept e.g. around keeping a confidence or that ‘nothing will happen.’
* share the information with colleagues where the allegation involves another member of staff.

**When should the Police be involved?**

* Police Scotland should be contacted whenever it is believed that a criminal offence may have taken place. If in doubt, Police Scotland should be consulted in order to clarify the position with them.
* Where inquiries subject to section 4 of the 2007 have indicated that a criminal offence may have been committed against the adult, this should be reported to the police at the earliest opportunity.
* Where there is evidence of a criminal offence having been committed, and unless otherwise directed by the Crown Office Procurator Fiscal Service, the Police will lead the investigation into the crimes, at this stage.
* Social Work will retain overall responsibility as lead under AS & P inquiry activity, even where there is a suspected criminal offence, and a Police investigation is underway. This does not remove the responsibility on the council to take any immediate action to protect the adult at risk. In such cases, however, any proposed action should be taken in consultation with the Police, as the Police investigation might take precedence over any other inquiry activity.

**How might my agency be involved in ASP Activity?**

As discussed in Chapter 2, the Council- Social Work- should consult and work in partnership with other agencies to conduct inquiries, to establish whether there is a need for further investigatory activity and/or intervention subject to the 2007 Act.

Other professionals, such as the Police, Care Inspectorate, third or independent sector care providers or Health professionals may be asked to assist.

The timescale for the inquiry to be completed will depend on the level of inquiry activity, as an Inquiry without use of investigatory Powers (desktop process which can include the collation and consideration of relevant material, including consideration of previous records relating to the individual, and seeking the views of other agencies and professionals) should be within 5 working days of receipt of referral.

Whilst the Inquiry without use of Investigatory powers does not necessarily need a Council Officer (CO) to carry out the process, it does require CO to have ‘oversight’ of the process.

CO oversight: Once they have completed the tasks required as part of the desktop inquiry, their findings should be reviewed by a Council Officer and/or a manager\*.

\*Best practice would indicate this manager would be a Council Officer or have undertaken Council Officer training as per localised training requirements (taken from further guidance issued by National Implementation Group 4 on Inquiries, use of Investigatory Powers and Role of CO).

If desktop inquiries do not provide sufficient information to determine whether or not the adult is at risk, the Inquiries can progress to use of Investigatory Powers (see chapter 2). This should be conducted by a CO and the CO has up to an additional 15 Days to complete the investigation.

Note: Input from independent advocacy services should always be considered as part of the investigative process (see chapter 2 Advocacy)

If it is established that a formal investigation subject to the Act is required, this should be carefully planned.

A formal Multi-agency Planning Meeting (multi-agency as appropriate) may be helpful in the following circumstances and is considered to be best practice: (Planning meetings should have a formal minute produced by Business Support).

* where the risks to the adult (or others) appear to outweigh the adult’s wishes and there is a need to override a refusal of consent.
* where the situation is assessed as being complex by the Operational Manager. Examples of indicators being multiple risk factors, multiple agencies and individuals involved, capacity.
* where there is a risk of significant harm to the adult or others.
* where difficulties are anticipated in accessing the adult or harmer or in setting up interviews.
* where there is a criminal investigation and/or a need to preserve evidence.
* where it is believed that more than one person is causing harm, or the harmful behaviour may involve more than one adult at risk.

**The Planning Meeting:**

* should take place within 3 working days of the referral and be treated by all agencies with the greatest priority.
* will not involve either the adult or his/her family or the alleged harmer to allow professionals to plan the investigation in an open manner with maximum information made available to those attending. However, the views of the adult (if known) as well as issues regarding consent and capacity should be central to the discussion and referral to advocacy services should be considered. The adult concerned may or may not be advised of the Planning Meeting depending on whether to do so would be detrimental to the investigation.
* will clarify and agree roles and responsibilities of those involved in the investigation and set a clear timescale for completion. A Planning Meeting forms part of a formal investigation, and a minute of the meeting will be circulated to those attending and any other key professionals.

Note:

1. Where there is evidence of a criminal offence having been committed unless otherwise directed by the Crown Office Procurator Fiscal Service, the Police will lead the investigation at this stage.
2. Where harm to an adult at risk has occurred in a registered establishment or hospital setting any action should be co-ordinated with the Care Inspectorate or NHS.
3. Where a formal planning meeting is not required the Team Manager, Council Officer and any second worker should meet to agree the necessary actions of the investigation. Some key areas to consider as part of the investigation are:

* the immediate safety of the adult at risk
* agreeing the Council Officer who will lead investigation and the second worker.
* discussing and agreeing the roles and tasks of the Council Officer and second worker. This will include discussing what interviews, visits and further information is required and who should complete.
* the rights of the adult
* referral to advocacy
* considering the role of other statutory agencies and the private/voluntary sector
* considering the need to gain access to records, e.g., health or financial records, as part of the investigation (see Appendix 3)

Considerations around Capacity when using Investigatory Powers, intervening, and using Protection Powers under the Act:

**Capacity**

While capacity or lack of capacity does not determine an assessment of the three-point criteria, capacity is relevant in relation to the ability to consent to, for example being interviewed, or the use of other Investigatory Powers, such as medical examination; and/or interventions, such as protection orders, under the Act.

If the adult lacks capacity to consent, or lacks capacity to refuse to consent to, the council should contact the Office of the Public Guardian to ascertain whether the person has granted a Welfare Power of Attorney or if there is a Welfare Guardian, with the relevant powers to consent (or refuse to consent) on their behalf. Where no Guardian or Attorney has such powers, consideration may be given to whether it is appropriate to use provisions in the Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Care and Treatment) (Scotland) Act 2003.

In relation to Protection Orders, the Sheriff has discretion to appoint a safe guarder to safeguard the interests of the ‘adult at risk’ before deciding the application, as per Section 41(6) of the 2007 Act.

A person’s capacity can be transient, vary over time and vary in respect of different types of decision making. As capacity can change over time, it should be assessed at the time that consent is required. Capacity applies to both decision making and the implementation of decisions. All adults who have capacity have the right to make their own choices about their lives and these choices should be respected if they are made freely.

For many people, the effects of trauma and/or adverse childhood experiences may impact upon both their ability to make and action decisions, and the type of choices they appear to make. In this context it is reasonable to envisage situations in which these experiences, and the cumulative impact of them through life, may very well have rendered some people effectively ‘unable,’ through reliable decision making or action, to safeguard themselves (as noted in chapter 1)

Similar considerations apply to ‘**coercive control’ or ‘undue pressure.’** In such situations the control exercised over a person may also effectively render them unable to take or action decisions that would protect them from harm. If the adult is thought to have been influenced to refuse consent, consideration should be given to whether the above factor applies.

A person may also have the capacity to make a particular decision but through illness or infirmity may not have the physical or emotional capacity to retain a memory of a decision and/ or to implement that decision.

While someone who lacks capacity may be unable to safeguard their own well-being, property, rights and other interests, it should never be assumed that an adult who has capacity is able to do so, nor should any decision made, regarding whether an adult is an adult at risk, ever be delayed for an assessment of capacity to be undertaken.

Capacity assessments may, however, be of benefit as means of identifying other legislative options available to support the individual (noted in chapter 1).

Note: Input from independent advocacy services should always be considered when there are concerns that an adult may lack capacity to consent.

**Investigative powers subject to the 2007 Act**.

Investigative Power under the Act relate to Sections 7 to 10 of the Act.

* a visit.
* an interview with the adult.
* a medical examination of the adult.
* the examination of records.

Use of Investigative Powers under the Act *may only be undertaken by a Council Officer* or by another person accompanying them.

**These powers can be used as a combination as part of Inquires; and are used:**

* to determine what action is required to protect the adult from harm.
* to gather further information not already captured in order to determine whether the adult is at risk; or
* to gather further information not already gathered to determine whether further action is required to protect the adult from harm.

**Investigative activity should be carefully planned and managed to ensure that:**

* all available information is gathered and considered.
* the adult is fully supported to contribute;
* . any medical evidence and medical intervention is provided; and
* the police are notified if it is thought a crime may have been committed.
* a determination can be made as to whether the adult meets the three-point criteria as an adult at risk; and
* appropriate arrangements can be made for support for, and protection of, the adult, by performing functions under the Act or otherwise.

**What is the purpose of a visit?**

It is likely that a visit to the adult and the interview with them will be central to adult support and protection processes, including information gathering, determination of the three-point criteria, risk assessment, and determination of actions to be taken.

**A Council Officer must:**

• state the object of the visit; and

• produce evidence of the officer’s authorisation to visit the place.

It is essential that anyone supporting the Council Officer on a visit provide evidence of their professional identification, to ensure that the adult is fully aware of the identity of each individual attending for AS & P purposes.

There is an obligation to be clear that the purpose of the visit is to investigate a suspected risk of harm. Wherever possible, other people in the household should also be offered an explanation as to what is happening and why, without breaching the adult’s right to confidentiality.

Section 7 of the Act allows a council officer to enter any place and adjacent place to make the necessary investigations to:

• enable or assist the council in conducting inquiries under Section 4 to decide whether the adult is an adult at risk of harm.

• establish whether the council needs to take any action in order to protect the adult at risk from harm.

**Who may undertake the visit?**

Only a Council Officer, as defined in Section 53 of the 2007 Act, and who meets the requirements of the Order described previously, can undertake a visit. The Council Officer may be accompanied by another person.

A joint visit with another person could assist the investigatory activity in a number of ways, for example by:

* allowing the Council Officer to jointly make inquiries into concerns with, for example, a key worker, a Police Officer, Health Professional or representative from the Care Inspectorate or Office of the Public Guardian.
* assisting an assessment of the risk to the adult, such as with a General Practitioner, Community Nurse, key worker, or other person already known to the adult and any other members of the household.
* assisting in record taking of the interview, and potentially being available as a second witness in the event of court proceedings; and
* assisting communication with the adult (or any other member of the household) by being accompanied by an interpreter in British Sign Language, lip speakers, a Makaton communicator, a deaf-blind communications interpreter, or a language interpreter where English is not the visited person’s first language.

**What places may be visited?**

Section 7 of the 2007 Act permits a council officer to enter any place. In the majority of cases this will mean visiting the place where the adult normally resides, for example:

* the adult’s rented or owner-occupied accommodation.
* the home of relatives, friends, or others with whom the person resides.
* supported or sheltered accommodation staffed by paid carers.
* temporary or homeless accommodation; or
* a care home or other care setting.

A place could also include entering premises where the person is residing temporarily or spends part of their time, for example: a day centre.

* a place of education, employment, or other activity.
* respite residential accommodation; or
* a hospital or other medical facility.

The Council Officer is allowed access to, and can examine, all parts of the place visited which might have a bearing on the inquiries into the welfare, care, and safety of the adult at risk. This right also includes access to any adjacent places, such as sheds, garages, and outbuildings.

**What if entry is refused?**

There may be times when the Council Officer (CO) is refused entry to the premises. Where this happens, the CO should initially consider how entry may be achieved, without resorting to seeking a warrant from a sheriff authorising entry as a first course of action.

As stated in Section 36 (4) of the 2007 Act, a Council Officer may not use force during, or in order to facilitate, a visit. Provided delay would not increase the risk to the adult, it would be good practice to have a multi-disciplinary discussion and plan to coordinate action by those involved before deciding whether to apply for a warrant for entry, authorising a Police Constable to use force.

Wherever possible, entry to premises should first be attempted without force. Particular regard should be given to minimising distress and risk to the adult.

**Interviews**

Adult's rights during an interview Section 8(2) provides that the adult is not required to answer any questions, and that the adult must be informed of that fact before the interview commences. The adult can choose to answer any question put to them, but the purpose of this section is to ensure that they are not forced to answer any question that they choose not to answer. However, seeking the consent of the adult to be interviewed should not be a matter of simply advising that they are not obliged to answer.

Good practice would be to ensure that the adult is clear regarding the purpose of the interview and is given reasonable opportunity and support to answer questions whilst respecting their right not to.

In any interview, as discussed above under the section relating to capacity, gaining the consent of the adult to be interviewed should be the norm. The Council Officer (CO) should consider the adult’s capacity and promote the adult’s participation in the interview.

Some or all of the following factors may be considered where there is doubt about the adult’s mental capacity:

* does the adult understand the nature of what is being asked and why?
* is the adult capable of expressing their wishes/choices?
* does the adult have an awareness of the risks/benefits involved?
* can the adult be made aware of their right to refuse to answer questions as well as the possible consequences of doing so?

**What is an interview?**

Section 8 permits a Council Officer (CO), and anyone accompanying the CO officer, to interview an adult in private within the place being visited, as part of undertaking AS & P inquiries With use of investigatory powers.

This power applies regardless of whether a sheriff has granted an assessment order authorising the Council Officer to take the person to another place to allow an interview to be conducted.

The purpose of an interview is to enable or assist the council to gather information directly from an individual to assist the council in determining if the individual is at risk or harm, and/or what action may be required. The interview may include:

* establishing if the adult has been subject to harm.
* determining whether the adult is at risk of harm.
* establishing if the adult feels their safety is at risk and from whom.
* discussing what action, if any, the adult wishes or is able to take to protect themselves; and
* discussing what action, if any, others can take to protect the adult

The Council Officer, and the person accompanying them, conducting interviews will need to ensure appropriate recording of the content of the interview and any decisions made by the adult, including those about who attends e.g. a family member.

**Presence of others at interviews**

It is good practice to ask the adult if they would wish another person to be present during an interview to support them. Whether or not the adult should be interviewed in private will be decided on the basis of whether this would assist in achieving the objectives of the investigatory activity. The Council Officer or persons accompanying them may decide to request a private interview with the adult where: -

* a person present is thought to have caused harm or poses a risk of harm to the adult.
* the adult indicates that they do not wish the person to be present.
* it is believed that the adult will communicate more freely if interviewed alone, or
* there is a concern of undue influence from others.

**Interviews with others.**

Section 8 allows a Council Officer to interview any adult found in a place being visited under Section 7. For example, another person who shares their home with the adult or a paid carer in a regulated care setting- if not implicated in the harm.

Section 8(2) provides that persons interviewed on this basis have the same rights as the adult at risk. They are not required to answer any questions and must be informed of that fact before the interview commences.

As with the adult at risk, the consent of the person to be interviewed should not be a matter of simply advising that they are not obliged to answer- as discussed above.

**Virtual Interviews or meetings.**

Circumstances may arise where an interview would not be undertaken as a physical visit to meet with the adult. The experience of the coronavirus pandemic in 2020 and 2021 showed that there were options for the use of telephone and new technology to allow for virtual meetings with both individuals and wider groups. Such options should only be used if there are strong reasons to do so (largely related to safety and infection control concerns arising out of a physical visit), and these reasons should be recorded.

It is reasonable to assume that a virtual encounter with an adult thought to be at risk of harm, for the purposes of inquiries into their circumstances, should be regarded as an interview in exactly the same way as if it had been a physical encounter. This means that in such cases all the requirements of a physical visit should still be met, including the council officer providing evidence of their authorisation.

The Council Officer’s power to interview an adult found in a place being visited, is a power to interview them in private. Where such virtual meetings and interviews do take place, council officers should be alert to whether there may be other people in the room of the person being interviewed who may therefore be in a position to influence by word or gesture the responses from the adult.

**Communication Difficulties.**

If communication is a problem or barrier e.g. due to English being a second language, sensory impairment and/or the need for special aids, the appropriate communication equipment and/ interpretation service should be identified and offered.

Whenever possible, the adults should be asked which format for communication they prefer. All aids and adaptations which can support and enable communication, as well as 'human aids to communication' such as British Sign Language interpreters, lip speakers, Makaton, and deaf-blind communicators should be considered. Where possible, materials should also be available in alternative formats such as easy read, large print, audio tape, Braille and computer disc, and use made of “read aloud” or equivalent software.

This should be considered at the planning stage of initial referral as it allows any obstacles to be identified at an early stage and action to be taken to allow progress. The adult should be provided with any assistance or material appropriate to their needs to enable them to make their views and wishes known. Reasonable adjustments should be made to support the adult's needs wherever identified. Consideration should also be given to the surrounding environment. This can affect communication due to, for example, noise levels, provision of loop systems or lighting.

**Medical Examination**

A Medical Examination includes any physical, psychological, or psychiatric assessment or examination. The examination can take place either at a place being visited under Section 7 of the Act, or at the premises where the adult has been taken under an Assessment Order granted under Section 11 (further information on Protection Orders below).

**Who may conduct a medical examination and what is its purpose?**

A medical examination may only be carried out by a health professional as defined under Section 52(2) as:

* a doctor,
* nurse,
* midwife

(NB It is normally the case that doctors would carry out a “medical examination,” nurses and midwives would carry out an assessment of current health status).

A medical examination may be required as part of investigation activity for a number of reasons including:

* the adult’s need of immediate medical treatment for a physical illness or mental disorder.
* to provide evidence of harm to inform a criminal prosecution under police direction or an application for an order to safeguard the adult.
* to assess the adult’s physical health needs; or
* to assess the adult’s mental capacity. Examples of circumstances where a medical examination should be considered include:
* the adult has a physical injury which he or she states was inflicted by another person.
* the adult has injuries where the explanation (from the adult or other person) is inconsistent with the injuries and an examination may provide a medical opinion as to whether or not harm has been inflicted, or whether there are concerns around self-harm.
* there is an allegation or disclosure of sexual abuse, and the type of assault may have left physical evidence (following local procedures for liaison with the police).
* the adult appears to have been subject to neglect or self-neglect and is ill or injured and no treatment has previously been sought.

**Considering the adult’s wishes with regard to a medical examination:**

Section 9(2) of the Act states that the person to be examined 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.

Where it is not possible to obtain the informed consent of the adult because they lack the mental capacity or have difficulty communicating in order to provide consent, the council should check local records to ascertain whether the person has completed a welfare power of attorney with the relevant powers. Where no guardian or attorney has such powers, consideration may be given to whether it is appropriate to use the provisions in the Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Care and Treatment) (Scotland) Act 2003.

**Examination of records**

The purpose of accessing records is to enable or assist the council to decide whether it needs to do anything in order to protect an adult at risk of harm.

Under Section 10 of the Act a council officer may require any person holding health, financial or other records relating to an individual whom the officer knows or believes to be an adult at risk, to give the records, or copies of them to the officer. This includes records held in audio, visual or other formats.

Section 10 refers to existing records held by a professional or organisation rather than information created specifically to meet a request.

The type of records to be inspected will depend on the type of harm suspected and will need to be judged on an individual basis. Any information requested must be relevant. Records should be accessed, and information shared only where disclosure will provide benefit to the adult which could not reasonably be provided without such an intervention.

The ASP Codes of Practice makes clear that it is permissible for agencies to share information when the request arises from a Section 4 inquiry.

**Does an adult have to consent to access to records?**

If possible, the individual’s consent should be attained prior to sharing information but, for the avoidance of doubt, where disclosing information to the appropriate authorities seeks to address a perceived risk of harm to that individual, it is in the public interest to do so. This legal duty applies to all employees and officers of the relevant public bodies and overrides any general duty of confidentiality.

**Who may access and inspect records?**

Section 10 (4) allows for records given to the Council Officer to be inspected by the officer and any other person whom the officer considers appropriate in relation to the content of the records.

Section 10 (7) defines health records as records relating to an individual’s physical or mental health which have been made by or on behalf of a health professional in connection with the care of the individual.

The Council Officer, or any other person whom the officer considers appropriate, may inspect health records only for the purpose of determining whether they are health records. In the case of health records, the council officer is empowered by the Act to identify, take, or take copies of, medical records held by a service but having obtained them, must ensure they are interpreted by a health professional.

**How may records be accessed?**

A requirement to provide records may be made by the Council Officer during the time of a visit to the person holding the records or at any other time.

The Council Officer should be able to demonstrate to the record holder that they require records to be given under section 10.

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.

Usually only the relevant parts of a record will be copied to be given to the Council Officer.

It is essential that copies of records are treated with the same degree of confidentiality as the original records.

Good practice would be to discourage the use of original records except in circumstances where verifying the wording as it appears on the original source document (and is therefore verifiably unaltered) is pertinent to the investigatory process (for example if neglect has been alleged in a registered care setting).

It would be good practice for agreement to be reached with the record holder, when records are obtained, on how their records are to be treated. For example, whether copies of records should be kept for the minimum length of time necessary and then returned to the original record keeper or whether they should be destroyed.

**Must the record keeper comply with a request for access?**

**Obstruction**

Section 49 provides that it is an offence to prevent or obstruct any person from doing anything they are authorised or entitled to do under the Act, without reasonable excuse. It is also an offence to refuse, without reasonable excuse, to comply with a request to provide information made under Section 10 (examination of records etc.).

However, if the adult at risk prevents or obstructs a person or refuses to comply with a request to provide access to any records, then the adult will not have committed an offence.

A person found guilty of these offences is liable on summary conviction to:

* a fine not exceeding level 3 on the standard scale; and/or
* imprisonment for a term not exceeding 3 months.

**Multi-agency risk assessment and decision-making processes.**

Risk Assessment:

The definition of an adult at risk requires an assessment to be made about the risk of harm to the person at the outset.

Many referrals that are made concerning people who are believed to be at risk of harm will result in a determination that they are not at risk of harm and therefore require no further action under the provisions of the Act. This does not preclude other support or involvement through other relevant legislation, or alternative services to respond to the individual’s needs.

For other adults, the inquiries will determine that they are at ‘risk of harm’ and will need continuing assistance with their support and protection. Such a determination will follow from an assessment process, that should involve all relevant agencies. Some cases will involve few or single agency involvement. Others will require the involvement of a wide range of agencies.

In all cases the assessment process should be based on information supplied by all relevant agencies. This will be coordinated through the Council, with the Council Officer having a key role in the process.

In Renfrewshire, all cases progressing to an AS & P Case Conference require a Risk Assessment (Investigatory Report, previously known as AP2,) to be completed.

A risk assessment could be completed in other situations, where this is felt to be appropriate following discussion with the appropriate Social Work Manager.

The risk assessment will concentrate on the following:

* an assessment of whether the adult is at risk of harm.
* an assessment of the nature and severity of any risks identified, including when and where the adult may be placed at risk and an identification of the factors that will impact on the likelihood of risk.
* provide a clear overview of the risks, and protective factors.
* an analysis of risk and the adult’s ability to ‘safeguard’ themselves are key.
* information pertaining to significant others in the adult’s life.
* the adult’s views.
* consider whether the adult requires an AS & P Protection Plan (that can be single or multi-agency), that identifies actions and supports that will eliminate or reduce the risks identified.
* reviewing whether the adult continues to meet the criteria for an adult at risk of harm, and if not whether there are other supports that will still be required out-with the provisions of the Act.

To ensure robust risk assessment, any reports generated as part of, or at the conclusion of, inquiries, including use of investigative powers, should include all relevant information and a chronology, to be completed by the Council Officer.

**Chronologies**

Chronologies are an essential feature of risk assessment in adult support and protection activity.

It is widely recognised that adults at risk of harm are most effectively protected when professionals work together and share information. Individual events may appear to be insignificant ‘one-offs.’ However, they should be recorded in the chronology as they may be part of a pattern, which would raise serious concern. As a result, contribution to the chronology is a collective responsibility.

A chronology is:

* a summary of events key to the understanding of need and risk, extracted from comprehensive case records and organised in date order
* a summary which reflects both strengths and concerns evidenced over time
* a summary which highlights patterns and incidents critical to understanding of need, risk, and harm
* a tool which should be used to inform understanding of need and risk. In this context, this means risk of harm to an adult.
* A chronology may be:
* single agency
* multi-agency

A multi-agency chronology must comply with information sharing guidance and protocols in the way that it is developed, held, shared, and reviewed; reflecting information sharing guidance in this document. It must be accurate, relevant, and proportionate to purpose.

A multi-agency chronology:

* is a synthesis which draws on single-agency chronologies
* reflects relevant experiences and impact of events for the adult.
* will include turning points, indications of progress and/or relapse
* will inform analysis but is not in itself an assessment.
* may evolve in a flexible way to integrate further necessary detail.
* may highlight further assessment, exploration or support that may be needed.
* is a tool which should be used in supervision

**A chronology, whether single- or multi-agency:**

* is not a comprehensive case record and cannot substitute for such records.
* is not a list of exclusively adverse circumstances.

**Risk Management & Adult Support & Protection Plan**

Risk Management:

It is recognised that mechanisms might exist within organisations, which can contribute to the protection of adults at risk.

These may operate at an organisational level to limit the organisation’s exposure to risk. For them, the term ’risk management’ incorporates all the activities required to identify and control the exposure to risk that may have an impact on the achievement of an organisation’s objectives. Nonetheless, this activity often mitigates the risks identified for the adult at risk of harm.

The principles of ‘risk management’ are to:

* Think logically.
* Identify the key risks.
* Identify what to do about each risk.
* Decide who is responsible for actions.
* Record the risk and changes in risk.
* Monitor and learn.

At times, this level of corporate risk management activity can run in parallel with Adult Support & Protection procedures.

It is also recognised that other formal mechanisms exist within other partner agencies which contribute to the protection of adults at risk. Again, these may operate in parallel with adult protection procedures.

Examples of this would include:

* Care Programme Approach – multidisciplinary meetings convened by a psychiatrist which are used to co-ordinate the care and protection of adults with a mental disorder (including those with a learning disability)
* Measures in relation to registered establishments taken by the Care Inspectorate.
* Investigations by the Office of the Public Guardian into allegations of financial harm.

Where relevant, the Senior Operational Manager will link with other partner agencies to avoid duplication and ensure effective co-ordination, clear lines of responsibility, and encourage a consistent approach.

Adult Support & Protection Plan (ASP Plan)

The AS & P Plan has been designed for use when allegations of harm/exploitation have been made and an Adult Support and Protection Case Conference has agreed that there is a risk of serious harm; or when high levels of risk cannot be managed within a generic care & support plan.

In many cases the provision of care and support may be important in addressing the risk of harm. An AS& P Plan differs from a care & support plan, however, as it will focus on care provision only in relation to the aspects that provide protection against harm, or which offer a therapeutic or recovery-based resolution.

An Adult Support & Protection Plan will clearly outline the risks, but this will also outline the protective factors; invite some analysis that reflects multi-agency views including concerns; and say clearly what action was being taken to mitigate the risks identified.

The AS & P Plan will clearly demonstrate what support and protection measures are being put in place where, when and why and will be person centred.

**Adult Protection Case Conferences, Core Groups and Reviews.**

An Adult Protection Case Conference is a multi-disciplinary, inter-agency meeting which is called by Social Work to share information and make decisions about an adult at risk in cases where harm has occurred or is suspected.

An Adult Protection Case Conference should take place within 20 working days of the decision to proceed to investigation. Investigations, including a risk assessment should be recorded on an AP2 and completed at least 2 working days before the case conference.

If the investigation is protracted the reason for delay should be noted on Eclipse. The operational Service Manager is to be advised accordingly and a new timeframe agreed and recorded on Eclipse for the completion of the Investigatory Report and Case Conference. In some cases, the decision will be not to progress to a case conference but unless agreed and noted on Eclipse by the Operational Investigatory Report will still be completed.

An investigation completed subject to the Act Adult Protection procedures may/may not lead to a case conference. The decision on whether to hold a case conference will be made by the senior manager (Operational Manager/Equivalent) and be informed by the Investigatory Report. Where allegations cannot be substantiated or there is insufficient evidence a case conference should still be considered. This will provide the opportunity to carefully consider the situation and agree actions still required in terms of the management and overview of risk and the grounds for review.

Any decision not to proceed to a case conference will be shared with other agencies and clearly recorded on Eclipse. Key staff from any other involved partner agency may however request that a case conference (or similar inter-agency meeting) is convened if they disagree with the decision not to hold such a meeting. Having considered any such request, the Operational Manager will decide whether a further meeting is required. Any formal dispute will be subject to the Multi-agency Escalation of Risk Protocol (MaREP 2023)



The case conference will be chaired by a The Operational Manager who is a registered Social Worker and should follow the agenda set out in appendix 2 Although this is not prescriptive and should be updated to reflect the specifics of individual cases. The Chair of the Adult Protection Case Conference will have a responsibility to consider wider legislation that contributes to the protection of the individual at risk of harm, such as the Adults with Incapacity Act 2000 and the Mental Health (Care and Treatment) Scotland Act 2003.

The Act provides a range of Protection Orders which should be considered as part of developing a risk management and protection plan. A petition to the court for a Protection Order will require considerable supporting evidence and will demonstrate that less restrictive options have been considered and that significant risk exists.

Renfrewshire Council Legal Services staff should be invited to any ASP Case Conference for advice and guidance where consideration may be given to seeking a Protection Order or it is believed that other legal considerations may apply.

Other formal mechanisms exist within partner agencies which contribute to the protection of adults at risk and may operate in parallel with Adult Support and Protection procedures. Where relevant, the operational Team Manager/Senior Social Worker manager will link with other partner agencies to avoid duplication and ensure effective coordination, clear lines of responsibility, and encourage a consistent approach. It should be noted that ASP statute should primarily take precedence over non statutory practice in relation to practice issues.

Examples of this could include:

* Care Programme Approach – multidisciplinary meetings convened by a psychiatrist which are used to co-ordinate the care and protection of adults with a mental disorder (including those with a learning disability)
* Multi-Agency Risk Assessment (MARAC)
* Multi- Agency Public Protection Arrangement (MAPPA)
* Compulsion & Restriction Orders (CORO)
* Measures in relation to registered establishments taken by the Care Inspectorate

**The Inter-Agency Procedures provide general guidance on conducting and managing the Conference.**

* Should the Conference agree an Adult Protection Plan where significant risks are identified this should be recorded in the completed Minute and Adult Protection Plan. The Protection Plan must be signed by the Chair of the Case Conference. Where it is agreed that an Adult Protection Plan is not necessary this should be noted explicitly in the minute and in case records/chronology on Eclipse.
* All required forms are available as templates and should be recorded on Eclipse.
* The Eligibility criteria given to adults subject to an ASP investigation or ASP Protection Plan is “Critical” and should be recorded on Eclipse.
* The manager of the service is accountable and responsible for ensuring effective performance and governance arrangements are in place for those subject to protection plans. The locality managers of the two Renfrewshire Locality Teams and relevant managers of the Learning Disability, Mental Health and Addictions will have overall responsibility for practice and management of adult protection within these services.
* The case conference chair will be responsible for ensuring that a full and accurate minute of the meeting is circulated to relevant individuals and agencies. The chair will decide who should receive a copy of the minute. Where it is deemed inappropriate for reasons of confidentiality to give a copy of the minute to a particular individual or agency, consideration will be given to providing a summary version or a copy of the protection plan. Care should be exercised when sending the minute to the adult at risk where other individuals (including the person alleged to be causing harm) are able to access it and where the adult lacks the capacity to safeguard the information.
* Written reports provided at the case conference by agencies will not be circulated with the minute unless this has been specifically agreed at the meeting.
* The minute of the case conference will be circulated within 10 working days of the meeting and will include.
* A record of the discussion
* A copy of the protection plan, including the allocation of roles and responsibilities
* Decisions made regarding statutory intervention with reasons as to why pursued or not pursued.
* Confirmation of who will lead the Core Group and timescales.
* Identity of key worker allocated to care manage the case.
* Any other decisions taken.
* Note of any dissent from decisions
* Date of review case conference
* Investigations by the Office of the Public Guardian into allegations of financial harm.

The Council Officer will coordinate 4 weekly meetings of the **Core Group** involved in the protection plan. This should involve the adult who is subject to the Protection Plan and, where appropriate, family/ unpaid carers and advocacy. The Team Manager will chair the meeting.

Following commencement of an Adult Protection Plan an Adult Protection Review Case Conference should be held within 3 months and subsequently within another 3 months if the adult remains subject to a protection plan. Reviews should be brought forward within a shorter timescale if considered appropriate due to higher risk, lack of progress, new risk etc.

The protection plan will be formally reviewed through review case conferences. These will involve those professionals and agencies who attended the original case conference however membership may need to be updated to reflect those currently working with the adult and to maximise the participation of the adult and his/her representatives and family.

The purpose of a review case conference is to:

* summarise the work undertaken since the previous conference.
* establish the current level of risk to the adult.
* review the effectiveness of the protection plan.
* update, amend or discontinue the protection plan as required.
* ensure that action agreed under the protection plan has taken place and if not the reasons for this.
* confirm any change in Council Officer
* be co-ordinated by the lead professional.
* meet on a regular basis to carry out their functions (generally every 4 weeks).
* keep effective communication between all services and agencies involved with the adult.
* activate contingency plans promptly when progress is not made, or circumstances deteriorate.
* recommend the need for any significant changes in the plan to the case conference chair and provide updates to the review case conference, including any update to risk assessment and chronology.
* be alert, individually and collectively, to escalating concerns that may require immediate response and/or additional support.

**Protection Orders**

What follows are the salient points of each of the Protection Orders. This does not replace the more detailed information contained within the Act and the AS & P Code of Practice (2022). These should be referred to if consideration is being given to an application under this part of the 2007 Act.

Any protection order under the Act represents a serious intervention in an adult's life, a sheriff must be satisfied that the council has reasonable cause to suspect the person in respect of whom the order is sought is an adult at risk who is being, or is likely to be, at risk of ‘serious harm.’

There is no requirement under the Act for the council to have previously arranged a visit under Section 7, an interview under Section 8, or medical examination under Section 9 prior to applying for a protection order. Protection orders may be applied for at any time in the process, depending on the individual circumstances of a case.

Note: Before the council or any person makes a decision or undertakes any function under the Act, they must have regard to the general AS & P principles set out in sections 1 & 2 of the Act, and as outlined in Chapter 1 of this guide.

Where the adult at risk has refused to consent, Section 35 provides that the Sheriff in considering making an order, or a person taking action under an order, may ignore the refusal where the sheriff, or that person, reasonably believes:

* that the affected 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.

In relation to Protection Orders, the Sheriff has discretion to appoint a safe guarder to safeguard the interests of the ‘adult at risk’ before deciding the application, as per Section 41(6) of the Act.

**Assessment Orders**

The purpose of an Assessment Order under Section 11 of Act is to determine whether the adult is an adult suspected to be at risk; and whether there is reasonable cause to suspect that the adult at risk is being, or is likely to be, seriously harmed; and whether any action should be taken to protect the adult from serious harm. Application for an assessment order must be made by the council's legal department, which authorises the council, if necessary, to take the adult from a place being visited under the order to allow:

* the interview to be conducted in private and /or
* a private medical examination by a health professional nominated by the Council.

Note:

* The Assessment Order is valid for 7 days after the date specified in the order e.g. an order dated 13 November would expire on 20 November at midnight.
* The date specified in the order may be different from the date the order is granted.
* An assessment order does not have the power to detain the adult in the place they are taken to. The adult may choose to leave at any time.

**Removal Orders**

Removal Order, Section 14, can only be granted in respect of an adult at risk of harm and is primarily for protection purposes and not for a council interview or a medical examination.

It permits the person named in the order to be moved from any place to protect them from harm. A removal order will be granted only where the sheriff is satisfied that the adult is likely to be ‘seriously harmed’ if not moved to another place and that there is a suitable place available to remove the adult to. The Removal Order should specify where the adult is to be removed to.

Note:

* The place the adult at risk actually lives may be a contributory factor in the harm and the move may provide "breathing space" for the specified person.
* The council can make application to the Sheriff (or Justice of the Peace in certain circumstances) for a Removal Order, which would allow the removal of the adult to another place primarily for the purposes of protection.
* There is a 72-hour period in which to enact the Removal Order. It expires 7 days (or such shorter period as may be specified in the order) after the day on which the person specified in the order is moved to the named place of safety.
* A removal order does not contain powers of detention. The adult can refuse to stay in the place specified.
* Although the Act does not make explicit what happens after the order expires or the adult chooses to leave, the Council continues to have a ‘duty of care’ to return the adult safely to the place from which they were removed or to a place of their choice, within reason. To this end, the Council may consider agreeing some form of support plan with the adult, or where appropriate, convene a multi-disciplinary meeting to discuss further care and protection issues.

**Warrant for entry:**

Where it is anticipated that the use of ‘reasonable force’ may be necessary to execute an Assessment or Removal Order, a Warrant for Entry should be considered subject to Section 37 of the 2007 Act.

The sheriff (or justice of the peace) must grant a Warrant that authorises a police constable to use reasonable force where necessary to achieve the purpose of the visit. Wherever possible, entry to premises should first be attempted without force. The use of force is an absolute last resort, to be used in very exceptional circumstances, and only when all other options have been exhausted.

The Warrant permits a Constable to accompany a Council Officer and to do anything, including the use of reasonable force, where necessary which the Constable considers to be required in order to fulfil the object of the visit. Only the constable has a right to use reasonable force.

Note: Once a warrant has been executed, it cannot be used again.

**Banning Orders (section 19) or Temporary Banning Orders (section 21)**

These orders will only be granted where the adult at risk is in danger of being seriously harmed.

A Banning or Temporary Banning Order, which bans the subject of the order from a specified place, may have other conditions attached to it, and may last for a period of time not exceeding 6 months. The purpose of these orders is to better safeguard the adult at risk's well-being and property more effectively than would removing the adult from a place where they are at risk of harm from another person.

A Banning or Temporary Banning order may:

* ban the subject from being in a specified area in the vicinity of the specified place.
* authorise the summary ejection of the subject from the specified place and the specified area.
* prohibit the subject from moving any specified thing from the specified place.
* direct any specified person to take specified measures to preserve any moveable property owned or controlled by the subject which remains in the specified place while the order has effect.
* be made subject to any specified conditions; and
* require or authorise any person to do, or to refrain from doing, anything else which the sheriff thinks necessary for the proper enforcement of the order.

A condition specified in an order may authorise the subject of the order to be in a place or area from which they are banned, but only in specified circumstances, for example while being supervised by another person or during specified times.

**An application for a Banning Order may be made by or on behalf of:**

* an adult whose well-being or property would be safeguarded by the order; or
* any other person who is entitled to occupy the place concerned; or
* a Council.

**Power of Arrest (section 25)**

The sheriff can make a decision to attach a Power of Arrest based on the facts and circumstances of the case presented. This would be based on the likelihood of the subject breaching the Banning Order or any of the conditions attached to the Banning Order.

**Chapter 4: Management of Professional / Organisational Disagreements / Disputes**

Professional disagreements should be managed with due respect whether it is a disagreement between practitioners of the same profession or those of different professions. Disagreements may well facilitate a more detailed conversation before concluding on a way forward.

Disagreements may be noted and recorded in the minute of Initial Case Conferences, Review Case Conferences and Core Groups.

Practitioners of the same profession should be empowered to note their disagreement with their line manager and authorised to request the matter discussed with the next senior manager in the management structure as appropriate. In doing so, the expectation is that the issue is presented in writing highlighting risks etc and an alternative protection plan. Expectation is that this would be managed out with the Case Conference/Review process.

20.4 Disagreements between professionals /organisations can be dealt with via the Multi-agency Escalation of Risk Protocol (MaREP 2023).



**Appendix 1**

**Adult Protection Referral Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **ADULT AT RISK DETAILS**  (Please PRINT details – thank you) | | | |
| **Name:** |  | | |
| **Home**  **Address:** |  | | |
| **Postcode:** |  | **Tele No:** |  |
|  | | | |
| **Current: Whereabouts:** |  | | |
| **Postcode:** |  | **Tele No:** |  |
|  | | | |
| **DoB:** |  | **Gender:** |  |
| **Ethnic Origin:** |  | **Religion:** |  |
|  | | | |
| **Communication**  **Needs:**  (Please provide details including communication aids by the adult and specify first language if not English.) |  | | |
|  | | | |
| **GP Name:** |  | | |
| **Address:** |  | | |

|  |  |
| --- | --- |
| **REFERRER DETAILS**  (Please PRINT details – thank you) | |
| **Name:** |  |
| **Designation:** |  |
| **Agency:** |  |
| **Direct Dial Tele No:** |  |
| **Email Address:** |  |
| **Relationship to adult being referred:** |  |
| **Signature:** |  |
| **Date:** |  |

|  |
| --- |
| **IS IT SUSPECTED THAT A CRIME HAS BEEN COMMITTED**  **AND HAVE THE POLICE BEEN INFORMED?**  (Include: date, time, known action taken etc.) |
|  |
| **DETAILS OF CONCERN**  (Please PRINT details – thank you) |
| **In your opinion is the adult able to safeguard their own wellbeing, property, rights, or other interests?**  (If no, please state reason) |
|  |
| **In your opinion is the adult at risk of harm?**  (If yes, please state reason) |
|  |
| **In your opinion is the adult affected by disability, mental disorder, illness or physical or mental infirmity.**  (If yes, please specify) |
|  |
| **Give details of harm (suspected / witnessed / disclosed / reported.**  **Dates, protective actions taken include details of any previous concerns.**  (Please use separate sheet if required) |
|  |
| **Have you (or any other person) told the adult that this information will be shared with social work or other relevant agencies.** **YES / NO** (Delete as appropriate)  If **NO,** please state reasons? |
|  |

|  |  |
| --- | --- |
| **DETAILS OF PERSON SUSPECTED OF CAUSING HARM**  (If known) (Please PRINT details – thank you) | |
| Name: |  |
| Address: |  |
| Tel no: |  |
| Relationship to adult: |  |

|  |  |
| --- | --- |
| **DETAILS OF MAIN CARER / RELATIVE / POA / GUARDIAN**  (Please PRINT details – thank you) | |
| Name: |  |
| Address: |  |
| Tel no: |  |
| Relationship to adult: |  |

**Appendix 2.**

****

**Multi-agency Escalation of Risk Protocol (MaREP)**

This protocol should only be used within Adult Support & Protection practice contexts, following that agency having made an ASP referral, as **this protocol is not intended as a replacement for following local ASP guides & procedures** but to **augment the duty to refer and cooperate process.**

It is also **not** for matters relating to e.g., assessment for more general care and support needs, funding of care and support needs, which are outside the scope of this process.

Developing multi-agency Adult Support & Protection practice is enshrined in the 2007 Act under [Section 5](https://www.legislation.gov.uk/asp/2007/10) relating to refer and cooperation between public bodies or office holders.

***NOTE: If an adult is thought to be at imminent risk of harm, the matter should be referred immediately to the Police/Social Care to decide what action to take to safeguard/protect them whilst the area of disagreement is being resolved.***

All staff, including those in partner agencies, are accountable for their professional practice, which includes decisions and actions in ensuring a high standard and efficient Adult Support & Protection interventions which promote best outcomes for the adult at risk of harm.

Furthermore, problem resolution is an integral part of professional co-operation and joint working to protect adults. The safety of adults at risk and/or the impact on the adult’s wellbeing must be the paramount consideration in any professional disagreement.

Transparency, openness, and a willingness to understand and respect individual and agency views are a core aspect of multi-agency / inter-agency working. However, there may be occasions where individuals / agencies disagree on how best to keep ‘adults at risk’ safe and promote their welfare.

**The ‘adult at risk' safety and welfare should be the key focus at all times.**

**Disagreements can arise in a number of areas, but are most likely to arise around:**

* Adult Support & Protection concerns or inquiries, where disagreement exists around thresholds for intervention.
* Perceived levels of risk.
* Levels of need and whether a concern has met the threshold for a service or intervention.
* Lack of understanding around roles and responsibilities, particularly managing expectations.
* Level or quality of communication/ information sharing.
* Action or lack of action progressing plans- drift.
* Cases being / not being stepped up or down and / or closed.
* An agency believes there is a vital or public interest, which makes it necessary to seek a multi-agency response.
* Perceived lack of engagement, from key partners, in the multi-agency risk management process.

Renfrewshire Adult Protection Committee is clear that there must be respectful scrutiny whenever a professional or agency has a concern about the action or inaction of another. The aim must be to resolve a professional disagreement at the earliest possible stage, always keeping in mind that the adult at risk’s safety and welfare is paramount.

**Resolving Differences of Opinion:**

Any worker who feels that a decision is not safe, or is inappropriate, can initially consult their supervisor / manager to clarify their thinking, if required.

**Pre-Escalation:**

Recognition that there is a disagreement over a serious issue, which impacts on the safety and welfare of an adult at risk of harm.

* Identification of the problem, and clarity about the disagreement and what you aim to achieve.

**Discussion between workers**

The practitioners/ people who disagree should have a discussion to try to resolve the problem. This discussion must take place as soon as possible and could be a telephone conversation or a face-to-face or virtual meeting. It should be recognised that differences in status and /or experience may affect the confidence of some workers to pursue this unsupported.

They should be able to evidence the nature and source of the concerns and should keep a record of all discussions.

**As soon as Stage 1 is initiated, the form in** [**Appendix 1**](#Appendix1) **should be completed, identifying the area of disagreement, and** **ensure a copy is saved in adults case file/ records.**

**At all stages of the protocol**, it is important to create a supportive environment that promotes constructive professional dialogues with respect for individual/ agency perspectives to address concerns or areas of disagreement.

**Each meeting convened will receive representations from those involved in the disagreement and will aim to collectively resolve the professional differences concerned.**

At all stages of the protocol, actions and decisions must be timely, recorded in writing and shared with relevant personnel, including the worker who initially raised the concern. This must include written confirmation between the parties about an agreed outcome of the disagreement, the timescales for responses/actions and how any outstanding issues will be pursued.

**Stage One:**

**Discussion between Direct Line Managers:**

If the issue is not resolved and concerns remain, the worker should contact their supervisor / line manager / safeguarding or ASP lead within their own agency to consider the issue raised, what outcome they would like to achieve and how differences can be addressed.

The line manager should contact their respective counterpart to try to negotiate an agreed way forward. This could involve a professional meeting if deemed appropriate.

**If there remains disagreement, escalation continues through the appropriate tiers of management in each organisation until the matter is resolved.**

**Stage Two: Discussion between Operational/ (equivalent level) Senior Manager**

If the issue is not resolved at stage two, the supervisor/ line manager reports to their manager or named/ lead ASP/ safeguarding representative. These senior managers of the individual/ partner organisations must liaise and attempt to resolve the professional differences through discussion.

**Stage Three:** If the problem is not resolved at stage two, the respective Operational/ equivalent Senior Manager, **must escalate the concern to their Service Manager/ equivalent level in other agency** involved.

**Stage Four:** If there is no resolution, and having exhausted all previous stages, the matter should be escalated **to the relevant Heads of Service/ equivalent level in the other agency involved.**

If the area of disagreement remains unresolved, **the Head of Service (Social Work) should refer to the Chief Social Work Officer for consideration.**

The CSWO may make a decision or ask for further information before making a final decision.

**Renfrewshire Adult Protection Committee (RAPC).**

If any stage highlights gaps in policies, procedures, raises issues with protocol implementation; this should be brought to the attention of RAPC**.**

**Appendix 3**

|  |  |
| --- | --- |
| **Professional Concern / Outcome Resolution Form**  This document MUST be sent and stored securely on the adult’s electronic records. | |
| **Date of Notification** |  |
| **Name of Adult** |  |
| **Identification number/NHS number (if known)** |  |
| **DOB** |  |
| **Name of person raising the concern** |  |
| **Role** |  |
| **Agency/Team** |  |
| **Name of Line/Team Manager** |  |
| **Contact details of person and Line Manager** |  |
| **Details of Area of Disagreement** |  |
| **Details of the professional scrutiny of decision/ actions** |  |
| **Desired outcome** |  |
| **Evidence of action taken:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Stage** | **Date of discussion** | **Evidence of discussion to resolve disagreement.** | **Date outcome/ issue resolved.** |
| **1** |  |  |  |
| **2** |  |  |  |
| **3** |  |  |  |
| **4** |  |  |  |
|  |  |  |  |
| **Achieved outcome (please state the achieved outcome to the disagreement):** | | | |

1. [Adult Support and Protection: everyone's business | Iriss](https://www.iriss.org.uk/resources/reports/adult-support-and-protection-everyones-business) [↑](#footnote-ref-1)
2. Sec 35 (4) An adult at risk may be considered to have been unduly pressurised to refuse to consent to the granting of an order or the taking of an action if it appears— (a)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 (b)that the adult at risk would consent if the adult did not have confidence and trust in that person. [↑](#footnote-ref-2)
3. <https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2022/07/adult-support-protection-scotland-act-2007-code-practice-3/documents/adult-support-protection-scotland-act-2007-code-practice/adult-support-protection-scotland-act-2007-code-practice/govscot%3Adocument/adult-support-protection-scotland-act-2007-code-practice.pdf> p.15 [↑](#footnote-ref-3)