Interagency collaboration in adult support and protection in Scotland

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Interagency Collaboration in Adult Support and Protection in Scotland: Processes and Barriers

Volume 1: Final Report

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This study was heavily dependent upon the goodwill and efforts of a large number of people. First, our thanks to those who had been abused or allegedly been abused for their informed consent to study their cases. Where it was not possible for them to grant consent themselves, welfare guardians were equally cooperative and we are most grateful to them, too.

Identification of cases and the follow through to secure informed consent was dependent upon senior managers in the social work departments involved in the study. This was no easy task for them, and we very much appreciate the investment of time that they committed. In addition, they had to ensure case files were available to us and that it was practically possible for us to occupy office space in their departments for several days. This they did with great efficiency and were always hospitable towards us. Their openness was very much appreciated.

We interviewed many people in a variety of different agencies. Again, with only a few very rare exceptions, we had full cooperation from them. They not only gave freely of their time but acted as a generous resource when we went back for still more information.

Our sincere hope is that the outcome of this research provides some return to them as they carry out the extremely complex and demanding task of protecting and supporting individuals who are at high risk of abuse from a wide range of sources.

Andrew Reid has throughout given freely of his expertise in this area and encouraged us through a variety of difficult times: our thanks and appreciation to him.

Finally, our thanks to the Scottish Government and Capability Scotland for supporting this work. We are obviously highly appreciative of this.

SUMMARY

A multiple methods research study of cases entailing adult protection in Scotland prior to the implementation of the *Adult Support and Protection (Scotland) Act 2007* was undertaken to: (a) examine the fine grain of agency and interagency working in adult protection cases; (b) provide a basepoint to compare such activity before and after implementation of the Act; (c) provide the groundwork for future audit in such cases after implementation of the Act. Twenty three cases were studied in detail through case file analysis, interviews with professionals across agencies involved in the cases, interviews with relevant policy makers and study of adult protection procedures in the four local authorities involved. A further 22 cases were also considered in settings in which multiple cases were identified. This information was synthesised in a tabular chronology with agency and interagency communication and activity coded and organised into key themes.

Cases related to a wide range of disabilities and conditions were considered including older people with and without dementia or neurological conditions, and people with intellectual disabilities, as well as individuals with brain damage, mental health problems and difficulties in mediating their social relationships. The setting in which the abuse took place or allegedly took place divided principally into family homes and managed or supported settings such as care homes and individual tenancies. While social work departments were involved in all cases, health professionals and the police also played significant roles, as did a range of service providers. Their activities are considered agency by agency and with respect to the collaboration of each with its partner agencies. The findings are considered with respect to how occupational cultures affected adult protection activity, how cases were conceptualised or framed as adult protection cases or otherwise, and operational considerations. Examples of good practice were identified, though a wide range of shortcomings in implementing operational procedures was also noted.

Consideration was given to a range of specific issues including multiple and serial abuse, risks posed to other adults in contact with the alleged perpetrator, consequences for the perpetrator, risks to children, independent advocacy in adult protection cases and the nature and role of risk assessment. Detailed attention is given to the role of the alleged victims and their families in the cases.

In volume 2 of this report, 25 recommendations and the associated action required are made on the basis of the findings[1].

A detailed executive summary of volumes 1 and 2 of the report is also available[2].

[1] Hogg, J., Johnson, F., Daniel, B. & Ferguson, A. (2009) Interagency Collaboration in Adult Support and Protection in Scotland: Processes and barriers. Volume 2: Recommendations. Dundee: White Top Research Unit: University of Dundee.

[2] Hogg, J., Johnson, F., Daniel, B. & Ferguson, A. (2009) Executive summary: Interagency Collaboration in Adult Support and Protection in Scotland: Processes and barriers. Dundee: White Top Research Unit: University of Dundee.

1 BACKGROUND TO THE STUDY

The research reported here has been initiated and undertaken in the context of the development of Scottish Government legislation to support and protect adults from abuse. This process was on-going when the (then) Scottish Executive commissioned the study, and during the course of the work the *Adult Support and Protection (Scotland) Act 2007* was passed and was implemented at the end of October 2008. A second year of the research was generously funded by Capability Scotland. The study provides a picture of the processes and outcomes involved in the response of statutory agencies to allegations and evidence of abuse prior to the Act. It offers the opportunity to compare the impact of the legislation at some future date by reviewing how cases are processed with the provisions of the Act available when compared with pre-Act cases. The study also provides the basis to develop a methodology to audit the process of agency and interagency[3] adult protection procedures.

1.1 The abuse and protection of adults

Concern with the protection of adults from abuse[4] is a major issue in Scotland, as it is throughout the United Kingdom and indeed, internationally. Much of what has been learnt about this subject has emerged from serious failures by responsible agencies to assess the risk to adults and provide appropriate protection. In addition, there is also evidence of professional uncertainly with respect to the limits and extent to which intervention in the affairs of adults is legitimate. In England and Wales the Department of Health and Home Office (2000)[1] has provided detailed guidance to local agencies which have a responsibility to investigate and take action when an adult is believed to be suffering abuse. As we have noted, legislation in Scotland has already been enacted while at local level considerable progress has been made in developing policies aimed at protecting adults from abuse, particularly with respect to inter-agency adult protection guidelines.

Recent considerations of adult protection have taken as their starting point the responsibility of those who provide services to particular groups of people and the contexts in which that care is provided. The identification of individuals who are deemed vulnerable to abuse through their membership of particular groups of people (e.g. older people or people with learning disabilities) has been strongly

[3] Note here we have adopted the term "*interagency*" rather than the current "*multiagency*". This distinction has long been made in the field of intellectual disability to distinguish collaborative, interactive working by professionals, as distinct from parallel but inherently independent work in relation to the same case.

[4] The terminology used in the case records and interviews typically referred to the "*abuse*" of a "*vulnerable adult*". The *Adult Support and Protection (Scotland) Act 2007*, however, uses the terms "*abuse*" and "*at risk*" and in current discourse and documentation with respect to adult protection in Scotland these have become the accepted, if not always preferred, terms. However, we felt it would be anachronistic to impose this more recent terminology on cases in which they were rarely used, and therefore continue to refer to "*abuse*" and "*vulnerable*" individuals. In employing the latter term, however, we accept that it is both inexact and potentially demeaning to use this adjective to describe whole groups of people. Reference here is limited to individuals whose vulnerability in the circumstances in which they lived was demonstrable.

rejected during the process of consulting on and framing the *Adult Support and Protection (Scotland) Act 2007*. However, based on a wide range of research findings, implicit in the identification of cases for the present study is a view that some individuals receiving community care services have a higher probability of being abused than members of the wider population. Hence the starting point here for case identification was individuals in receipt of some form of social work input or community care provision.

Such adults may be older people, have developmental disabilities or mental or physical health problems, or indeed, a combination of these. As we shall see, however, in some of the cases examined here any *simple* characterisation of the at risk individuals in terms of these descriptions is often not possible.

Internationally, there is increased recognition of a heightened vulnerability of older people to all types of abuse (e.g.[2,3,4]). The problem has received increasing attention in the UK from the perspective of specific professions (e.g. nursing and social care[5], general practice[6]) and politically in a House of Commons report[7,8] which, however, acknowledged the dearth of statistical information on the prevalence of abuse of elderly people in Britain and led to a UK wide prevalence study. In Scotland elderly people are clearly an important and growing target group in considerations of adult protection. Among these, those with dementia may be especially vulnerable to abuse. It is predicted, for example, that the population of people in Scotland over the age of 80 years will increase from 194,923 in 2001, to 258,023 in 2021 and 390,002 in 2041.

It has been known from the 1960s that some individuals with developmental disabilities (i.e. intellectual disabilities and autistic spectrum disorders) have been seriously abused, though it was only during the 1990s that the endemic abuse of people with disabilities began to receive serious attention[9]. In particular, there was an increasing focus on those with intellectual disabilities with a high, but variable, prevalence rate reported[10,11,12]. As with elderly people, the population of people with intellectual disabilities is set to grow as longevity increases and survival of infants with complex disabilities becomes more viable[13].

The abuse of people with mental health problems has received more limited consideration[14,15] though attention has been drawn in the UK to the abuse by professionals of individuals with mental health problems within psychiatric services and in the primary care sector[16].

While the context and impetus for the present study was the general situation described in the preceding paragraphs, it actually took its starting point from a key study in the field of child protection. The preliminary idea for the research and the methodological framework arose from *The Scottish Child Protection Review*[17]. This explored the effectiveness of the Scottish child protection framework with respect to practice in relation to child protection and the determination of the quality of child protection practice. A proforma was developed that permitted a single audit based on: (i) Case file scrutiny; (ii) Interviews with relevant personnel; (iii) Agency evaluation and (iv) Overall evaluation. The successful outcome of this study provided a procedurally firm and valid base on which to develop a parallel process to explore adult protection procedures.

1.2 Design of the study

1.2.1 Methodology and methods

The design of the study drew directly on The Scottish Child Protection Review described above. The project has been undertaken as mixed method, qualitative research based on document analysis and interviews with several key participants in each case. Each individual's social work case file was analysed from the initial accusation or suspicion of abuse, a process taking between 1.5 and 12 days. This involved the development of the chronology of the case from all available documentation, i.e. case notes, case conference minutes, letters, e-mails, records of telephone conversation etc. Latterly in the case the appearance of adult protection records and risk assessment documents were also covered. Both hard copy and electronic data were reviewed. The chronology was recorded directly onto a laptop computer and was therefore available electronically for analysis.

Key participants in the case from social work, NHS, the Care Commission and the police were identified, as were other local authority personnel involved, typically the housing department, legal department and commissioning/quality and standards department. Subsequently these key individuals were interviewed. The individualised questions addressed to them were pre-prepared on the basis of the chronological record. These fell into three categories. First, questions inviting clarification, e.g. filling a gap in the existing record; second, questions inviting reflection on the events, sometimes related to value judgements regarding the appropriateness of what had occurred; third, some questions that were addressed to all interviewees related to the use of policy guidelines, the typicality of the case, whether things could have been done differently, and knowledge and expectations regarding the *Adult Support and Protection (Scotland) Act* 2007.

At a more general level, key senior staff members within social work, the NHS and the police were interviewed regarding adult protection policy in their area while policy documents (e.g. adult protection guidelines) were reviewed.

It was beyond the scope of the study to interview alleged victims of abuse, their family members or alleged perpetrators of the abuse.

1.2.2 Participants

It was agreed with the Scottish Executive Adult Support and Protection Unit that the work would be conducted in four of the 32 Scottish local authorities representing some demographic contrasts (e.g. rural and urban). In each authority the aim was to review six cases, i.e. a total of 24 cases. These six cases were broadly to encompass two cases involving an older person, two persons with intellectual disabilities and two persons with mental health problems with cases in both managed settings (i.e. care homes, supported living settings, day services etc) as well as family homes included. In the event 23 individual cases were reviewed, though information on multiple cases in certain settings contributed to the review increasing the total to 45. Figure 1 provides details of the principal cases studied. It should be noted that the numerical order of cases in

figure 1 is not adhered to in other figures, in order to minimise the volume of information about individual cases which might be reconstructed from this report.

In the cases studied, all alleged victims were at increased risk because of a range of conditions including brain injury, chronic neurological illness and dementia. Others spanned the spectrum of intellectual disability from profound intellectual and multiple disabilities through to individuals for whom any conventional classification of intellectual disability would have been inappropriate, but who were clearly at risk because of limitations in acting protectively in social encounters in which they were potentially threatened. Capacity, too, spanned the full range. Some individuals could make their circumstances known and report allegations of their abuse (*). In several cases, individuals described as having "*...mild learning disabilities...*" were able to undertake an active role dealing with matters as diverse as choice of counsellor (*), financial arrangements (*) and care of relatives (*). Others clearly lacked, and seven were assessed as lacking, capacity during the course of the case.

1.3 Ethical permission and case identification

With respect to ethical permission, this had to be secured from four social work departments, three NHS authorities (two local authorities fell within a single NHS area) and two police forces (three local authorities fell within a single police jurisdiction). This process took over eight months, from April to November 2006. Following this came the process of case identification by social work staff which entailed a lengthy period of negotiation followed by an even longer period during which cases were identified and referred. The first case for inclusion in the study was identified in March 2007, a year after the inception of the study.

1.3.1 Social work departments

The four social work departments identified all readily agreed in principle to co-operate in the project. Meetings and in some cases follow up meetings took place to negotiate case identification. Despite the agreement in principle to co-operate, the requirement of the Caldicott Guardians (see below) that the subjects of alleged abuse in the identified cases should give informed consent to their cases being examined led to considerable difficulties with case identification.

The difficulties encountered also arose from many sources. With respect to social work departments these included:

1.3.1.1 **Practical difficulties:** securing informed consent in the context of the person's family or service sometimes proved problematical. For some individuals giving informed consent in a direct way was not viewed as feasible and there was a reluctance even to approach such individuals, e.g. those with advanced dementia or profound intellectual disabilities. Causing disturbances in the person's family or service was also raised as an obstacle.

1.3.1.2 **Wider issues of consent:** In one area, within which access was not successfully negotiated, a solicitor advising the social work department advocated informed consent be obtained from the alleged perpetrator as well as

the alleged victim, clearly a block on any further pursuit of cases. In a second, informed consent from to-be-interviewed staff members was raised. With respect to the former we indicated that no other authority had raised that issue, and even if perpetrators' names were blanked out in files, the name would readily be revealed in other source files. In the latter case we suggested that after the project had been explained, staff were free to agree to or decline to be interviewed and this implicitly was indicative of consent being given or withheld.

It should be added that despite these difficulties, once key staff became involved in the process of identification, cooperation was unstinting and the research team's many demands have been met with a good grace which is duly appreciated.

Figure 1: Summary of principal individuals' service user group, setting in which abuse was alleged to have occurred and interviewees' posts

	Service user group	Setting	Interviews
1	Intellectual disability? Mental health	Family / supported tenancy	Home support manager Home support worker Police officer Senior housing officer Social worker
2	Intellectual disability	Supported tenancy	Mental health officer Police detective Social worker Supported living service manager
3	Older people Mental health	Care home	Care Commission officer x2 Contracts team manager Police officer Social worker Social work manager
4	Intellectual disability	Day service	Senior social worker
5	Intellectual disability	Supported tenancies	Care Commission officer x2 Contracts team manager Police detective x2 Social work manager
6	Intellectual disability	Supported tenancy	Community nurse Hospital nurse Social worker Supported living senior
7	Physical disability	Care home	Care Commission officer Care home nurse Care home manager Social worker x2 Police officer
8	Older people	Care home	Care Commission officer Care home manager Police officer Social work assistant Social work manager
9	Older people Mental health	Care home	Care Commission officer Care home manager Social work assistant
10	Older people Mental health	Care home	Care home manager Social worker
11	Older people Mental health	Care home	Senior social worker (other joint interviews with further

			case in same setting)
12	Older people Mental health	Care home	Care Commission officer x2 Care home agency manager Care home manager x2 Police officer Social work assistant
13	Older people Mental health	Care home	Care home manager Social work assistant
14	Older people Mental health	Care home	Advocacy worker Care home manager Social worker x2 Social work manager
15	Intellectual disability	Family	Mental health officer Occupational therapist Psychiatrist Senior day centre officer Social worker Speech and language therapist
16	Intellectual disability	Family	Advocacy worker Mental health officer Occupational therapist Social worker
17	Intellectual disability	Family	Day centre manager Social worker
18	Physical health Mental health	Family	Day centre manager General practitioner Occupational therapist Police officer Rehabilitation team manager Social worker Social work manager
19	Intellectual disability	Family	Mental health officer Social work manager
20	Intellectual disability Mental health	Family / supported tenancy	Community nurse Mental health officer Psychiatrist Senior social worker Social worker Supported living service manager
21	Intellectual disability?	Family / supported tenancy	Community support worker Police officer Social worker
22	Intellectual disability?	Family / supported tenancy	Police officer Psychiatrist Senior community nurse Senior social worker Social work assistant Social worker
23	Older people Mental health	Family	Community psychiatric nurse Day centre manager Day centre officer Mental health officer Psychiatrist Social worker Social work manager

1.3.2 NHS permission

The eight month period taken to secure ethical permission arose largely from delays in securing permission from the Caldicott Guardians to access patients' files. The process involved was highly variable with permission given via e-mail in one case and entailing formal legal contracts between the University of Dundee and the NHS authority in two others. Permission was, however, eventually successfully secured.

1.3.3 Police permission

Permission from the three police constabularies was given rapidly and at an early stage with the only proviso that if a case was under investigation, information provided might be restricted.

2 ANALYSIS

What we refer to as "*an integrated chronology*" was developed on the basis of the case file chronology and the multiple interviews. Figure 2 illustrates one page of an anonymised integrated chronology. Each segment was numbered with reference to the alleged victim, e.g. here KP8, KP9 etc. Each segment was then coded in relation to the coding scheme aimed at capturing agency and interagency working, as well as the involvement of the alleged victim, the alleged perpetrator, family members and members of the community who may have become involved. Colour coded comments indicated the status of the information. It is the segmental coding that provides the data base for this report. Retaining the link between data and description and conclusions is problematical, partly because of the scale of the data (in excess of 2,500 such coded segments), but also because of the need to anonymise cases. Thus, use of the original initials is precluded and it would be relatively easy to reconstitute the main elements of a case if alternative initials were simply substituted and used consistently, e.g. FJ for JHH, i.e. the elements of FJ could be extracted and the case reconstituted to the point of recognition. We have therefore simply indicated were one or more segments from the integrated chronology support or illustrate the point made with (*). In the source copy of this report all original identifiers are retained and the researchers can readily return to this to clarify or amplify any questions that may arise.

Coding covered agency activity and interagency working which took place in the case, but extended to specific categories of activity, notably: (i) types of abuse experienced and information on perpetrators (section 3.2); (ii) use of adult protection guidelines (section 3.3.); (iii) reviews and case conferences (section 3.4) (iv) risk assessment (section 3.5); (v) issues related to legal provision (section 3.6); and (vi) advocacy (section 3. 7).

Judgements in this report regarding the quality and effectiveness of adult protection procedures and inter-agency working were based on knowledge of and reference to interagency adult protection guidelines for each local authority area in which the research was undertaken. Intra-agency guidelines were also available in some cases, e.g. the Care Commission's adult protection guidance document[18] and were duly employed. In interviews we explored how certain

courses of action measured up against expected procedures for that agency. Practice, therefore, was assessed against what agencies themselves said/documented as being acceptable practice. Consideration was also given to procedures not being followed/not being appropriate where relevant.

As in the Scottish Child Protection study, our focus on whether or not procedures/guidelines were followed was secondary to our focus on the outcomes for the adult. If an agency or agencies working together seemed to have helped to protect an individual on the basis of what followed, or conversely, if the process of protection appeared to have run into difficulty due to a particular agency's practice or to interagency misunderstandings or mis-communications, then this constituted grounds for comment, regardless of the status of the practice vis-à-vis guidelines/procedures.

At the outset, it is important to comment on the extreme complexity of many cases when allegations of adult abuse arose in family settings, as well as in managed facilities. The interpersonal relationships within families were themselves highly complex, with shifting dynamics and a wide range of external pressures creating a sometimes chronic, stressful environment. The historical experiences of family members could also play a significant part in family dynamics influencing contemporary behaviour and attitudes to allegations. In two cases, for example, the effect of sexual abuse involving family members decades before was still being played out in the contemporary situation. In addition, these families were under scrutiny from a variety of agencies with respect to the allegations that had been made and/or the concerns that had arisen. Within their stories, there is considerable poignancy and suffering.

Professionals, primarily social workers, addressed such family situations with many competing obligations to be met. Prevention of possible abuse had to be balanced with support for family members often including the alleged abuser. Evidence of abuse in such cases was often inconclusive but had sufficient face validity to demand sustained intervention. Alleged victims, sometimes sporadically and sometimes entirely consistently, did not wish to be "protected". In one case in which advice was sought from the Mental Welfare Commission (MWC), the commission was clear in its statement on the necessity of balancing the alleged victim's right to positive, if potentially risky, experiences and the social work department's duty to take protective action.

The legal context for intervention was also far from simple and involved close working with mental health officers (MHOs) and lawyers within the local authority. Social workers were also at the centre of a complex network of agencies and service providers all in varying degrees with information to provide and sometimes with a decisive potential role to play in addressing the allegations or their consequences. Expectations of each agency's role by the other agencies involved did not always coincide with that agency's actions (or lack of actions) creating frustration with and sometimes impeding multi-agency processes. For example, social work departments had only limited influence over the input of other agencies such as NHS staff or the police, yet nevertheless were obliged to engage in interagency working with them. The wider political context also had to be considered, with the possibility of councillors or Members of the Scottish Parliament (MSPs) becoming involved.

Figure 2: Example of one page of a merged chronology of an adult protection case

	Merged chronology from case files & interviews	**SW:** interpretation of own and other agencies' roles; thresholds	**Local authority providers:** interpretation of own and other agencies' roles; thresholds	**Police:** interpretation of own and other agencies' roles; thresholds	**Care home:**	**Victim involvement:**	**Family (non-perpetrator) involvement**
KP8	**26.08.06:** PC Ben Cave 'phoned SW re concerns about KP having contact with Douglas P a known sex offender [FJ: DP is RP's nephew].			**Police receive notification of contact from mother of KP & notify SW; interpret SW role as AP with respect to welfare & report to SWD**			**KP's mother notifies police of daughter's social contact**
KP9	**26.08.06:** [D2] Internal consultation in SW re: initiating AP proc.. Decision to interview KP first.	**Internal discussion of SW with manager; need to take lead confirmed;**					
KP10	**27.08.06:** [D2] Mtg with KP, by SWs JM & AG [FJ: see also detailed note below]. KP asked re nature of contact with DP. KP reveals other visitors to DP's flat with implication of sexual relationships. Provider notified. Police to be contacted.	**AP concerns confirmed and further issues raised; SW role to lead investigation SWD notify provider**				**KP interviewed by SW; alleges sexual exploitation**	
KP11	Police notified of SW concerns	**SW judges possible criminal behaviour & notifies police**					**Mother notified by police of investigation**

When these two areas are brought together – the family context and the interagency context within which allegations of abuse are addressed – then the overall complexity of the situation is clear. Significant tensions could arise from differing judgements regarding support for an at risk individual between social workers and the family and between social workers and professionals from other agencies.

In analysing the role of each of the agencies in the present adult protection cases, it is important to record that we were aware of the considerable challenges faced by professionals operating in an extremely difficult context. If some of the points made are critical, they are made to identify areas of operation in which there appears, from the independent perspective we were privileged to be able to adopt, a lack of clarity and/or less than optimal processes of intervention. In a very real sense we had the opportunity to look from the outside into cases with some distancing from the immediate concerns and pressures experienced by the professionals involved.

3 RESULTS

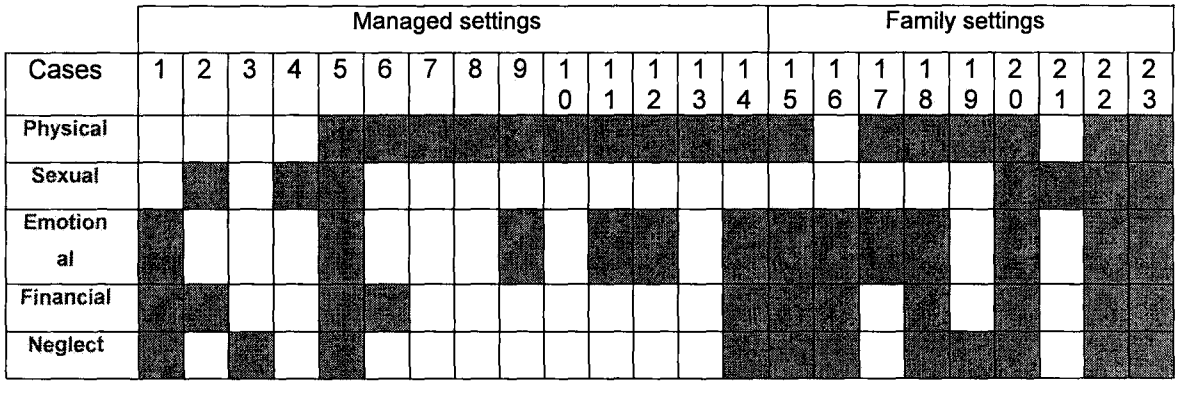
3.1 Overview of interviews

Ninety interviews were conducted with exactly 100 people with only six non-responses to the request for interview, three from NHS employees, two from the police, and one voluntary sector employee. The preceding figure 1 shows the interviewees case by case.

3.2 Types of abuse experienced/alleged and perpetrators

Figure 3 indicates the type of abuse in each case. The majority of the cases studied involved multiple types of abuse. Very conservative definitions of each category of abuse were employed. For instance, emotional abuse refers only to emotionally abusive acts which did not also fall into other categories; contact sexual abuse has not automatically been classed also as physically abusive, and so on. Even with the use of these restrictive definitions, four cases were identified as involving all five types of abuse. Seven cases concerned a single type of abuse, although in reality the person had experienced other types of abuse previously.

Figure 3: Types of abuse perpetrated in principal cases



Financial abuse underpinned many of the cases, with contact which was abusive in a number of ways maintained only for as long as the perpetrator had access to the targeted individual's money. In such a case, the granting of financial guardianship or appointeeship might mark the end not only of financial abuse, but potentially also of physical abuse, sexual abuse, emotional abuse and neglect.

3.2.1 Multiple abuse and serial abuse

Two or more types of abuse were sometimes allegedly inflicted in the same time period and/or by a single perpetrator, while in other cases individuals were abused in different ways at different times and/or by different perpetrators.

Sources of alleged abuse over time were varied, multiple and often serial. Figure 4 presents this information for the 23 cases.

It will be seen that in a majority of cases there were alleged multiple abusers. Figure 5 presents the available information on a variety of their characteristics.

Figure 5 undoubtedly presents a conservative estimate of the number of alleged perpetrators. Where "*local children*" or "*multiple acquaintances*" was recorded, we only counted this as two perpetrators, usually including them in the "*no known disability/health problem*" category. In addition, where a care culture/agency's management structure was directly implicated in the alleged abuse, the case is not included here. As may be seen, the majority of alleged abusers had no known disability or health problem. Of those who did, however, possible or assessed intellectual disability and possible or assessed mental health problems constituted the principal categories of alleged abusers.

3.2.2 Risk to other adults

For each case, we recorded whether the perpetrator or alleged perpetrator had direct access to other adults potentially at risk at the conclusion of the particular case studied. For the purposes of this analysis, an alleged perpetrator or perpetrator was counted as having direct access to other such adults at risk if: a) they were a care worker and did not lose their job as a consequence of events during the case; b) they lived with other adults potentially at risk; c) they had a track record of seeking out such adults and little/nothing had been done to address this as far as we were informed; d) they were a user of collective services for adults potentially at risk, e.g. in a day service. Someone was counted as having no direct access to other adults potentially at risk if, for instance, it was a very particular connection that brought them into contact with the alleged victim, usually through being their main carer, and there had been no suggestion that they would seek out any other victim.

We have also assumed that if a person was employed as a care worker, then there was no previous proven adult abuse, except for the one case where we now know otherwise. Similarly if the social work department knew a family member reasonably well and did not mention past abuse in case records or interviews with us, we have assumed there was no previous proven adult abuse.

Figure 4: Sources of alleged abuse over period of case

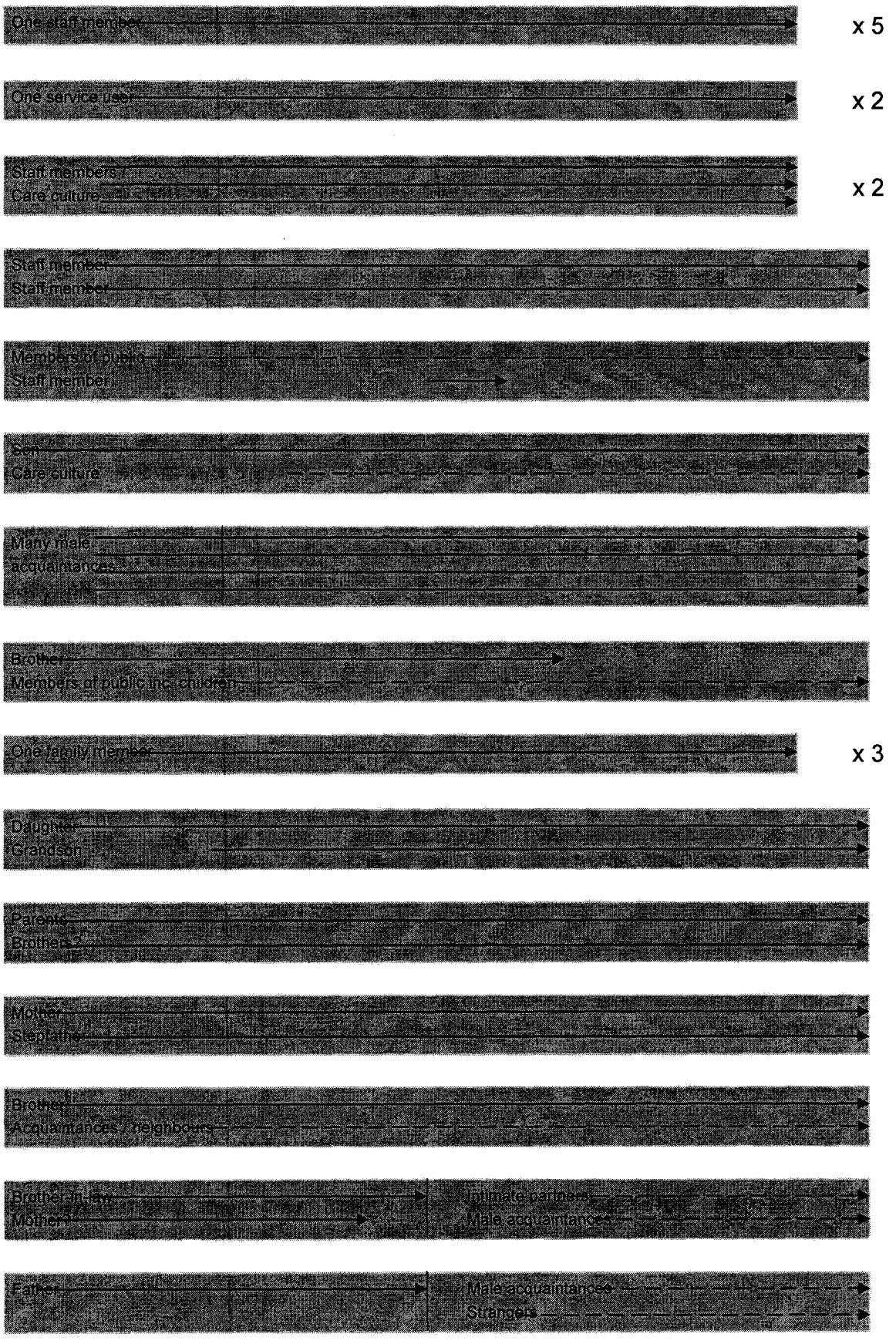
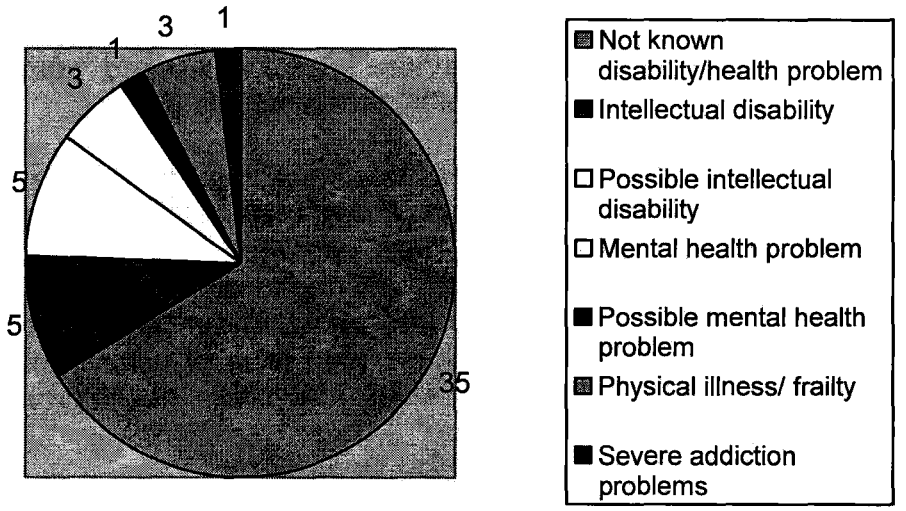


Figure 5: Known health and disability status of alleged perpetrators (managed and family settings)



As Table 1 shows, working on the basis of the above assumptions 13 of the 53 perpetrators or alleged perpetrators had no previous proven history of adult abuse, and no direct access to other adults potentially at risk. Indeed, the abuse or neglect in many cases arose in the context of extremely close and complex relationships, most often between the adult at risk and their long-term family carer. There were no particular grounds to predict that these carers might target other individuals.

Table 1: Access to other adults and evidence of previous abuse by alleged perpetrators and perpetrators

	Previous proven adult abuse	Not known	No previous proven adult abuse	Total
Access to other adults at risk	2	11	6	19
Not known	0	16	4	20
No direct access to other adults at risk	1	0	13	14
Total	3	27	23	**53**

In 19 cases, the alleged perpetrator had access at the conclusion of the case to other adults with possibly limited self-protective skills. This access was through immediate family, work and/or proven ability to target these individuals in community settings. In one case in which the alleged abuse had taken place in a family setting, but the alleged victim was relocated to a care home, stringent requirements regarding visiting were imposed on the alleged perpetrator to ensure he had no unsupervised contact with other residents (*).

Two of the alleged perpetrators with access to other potentially vulnerable people also had known histories of abuse of adults. *It is notable that the actions taken to protect the immediate victims of two of these perpetrators would do nothing to protect future targets.* The relevant social work departments were aware of this and monitored the situation as closely as they could. They were also involved in varying degrees in offering support to these men, one of whom possibly had intellectual disabilities and one of whom possibly had mental health problems.

3.2.3 Risk to children in managed and family settings

For each case, we recorded whether the perpetrator or alleged perpetrator lived with children during and/or at the conclusion of the particular case we studied, as far as we were able to ascertain from the information available. Here we have followed the same decision rules regarding inclusion of cases, i.e. where reference was made to "*multiple acquaintances*"/"*local children*" as perpetrators these have conservatively been counted as two extra alleged perpetrators. Similarly, where a care culture/agency's management structure resulted in abuse, the case is not included here. In addition, this analysis is restricted to co-resident children.

Table 2: Alleged perpetrators' history of child abuse and future contact with children

	Previous proven child abuse	Not known	No previous proven child abuse	Total
Co-resident children	1	1	3	5
Not known	1	22	8	31
No co-resident children	2	3	12	17
Total	4	26	23	**53**

Four of the alleged perpetrators had a proven record of child abuse, at least one having served a prison sentence (*). In this last case the alleged perpetrator's record was considered to put adults (*) at risk while contact with children in the family was entirely barred (*) and risk to other children assessed (*). In this

instance the police were kept informed of the social work department's concerns. For the majority, however, there was either insufficient information, or there was as far as the available case records indicated no evidence of child abuse. In five of the cases the alleged perpetrator lived with a child or children as well as other adults. As we note in discussing social work interventions in cases of alleged adult abuse, this fact led to action with respect to child protection measures. In only one case did an alleged perpetrator of adult abuse remain with access to a child. The relevant *Children & Families Team* was kept fully informed about this situation (*), though this referral was resented and led to a breakdown in the relationship between the social worker and the alleged abuser. This in turn mitigated against the strategy of family support as a means of dealing with the alleged abuse. In a second, decisive action by a social worker who explicitly initiated a vulnerable adult meeting led to her being threatened by a parent and accused of *"...making up lies.."* (*).

3.2.4 Consequences for alleged perpetrators in managed and family settings

Table 3 shows the consequences for alleged perpetrators. The "no further access to victim" category includes cases where measures have been taken to end access either by statutory or private agencies or by the adults at risk themselves, as well as where alleged perpetrators have themselves broken off all contact. The outcomes are all final outcomes, so might have taken some months/years to achieve.

Table 3: Consequences for alleged perpetrators (managed and family setting cases)

	No further access to victim	Some limitations on access/input	Continued access to victim	Total
Any (other) repercussions	5	1	0	6
No (other) repercussions	14	14	19	47
Total	19	15	19	**53**

Interpretation of these figures needs to be informed by several aspects of the cases. First, the alleged abuse was not proven in most cases, while in a significant number the alleged victim wanted continued contact with the alleged perpetrator. However, in only just over one third of instances (35.9%, 19/53) did the alleged perpetrator or perpetrator cease to have access to his/her alleged victim. For just under two thirds of cases (64.1%, 34/53) restricted or total access continued to be possible.

In managed settings in one case (*) the alleged perpetrator resigned prior to an internal investigation which still proceeded (*) and decided on a final warning rather than dismissal. The outcome for an unspecified number of employee perpetrators in response to allegations of negligence following an internal investigation in another care home was a non-specific statement that they "*...had been disciplined according to agency regulations*" (*), while contact with the individual at risk remained unchecked (*).

Alleged family perpetrators experienced the intervention of social workers or in a limited number of cases the police as a primary consequence of the alleged abuse and/or neglect in most cases. Such contact could be clearly highly aversive and resisted (*), while the intervention of the police added to the sense of being put under pressure. Nevertheless, one consequence that could occur in addition to the intervention in the family life was loss of the alleged victim through relocation (*) though action by the family member could preclude this (*). In one case the resulting separation led to the alleged perpetrator being considered to have had "*...grief reactions towards what amounted to a bereavement reaction (he was) distraught and his grief was palpable...*". Support for him was made available (*). No alleged perpetrator in family settings was prosecuted though three were interviewed (*) by the police and two had their case referred to the procurator fiscal (*).

3.2.5 Care culture and abuse of service users

Some care staff failed to maintain professional care standards in response to the behaviour of residents. Here some threshold was passed which resulted in abusive behaviour. Clearly a culture of abuse may develop where such behaviour becomes tolerated or the norm[19], with other care workers drawn into the service culture. With respect to one case (*) this was embedded in a series of other cases in which the perpetrators were found culpable and dismissed. In a second a number of staff members were investigated and some dismissed, though many allegations were not upheld either by internal investigations or the police (*). While it is to be expected that staff training and induction will remedy any inappropriate learning from past experience, this is not necessarily the case (*). For example the staff member alleged to have perpetrated physical abuse in one case had extended experience of working in a long-stay institution and was unable to adjust to the changed requirements of a care home (*).

Such perpetrators may be distinguished from what has been called the *predatory perpetrator*. Predatory perpetrators were identified in the present study, notably one (*) who worked in a service setting giving him trusted access to people with intellectual disabilities, a large number of whom he abused over several years. Control was exerted by the threat to return his victims to an institution, as well as their own feelings of shame should the activities become known (*). In addition, he ingratiated himself with other family members winning their trust. Another predatory perpetrator was identified in a case where a care worker had a history of financial exploitation of at risk individuals (*). It may also be argued that the abuse of at risk individuals in the community (by non-carers) represents a form of predatory abuse. (*). In only one case of a predatory perpetrator (*) did the police find that the alleged perpetrator had been convicted for a similar offence previously and had served a gaol term for the offence. Nevertheless, despite

claims that he had been "*carefully vetted*", he was given access to a highly exploitable individual.

3.3 Use of adult protection guidelines

We draw attention below to a variety of failures by agencies to implement adult protection guidelines with respect to both specific procedures (e.g. reporting the incident) and with respect to their general strategy in undertaking the protective measures. Though we use the word "*failure*", an implicit or explicit choice may have been made in which adult protection procedures were not implemented. This was explicit in one case (*) where in order to maintain family relationships it was decided that the concerns would not be dealt with through adult protection procedures, despite worries being expressed that the neglect might lead to a fatality (*). We have also noted a second case where use of adult protection guidelines was rejected on what appeared to be confused grounds and inconsistently with how subsequent cases were dealt with (*).

The study was undertaken at a time at which adult protection guidelines for individual agencies and for interagency working were well developed. Questions for the future are: (i) how far are such guidelines observed? (ii) are they optimal in dealing with the diverse range of cases that may be anticipated? (iii) how well do they map onto the distinctive philosophies and operational procedures of the many agencies involved? (iv) Finally, what difference will subsequent legislation, notably the *Adult Support & Protection (Scotland) Act 2007* make to the formulation and influence of adult protection guidelines?

3.4 Reviews and case conferences

It is at reviews and cases conferences that the multiple agencies involved in an adult protection case most overtly came together, typically at the initiative of the social work department. Such meetings ranged from essentially ad hoc encounters to deal with specific incidents, through community care reviews already scheduled and designated "Protection of vulnerable adults" and "Adult protection" meetings. Clearly who attended was determined by the nature of the case and the specific issues to be addressed. Minutes were not always available on the case file. Where they were available, it was clear that considerable time was spent reviewing the case, assumedly to ensure that all attendees were fully in the picture.

The decisiveness of the actions arising from the meetings varied. In some cases they were non-specific, e.g. to keep the case under review or to continue the pursuit of existing objectives with no specific actions (*). Less frequently a specific action was recorded, e.g. to seek increased resources (*), collect information on the possibility of guardianship (*), or terminate a day centre place (*).

Involvement of the alleged victim or family members varied from case to case and could be inconsistent within a case (*). Some alleged victims played no part in any meetings, typically because of judged lack of capacity or because it was thought they would become distressed (*). Their input was mediated by a social worker who would visit and sound them out prior to the meeting. Alleged victims

were rarely represented by independent advocates (see section 3.7). Where family members were closely involved in the case, usually through close communication with the social work department, they attended the meeting and their input was assimilated and informed outcomes

It is the day to day collaboration that results in successful interagency collaboration rather then adult protection meetings. These have, however, an important function in reviewing cases and information sharing, which can lead to specific actions being decided (*).

3.5 Risk Assessments

Risk assessments were an explicit part of adult protection procedures and were included in some local authorities' adult protection recording (e.g. *). Detailed risk assessments when undertaken rarely used a formal protocol though these were employed in three cases, one in a managed setting (*) and two in family homes (*). These were undertaken, for instance, by a forensic nurse at the instigation of a psychiatrist (*), and jointly by a social worker and occupational therapist, with additional input and at the explicit instigation of the multi-agency team (*). Direct input from an occupational therapist with respect to arrangements in the family home contributed to this assessment, as did input from dietician, physiotherapist and speech and language therapist, as well as a hospital consultant and staff. The risk assessment took three months. The document was based on an NHS protocol and was subsequently adopted by the child protection unit. Absent from this list of collaborators were day centre officers whose input would in some measure have modified the risk assessment.

The issue of risk assessment was also raised in further cases (*). In one, the past relationship between the alleged victim and alleged perpetrator indicated risk of friction between them but was never subject to formal risk assessment. In the second the social work department turned to a criminal justice specialist to assess the risk to an adult of a man who had been imprisoned for child abuse. Here the view was that the man was not likely to be a risk to the adult (*), though this view had no bearing on the social work department's subsequent monitoring of the man's possible sexual relationship with the adult which was protracted, intrusive and totally inconclusive (*). Subsequent attempts to undertaken a formal risk assessment were initially delayed by the unwillingness of the alleged perpetrator to co-operate and then when he did agree, by the unavailability for over a year of criminal justice staff to have time to undertake the risk assessment (*). The risk assessment was never undertaken (*).

3.6 Legal considerations in cases of alleged abuse

A variety of legal provisions was considered by social work departments or by other agencies in the context of adult protection meetings in relation to cases of alleged abuse in both managed settings and family homes. Of these guardianship was frequently pursued (see below). With one exception, other types of legal provision were raised only as possibilities and not pursued. Action under the *Mental Health and Treatment (Scotland) Act 2003* or its predecessor was suggested in three cases (*) but not followed up. Guardianship was awarded under *The Mental Health (Scotland) Act 1984* in one case, and subsequently

under the *Adults with Incapacity (Scotland) Act 2000* (*). In this same case family members requested that an alleged abuser of their relative be "sectioned" under *The Mental Health (Scotland) Act 1984*, a line of action dismissed by the council's legal department. With respect to one community based case an Antisocial Behaviour Order was considered as was eviction, both being rejected (*). Consideration was given to use of the *National Assistance Act 1948* but rejected on grounds of how little it was used (*). Similarly an injunction to prevent parents removing their adult child from a protective residential placement was considered and abandoned on legal advice (*). All of these avenues were considered because agencies judged that the means at their disposal did not offer the potential to achieve protective control over the person's circumstances and/or behaviour.

The most likely course to be considered and in some cases adopted was welfare and/or financial guardianship under the *Adults with Incapacity (Scotland) Act 2000*. While the principles of guardianship were well understood, the conditions that had to be met to achieve guardianship under the Act were less so. Nor were the actual implications for adult protection of guardianship as a means of adult protection. This may be illustrated through the case of a woman who would conventionally be considered to have mild intellectual disabilities (*), but with a high level of cognitive capacity. The possibility of guardianship was raised from the first meeting to reduce the risk to her of sexual exploitation. The attempt to manage these risks was initially through highly coercive supervision and restriction on her freedom with which neither the social work department nor the provider were happy (*). The assumption was that guardianship would legitimise supervision and facilitate it, a view that was unconvincing to both the MHO (*) and a key case worker. Psychological assessment focussed specifically on the woman's ability to protect herself from predatory behaviour, concluding she lacked capacity in this respect, but apparently no other. With advice from the local authority solicitor, guardianship was applied for, still with some concerns on the part of the MHO and continuing disagreement from the social worker. In the event, a question mark hung over the decision with respect to what would change in the situation, given that not only was intense supervision still considered necessary by some parties, but concerns to ensure this was "least restrictive" continued to be urged (*). In a second case when welfare guardianship was awarded to a local authority, the powers were used progressively to ensure protection and monitoring of her relationship with a co-habiting alleged abuser until her decline in mental health led to exercise of the powers to remove her to a nursing home (*). It was noticeable in this case that the social work department showed considerable restraint in exercising guardianship powers in a proportionate manner, given that guardianship was mooted as a strategy to remove her to a care home (*) three and a half years before the move was enforced (*).

Use of the *Adults with Incapacity (Scotland) Act 2000* was preceded by requests by social work departments for an assessment of the individual's capacity. Assessments of capacity formed an element of the protective activities of agencies in nine cases overall, three in managed settings (*) and six in families (*). In some of the other cases, particularly those involving people with dementia in care homes, incapacity had been established prior to adult protection concerns arising.

In some cases professionals raised the issue of guardianship with respect to individuals who at face value clearly had capacity. Such initiatives were rejected, for instance, by MHOs or council solicitors whose understanding of the legislation was clearly more informed (*). In one case guardianship was pursued though it was evident that the individual had a high level of competence to take decisions, though not, it was deemed, with respect to her personal safety (*).

Where tension existed between the social work department and a family member, guardianship was also considered as a means of preventing the relative from removing the individual from a managed setting to which they had been relocated as a protective measure (*).

It was evident that the guardianship application process was a lengthy one and could not provide an immediate response to serious concerns. For example, in one family case in which neglect was potentially life threatening. It took just over 12 months from the initial decision to the application being made (*), resulting in interim financial guardianship being granted shortly afterwards (*) and interim welfare guardianship some months later (*).

3.7 Advocacy

Independent advocacy was rarely involved in any of these cases. One man with intellectual disabilities requested advocacy support (*) and was introduced to an advocate whose support was seriously curtailed by resistance from family members (*). One relative who was the alleged perpetrator sought and received independent advocacy on behalf of the alleged victim, though it was inferred that his expectation was that the advocacy worker would support his view of the situation (*). A second advocacy worker also engaged in this case represented the views of the relative to the social work department (*) regarding a series of allegations by a relative of ill- and poor quality- treatment in a care home. The advocate appropriately referred concerns to the social work department (*) which communicated with the advocate on the outcome of her enquiries. Where a highly restrictive adult protection strategy was pursued in another case it was urged that independent advocacy should be prioritised, though this had not yet been pursued. In one further case the presence, but not the input, of an independent advocate was consistently recorded in the minutes of adult protection meetings; we were unable to interview this advocate.

In one family case an advocate became involved though the way in which this came about was not documented (*). It appeared that the advocate's role was in relation to both the alleged victim and her family, and the advocate provided a high level of support to the latter (*).

It should be noted that advocacy is potentially of considerable importance in situations in which, despite concerns on the part of social workers, the alleged victim is firm in denying abuse and is finding the intervention unacceptable and intrusive. In one case where this occurred consistently over a number of years, at no point was representation offered to the alleged victim (*), though the alleged perpetrator was invited to bring a supporter (not a designated advocate) to case

reviews (*). The conditions under which decisions are taken regarding the offer of independent advocacy need to be made explicit in this, and other types, of case.

4 INTERAGENCY WORKING IN CASES OF ALLEGED ABUSE

We have maintained a distinction between allegations of abuse that have occurred on the one hand in managed settings, i.e. care homes, day centres and supported living in the community, and on the other, in family homes. This decision is based on some of the differences in the processes of investigation to be discussed here and in Section 4.2. However, within cases the distinction is not absolute. In some cases allegations of abuse began while the person lived in the family home, but continued involving different perpetrators following a move to the community (*) (see figure 4). Such cases receive attention in both sections 4.1 and 4.2. Nor in terms of process are the categories absolutely distinct. For example, as we shall see, support by social workers of alleged victims and their families is evident in both the managed setting and family home cases; the police encountered similar difficulties in collecting evidence that would stand up in court in both contexts; confusion over issues to do with the capacity of alleged victims also occurred across the two settings.

4.1 Allegations of abuse in managed settings: Interpretation and implementation of agencies' own and others' roles

The detailed case record analysis here focuses on 14 cases in which the alleged victim lived in a managed setting, i.e. one in which staff support was available. Here we use the generic term "*managed setting*" to cover all forms of residential provision, home support in the community and day services. Of the 14 cases we are treating as managed setting cases, 11 involved alleged abuse in day or residential settings (*), and three involved abuse/risk in the community, but with protective responses developed in the context of supported living services (*). The alleged abuse, however, may or may not have been perpetrated by staff or residents in these settings. The alleged perpetrator may have been from another service setting or a member of the wider community.

We estimate that in the 13 settings from which these cases were drawn, 30 other cases of alleged or proven abuse were cited. These were far from evenly distributed over the 13 settings: in those in which more than one individual was allegedly abused the number of cases ranged from three to 16. Though, therefore, we take as our starting point the individual cases for analysis, some of our observations are also based on reference in the case records to the wider cases in which abuse of multiple individuals allegedly occurred.

Below we describe the role of the principal agencies in responding to allegations of abuse with respect to their own role and in collaboration with the other agencies. Here we focus on: (i) the social work department; (ii) the Care Commission; (iii) the NHS (typically general practitioners (GPs) or consultants); (iv) the police; (v) private providers of services.

Within any single agency there may be multiple players whose interaction merits comment, e.g. within the NHS, community psychiatric nurses, GPs and consultants all may play a part. In some cases other agencies or departments

become significant, e.g. the local authority housing department or the senior managers of the care home company. Information on the part these play in an individual case will be introduced under the relevant category, i.e. (i)-(v) above.

The duration of each case is given in figure 6 and we will comment later on comparison with figure 8 (section 4.2) below which deals with alleged abuse in family settings.

Figure 6: Duration of cases in managed settings from initial recording of concerns regarding possible abuse

Managed settings

	Days to reporting to external agency	**Period from first concerns to resolution of protection issues**	**Main protective interventions(s)**
1	60+	11 weeks+	Relocation of victim
2	Immediate	9 months	Arrest of perpetrator (immediate) Prosecution and jailing of perpetrator
3	8-15 months		
4	3	8 months	Closer monitoring of victim in existing setting Relocation of victim (after 8 months)
5	9	6 weeks	Suspension of perpetrator (after 4+ days) Relocation of perpetrator
6	19	5 weeks	Suspension of perpetrator (after 19 days) Dismissal of perpetrator
7	Immediate	3 months	Suspension of perpetrator (immediate) Relocation of perpetrator
8	5	7 weeks	Suspension of perpetrator (after 5 days) Disciplinary action against perpetrator
9	1	7 weeks	Suspension of perpetrator (after 1 day) Disciplinary action against perpetrator
10	1	3 weeks	Closer monitoring of victim in existing setting
11	n/a	13+ months *and ongoing*	Relocation of victim (after 3+ weeks) Close monitoring in managed setting Guardianship proceedings commenced
12	n/a	17 months	Relocation of victim (after 8 months) Support and monitoring in community setting Second relocation of victim (after 17 months)
13	Immediate	13 months *and ongoing*	Closer supervision of victim Perpetrator arrested (later released) Guardianship proceedings commenced
14	n/a	7 years *and ongoing*	Several early relocations of victim Support and monitoring in community setting

For the purposes of this figure we have considered as decisive protective action those interventions which ended or significantly changed the terms and/or level of access of the alleged perpetrator to the adult at risk. This might have involved relocation of the adult, for instance, or termination of employment in the case of abuse perpetrated by a staff member. It is important to note, for managed settings to some extent and even more so for the family settings discussed below, that multiple factors might raise questions about how appropriate and/or feasible such interventions might be in some circumstances. The absence of "decisive protective action" as defined above does not necessarily imply the absence of professional input: sometimes there was extensive monitoring and/or other input.

Several agencies were involved in all cases, collaborating in a variety of ways depending on the case. The specific agencies are presented in figure 7 for managed settings.

It should be noted that *involvement* here means that the agency played an active role in the case. For example, notification of concerns to an agency that did not become directly involved is not included. Social work and care staff (residential and day service) are typically involved in nearly all cases. It is the principal agencies identified in figure 7 that are the subject of the following analysis of interagency working.

4.1.1 *Social work*

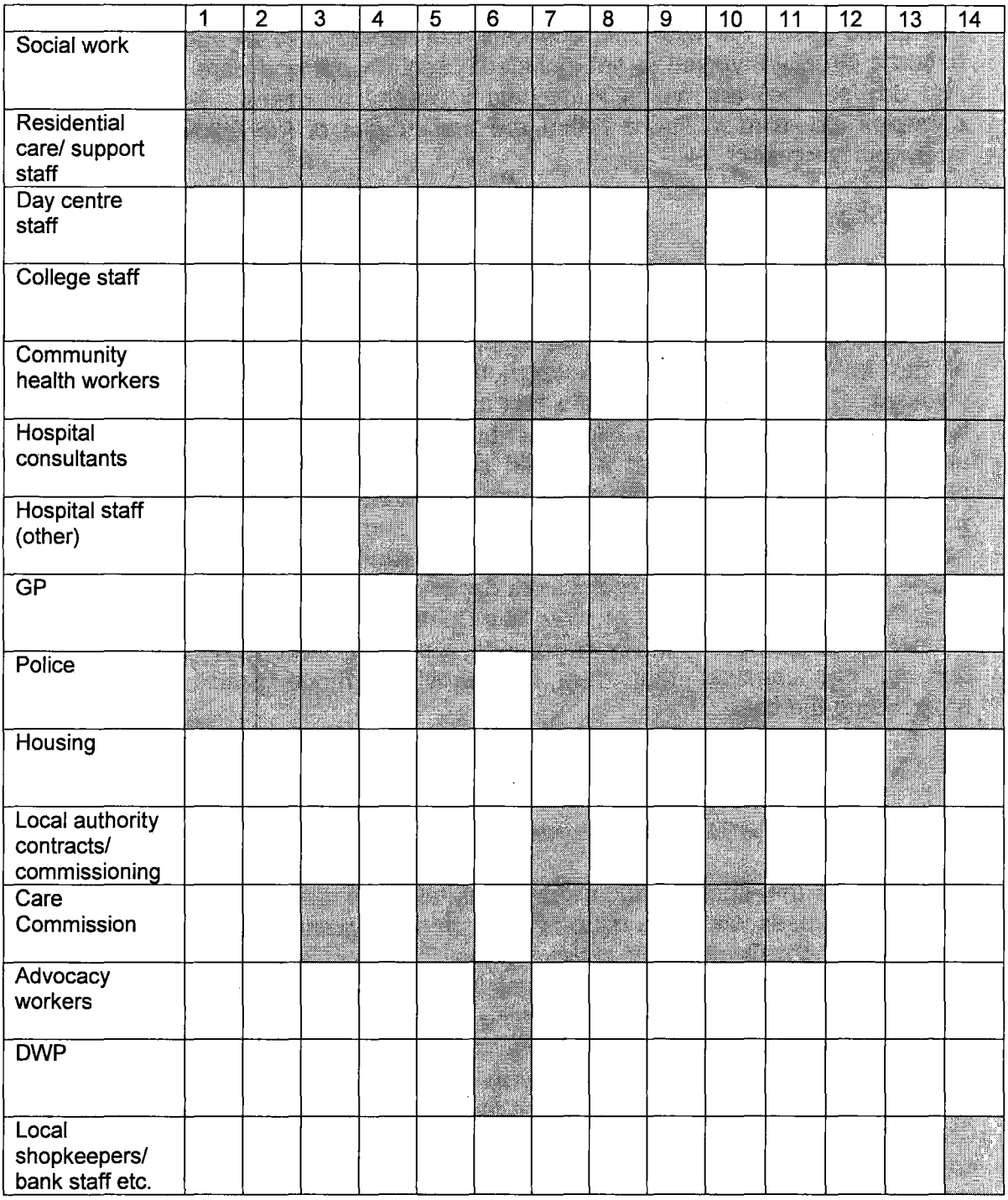
As may be seen from figure 7, social work departments were centrally involved in all allegations of abuse in managed settings and in the wider community. With respect to the victim, his or her family and other involved agencies, a member(s) of the relevant social work department should be directly and consistently involved. This reflects in part the fact that the social work department was the lead agency in multi-agency initiatives, but also its duty of care to alleged victims and their families. However it should be borne in mind that referrals for the present project did come from social work departments. Perceptions of the social work department's role by social work staff and by other agencies was not, however, necessarily that clear cut. Nor did adult protection guidelines usually shape the way in which the social work department progressed the case. Indeed, social work interviewees, in answer to a question on the value and use of adult protection guidelines, typically expressed a positive view regarding their value, but did not consider that they had provided much practical direction in progressing the case.

4.1.1.1 Own role

SOCIAL WORK DEPARTMENT LEADERSHIP

Examples of the social work department taking a decisive role as leader in interagency cases were in a minority, though three good examples may be cited. In a case of an allegation of serious sexual abuse of a woman with intellectual disabilities, the social work department from the outset took a decisive lead in convening an adult protection meeting which involved the local authority's criminal justice department, service providers and police. The approach adopted involved not only supportive and protective measures for the alleged victim, but a much wider consideration of other possible victims of the alleged perpetrator. Child protection issues were also raised and dealt with. Throughout this case the social work department remained central to adult protection procedures and took responsibility for multiagency meetings. In a second case in response to an allegation of physical abuse of a woman with dementia, the social work

Figure 7: Agencies actively involved in responding to the protection concerns in managed settings



department took the initiative with respect to co-ordinating interagency working. This entailed regular and appropriate contact with all other agencies (NHS (*) the Care Commission (*), police (*) and the provider agency (*), the alleged victim (*) and family members (*). Third, alertness by a staff member in a hostel to a passing remark by a woman with intellectual disabilities regarding a male staff member's sexual activities alerted social work mangers to possible concerns regarding this staff member. Referral to the police was immediate, with the police investigation finding clear documentary evidence of abuse of possible 16 individual with intellectual disabilities (*).

Where multiple allegations were made, the social work department was in the position of leading on individual cases, but also of confronting the wider malaise that such incidents may reflect. In one case of multiple allegations of abuse while the social work department continued to intervene to improve the situation and contract monitoring visits were undertaken, it was 8-15 months before decisive action was taken (*). In a real sense the social work department led in this case though the effectiveness of the leadership was subsequently questioned internally (*).

In seven other cases, (*), however, the social work departments, though involved throughout in processing the allegations, did not take a decisive leadership role in relation to investigations into the allegations of abuse by staff or fellow residents in managed settings. In one case a genuinely functioning interdisciplinary team was not established until almost six years into a case (*).

While there is extensive evidence of internal communications within social work departments regarding each case, this did not centre on explicitly defining the department's leadership plan. In addition, lack of leadership planning could result from assumptions being made regarding what was happening elsewhere, e.g. because the care home was investigating the allegation the well-being of the victim was protected, or since the Care Commission still permitted admissions to the care home all was well. In such cases the course of events was not strategically or operationally shaped by the social work department. In one case the provider and police worked in parallel to the social work department, even holding a meeting at the same time as a social work department review, unbeknown to the latter (*). Confusion in this case extended to the social work department believing the police had conducted an investigation when they had not (*). Communication regarding police involvement was here between the social work department and the provider, not the social work department and the police (*). In a further case the social work department advised the family complainant to report to the Care Commission on the grounds that the care home's internal investigation was inadequate and the Care Commission would proceed with its own investigation. This reflected the social work department's view that the alleged neglect related to management issues within the home, which were not best addressed through adult protection procedures. While this reasoning seems logical, it does raise questions about the fit of adult protection guidelines with practice, given that this authority's guidelines extended to neglect from any source and placed responsibility for bringing in the Care Commission with the social work department.

This lack of clarity in how the social work departments should proceed may be seen in two cases (*) in which social workers considered that the family of the alleged victim should be involved in the decision to report the allegation to the police. There seems little justification for giving families the opportunity to influence this decision though clearly they should be informed of all relevant aspects of how the allegation is being dealt with. Elsewhere the social work assistant involved was unclear whether the police had a role in the case (*).

It is also important to note that independent or private providers are under contract to the local authority which has commissioned the provision. While such contracts embody a general duty of care to individuals, it was unclear how specific the obligations of providers were with respect to individuals at risk. Different perceptions of how risk was to be managed could lead to tensions between the social work department and the provider (*).

In only three of the cases examined here was there any attempt to draw together the events and experiences arising in the case to ensure some measure of reflective learning. In one, an interagency review was convened to "...*get closure*..." on the case, implicitly providing the opportunity for reflective learning (*). However, this initiative was to some extent diluted by the police reluctance to participate in the concluding review meeting (*). In the second case (*) social workers wrote an integrative report analysing what had happened and the lessons to be learned that could inform future service management in order to prevent recurrence of serious abuse. In a third case reports by the social work department, the police and the provider agency recorded and evaluated events but there was no comprehensive sharing of experiences that would inform future practice (*).

SOCIAL WORK SUPPORT FOR ALLEGED VICTIMS AND FAMILIES

For social workers the specific adult protection component of the case was embedded in a wider view of social work support for the alleged victim and possibly family members. This can most obviously be distinguished from the role of the police where the focus is *principally* on investigation of the alleged abuse. Social work support for the alleged victim was typically impressive, with multiple visits to them to determine their welfare and needs (*), as well as constructive engagement with other family members and relevant agencies (*). The social work department's duty to provide support for the alleged victim even after the ostensible conclusion of the case was fully met whether the person remained in their present accommodation or was relocated.

Nevertheless, as we shall see in the discussion of family cases (Section 4.2) this supportive social work role may in some cases be construed as overshadowing specific adult protection measures or even acting as a substitute for focussed adult protection procedures. The consequence of this wider client-focussed orientation may be illustrated by four assertions by social workers that their responsibility was to the alleged victim - not to deal with the wider context and alleged perpetrator. For example, a social worker refused to accept the offer by staff to be interviewed about the allegation on the grounds that her responsibility was to the alleged victim who *was* to be interviewed (*). In another case no report was made to the police because protection of the alleged victim was

viewed as the concern of the social worker (*). In a further two cases (*) suspicion of financial exploitation was not reported because it was thought relocation of the individual would remove the problem, i.e. the alleged perpetrator was not to be confronted.

Clearly it was appropriate for social workers to explore wider strategies for the well-being of their clients. These might extend to making arrangement for relocation of the alleged victim not purely in response to the specific allegation but in terms of his/her future general care (*), while liaison with the client's family was generally and appropriately a significant part of the social worker's case work (*). Wider support for the family was a direct outcome of contact resulting from the adult protection case. For example, in one case (*) physical abuse within the alleged victim's family was reported and in another concern with a family member's self abuse (*) was expressed. In others (e.g. *), the social work department might already be involved with respect to family issues.

When alleged abuse took place in the community as distinct from a managed setting, the respective social work departments worked closely with the relevant support agencies to develop well articulated strategies (*). These were highly specific with respect to the type of abuse, e.g. supporting financial arrangements to preclude financial exploitation (*) or ensuring supervision to reduce the risk of sexual exploitation (*).

WHEN IS AN ADULT PROTECTION CASE AN ADULT PROTECTION CASE?

The "seriousness" and plausibility of an allegation influenced the likelihood of decisive, formal adult protection procedures rigourously being exercised and pursued by the social work departments. An allegation of rape by a woman with intellectual disabilities (*) (during a police interview on another allegation) resulted in the social worker informed of this initiating a *Protection of Vulnerable Adults* process on the same day and ensuring that protective measures were in place to support the woman (*). The following day a meeting was convened by the social work department at the woman's supported living accommodation to put in place a multidisciplinary adult protection meeting which was held within seven days. This meeting addressed not only the risk to the alleged victim but set in process a wide ranging review of all risks to all clients who were in contact with the network of people associated with the alleged rapist. This process was rigourously followed through with five further adult protection meetings conducted over the next six months interleaved with less formal or more limited reviews. (However, within a matter of months social work and support staff considered that the woman was again putting herself at risk and further measures were introduced.) A second case of multiple allegations of sexual abuse again resulted in decisive action with the police informed immediately (*). Comparable rigour and speed of response was observed in a case of physical assault (*) in which adult protection measures and interagency co-ordination were put in place as soon as notification of the allegation of abuse was received.

However, acknowledgment that an individual was at risk and protective action taken could precede the case being formally identified as "*an adult protection case*". Several examples may be noted. In one case (*), despite multiple types of abuse across a range of settings in the family home and community it was 14

months before a "*Vulnerable Adult Case Conference*" was convened (*). This decision was not related to any specific criteria or threshold that triggered the conference. Rather the protracted character of the abuse and the seriousness of its consequences were invoked, though our impartial reading of the case suggested the situation had remained unchanged over the 14 month period. However adult protection guidelines which had only recently been introduced were not applied, the social worker noting: *"...it is the capacity to change the situation that is critical – not the process".*

In some cases while allegations of abuse were investigated, the case never formally became an "*Adult Protection Case*" (*). In one case an explicit decision was taken that the protection of the alleged victim would *not* be treated as an adult protection case in order to maintain good relationships both within the family and with the family (*). This approach extended to evidence of financial exploitation with respect to which a decision was taken not to pursue prosecution as "*counterproductive*" (*). In one case allegations of abuse in a care home made by one family member were *not* treated formally within the framework of adult protection guidelines (*) though the allegations were informally investigated promptly by the social worker involved, supported by the alleged victim's independent advocate (*). Several justifications for not instigating adult protection procedures were proposed in retrospect by the professionals involved in this case. One interviewee noted that the family member's allegations had not been specific to time and place, and that he might have had his own motivations for undermining the alleged victim's residential placement; here the social work department's focus was on the behaviour and credibility of the family member making the allegation (*). Use of adult protection powers against him was being considered in separate circumstances (*). With respect to a possible link drawn by this family member between an injury sustained by the alleged victim and abuse, interviewees' justifications for not instigating formal adult procedures ranged from beliefs that the care home's version of events was more credible, to denials that the family member had made such an allegation and/or had pursued it when the events had been explained (*). Additionally one interviewee in this case felt that formal adult protection cases were only those involving the police. In addition there was difficulty in establishing what happened from a range of written and verbal accounts which did not always coincide, nor employ shared terminology. This case evidenced distinctions drawn and factors considered by professionals more varied and/or subtle than those encompassed by adult protection guidelines. In a second case (*), a similar logic was followed with the social work department similarly rejecting the suggestion that adult protection guidelines should be followed (*). Here two reasons were given. The first related to social work practice as being better conducted outside the context of adult protection processes: "*In social work we aim to fix things with minimum intervention; we don't have to go through the whole adult protection flow chart every time.*" (*). The second reason suggested, however, was that the alleged neglect related to management issues within the home, which were not best addressed through adult protection procedures (*). Though beyond the scope of this report, the same social work department subsequently responded to multiple allegations of negligence in a care home by immediately identifying all cases as adult protection cases and proceeding accordingly in collaboration with the Care Commission and the police.

A sub-agenda to some cases was the possible need for adult protection measures with respect to the relatives of the alleged victim. In two cases (*) there were suspicions that family members were abusing each other and in need of protection. In one of these cases action was taken to support the family member (*).

LEGAL OPTIONS

Social work departments, faced with ostensibly intractable situations with respect to protecting the adult frequently raised the possibility of obtaining guardianship under the *Adults with Incapacity (Scotland) Act 2000.* This entailed communication within the department and the involvement of the MHO and local authority solicitor. We have dealt with the appropriateness and outcome of such initiatives in section 3.6, above.

OUTCOMES

All cases involved an attempt to resolve the specific allegations of abuse, but equally as important was the need for ongoing protection for an individual who had been, or allegedly had been, abused. The most direct way in which this was achieved was through removal of the perpetrator, particularly where this had been a member of staff. Otherwise the individual at risk was sometimes relocated to a setting in which risk was reduced, coupled, of course, with on-going monitoring and support (*). With respect to individuals who were relocated the outcomes were regarded by social workers and family members as positive. In one case where 16 individuals were sexually abused over several years, the social work department mounted a careful and sensitive programme of counselling and support within a few weeks of the allegations coming to light (*). In addition, a support group was established to report to the victims on developments in the case and emotional support was given. Meetings with the procurator fiscal were held with victims and staff and contributed to the overall process of support (*). The healing process was further helped by social workers supporting victims successfully to claim Criminal Injuries Compensation.

4.1.1.2 Working with other agencies

WITHIN THE LOCAL AUTHORITY

Adult protection procedures within the local authority extended beyond the social work department. Given the frequency with which relocation from present accommodation (in both managed and family home cases) was part of the protective strategy, housing departments occupied a key, collaborative role. In interviews with housing officers this role was fully acknowledged and awareness of adult protection issues was high. One housing department had developed its own adult protection guidelines. In relevant cases (*) housing officers attended reviews and adult protection conferences. It was critical, however, that in arriving at protective strategies there was close integration of the provision of accommodation by the housing department and the care strategy for which the social work department was responsible. In only one case (*) was there significant disagreement on what was required, the housing department judging that the at risk individual required much more intensive support than the social

work department provided. Significant difficulties with the placement led to housing exploring a variety of legal means to end the tenancy. In the event a further relocation provided the solution.

Commissioning/quality and standards departments became involved or were notified in several cases (*), principally because of wider concerns regarding the quality of care in the facility. Where such concerns were inconsistent with the provider agency's overall contractual obligations then direct intervention could follow (e.g. *). In one case the commissioning department raised the possibility with the social work department that adult protection procedures might be implemented (*), a suggestion that was not followed.

Local authority solicitors were involved in some cases where a decision had been taken to proceed with guardianship under the *Adults with Incapacity (Scotland) Act 2000* (*) Given the misconceptions several social workers had regarding the conditions permitting guardianship, solicitors, together with mental health officers, played a key role in determining the course of adult protection cases. These issues were discussed above in section 3.6.

We have already commented above (section 3.5) on one case in which social workers approached their criminal justice colleagues with respect to risk assessment of a know (child) sex abuser (*).

NHS

The relatively specialised nature of NHS input to adult protection cases in managed settings meant that social work departments were clear with respect to the circumstances in which referrals to GPs or CLDTs were appropriate. This is not to say that NHS staff invariably agreed that the outcome requested by the social work department was appropriate (*) or that what was requested could be implemented.

There was some evidence that members of the medical profession had a lower threshold than social workers for considering that specific adult protection measures should be implemented (*). Both explicitly and implicitly on occasions GPs and consultants were critical of lack of decisive action on the part of social work departments (*). We consider this a reflection of the distinctive cultures of the two professions, with social workers attempting to deal with adult protection issues in the context of wide ranging case management processes and the medical profession focussing more on specific "treatable" aspects of the situation, e.g. self-neglect that can be dealt with by relocation and increased supervision.

POLICE

The "seriousness" of the allegation, particularly with respect to alleged sexual abuse, led social work departments immediately to report such incidents to the police, who in turn initiated investigations. In two cases of "serious" allegations (rape and multiple rapes) cases were progressed to the point at which the procurator fiscal's office initiated prosecutions, one of which resulted in conviction, while changed circumstances of the other alleged perpetrator led to the abandonment of the case.

In some cases there was a lack of clarity by the social work department with respect to reporting the allegation of alleged abuse to the police. Neither the threshold at which reporting should take place nor the criteria for reporting were explicitly stated. In one case reporting was undertaken by the care home in which the allegation of abuse had been made with no bilateral contact between the social work department and the police throughout the case (*). In another case, as noted above, the social work department did not consider referral to the police relevant on the grounds that this was an adult protection issue and prosecution of the alleged perpetrator was not of concern (*).

One incident that was unique to a single case did reveal a lack of clarity with regard to the respective roles of the social work department and the police. Here an alleged rapist was released on the instructions of the procurator fiscal. The social work department and police each saw the other agency as having responsibility for protecting at risk individuals from the released individual. This issue was not explicitly resolved, though intensive protective measures for the alleged victim and other at risk individuals were maintained and strengthened by the social work department. Though the relevance of the *Multi Agency Public Protection Arrangements* was noted by a social work department interviewee, this was entirely speculative and there was no direct reference in case notes to *MAPPA.*

In the one case where the social work department and police collaborated throughout the entire case and that resulted in prosecution, social workers judged that relationships with the police and procurator fiscal's office had improved significantly through the experience of successful interagency working (*). In general social workers reported improving working relationships with the police, though in the past communication with the police was extremely difficult to the point at which there were suspicions on the part of social workers of "*...evasion..*" (*).

INDEPENDENT AND LOCAL AUTHORITY PROVIDERS

Since it is highly probable that in the case of managed settings allegations or suspicions of abuse may first come to the attention of provider agencies' staff, their part in initiating adult support and protection procedures is critical. Examples of good practice were noted, in which the provider responded immediately with appropriate protective measures *and* notified the social work department timeously. In the best examples of such an approach the social work department was notified by the provider within hours of the allegation being made (*). In such cases the social work department then took the lead decisively, working with the provider to put in place effective adult protection measures.

Relations between the social work departments and care homes in the context of reported allegations of abuse were at times confused (*) and even fraught (*). This situation arose because of lack of procedural clarity on the respective roles of the social work department regarding the care home and its agency processes, as well as unhappiness on the part of the social work departments on how the care home was dealing with the allegation. Specific examples of the causes of such unhappiness included delay in reporting the allegation by the care home and

reporting (*) to the wrong local authority (*). Such delays were influenced by the care home manager's perception of the nature of the abuse (i.e. theft, assault etc. would constitute abuse, while manhandling a resident might not). This, however, is to miss the point that it is not the nature of the alleged incident which should determine reporting, but the fact that an allegation has been made and requires investigation. By the same token some care home managers (*) felt that they were not viewed as partners by the social work department and had effectively been judged as having failed.

One area needing clarification is the significance of internal investigations by the provider in relation to the lead responsibility of the social work department. Appropriately care home agencies undertook internal investigations in line with their own procedures. However, this seemed to preclude the social work departments from carrying out their own independent investigations. (This was particularly so where the police had also investigated and not proceeded with the case.) In one case (*) the documentation on the outcome of an internal investigation was requested by the social work department but never received.

The emphasis on the role of the social work department changes in some respects where the individual lives in a supported (non-family) setting in the community. Here the social work department has the obligation to support the individual by supporting the provider agency. In one case (*) the social work department was instrumental in relocating the man to his own tenancy with an independent agency's support. However, absence of a care manager and refusal to share information with that agency on grounds of data protection constrained the agency's work. In another case the social work department advocated a more restrictive approach to the individual's behaviour than that wished for by the more "liberal" support agency (*). This difference reflected in part the social work department's perception of itself as a publicly accountable agency unprepared to risk public opprobrium if things went wrong. Additionally, ethical issues concerning the appropriateness of the provider supporting certain choices made by the client influenced the decision. We draw attention to this one example as an illustration that, as with the social work-NHS comparison, there can be deep rooted cultural differences in views *implicit* in collaborative work. Similarly, in a further case the social work department found itself in disagreement with the council's own housing department regarding the degree of support required by an individual relocated for protective reasons (*).

4.1.2 Care Commission

Some of the cases studied here preceded or overlapped with the foundation of The Scottish Commission for the Regulation of Care (The Care Commission). Prior to the passing of and implementation of the *Adult Support and Protection Act (Scotland) 2007* the Care Commission had published its own *Interim Procedure for Care Commission Staff in Respect of Adult Protection* (Care Commission 2007[20]). (This document has been superseded by a post-Act policy and procedure document[21].) The twin, but closely related, elements of adult protection are expressed as: "*...to provide the mechanism whereby Care Commission staff can consider adult protection matters, both in the context of assessing the policies and procedures of providers and in responding to adult protection concerns they may come across in their day to day work.*" (p.3). As we

shall see, the "coming across" of concerns may result from direct allegations relating to adult protection from a variety of sources. The document deals in detail with both aspects of adult protection. The document explicitly acknowledges social work as the lead agency and directs "...*the immediate notification of the relevant social work department...*" (p.10) in the event of allegations of abuse being made. In parallel, the police may also be notified.

4.1.2.1 Own role

The Care Commission became involved in cases through a variety of approaches: (i) from the care home (*); (ii) from the alleged victim's family (*); (iii) through notification by the social work department (*); and (iv) through a member of staff making a direct complaint of multiple examples of abuse/poor practice (*). Responses to such reports were broadly in line with the two related functions noted above. In relation to the provider, Care Commission staff saw their role as ensuring that investigation of the allegation was properly conducted, rejecting in one case a cursory and essentially informal internal investigation by the care home (*). In a second case in which a staff member reported several incidents of abuse/poor practice, the Care Commission investigated meticulously upholding some of the complaints and criticising the provider for shortcomings in its own investigatory procedures (*). In a third the commission was critical of the provider for lack of awareness of interagency guidelines and lack of consistency between the provider's own and interagency guidelines (*). This criticism extended to the social work department for failing to ensure the provider was aware of guideline requirements. In a further case in which the social work department had taken a decisive lead, the Care Commission deferred consideration of the allegation until a future inspection (*), i.e. in line with its wider remit in adult protection.

In three cases the role of the Care Commission as perceived internally by staff was unclear with a significant disagreement between staff in one case. In another the role was expressed as "*information gathering*". Though this activity could be considered appropriate to the wider evaluation of the service, there was no evidence that this process had led to any action on the commission's behalf. In a further case (*) the Care Commission did not carry out its own investigation of the care home with respect to the allegation, the reason given being because the alleged perpetrator was a resident, not staff member (*). The rationale for this decision is unclear given that the care home had responsibility to have measures in place to protect residents regardless of the source of the abuse.

4.1.2.2 Working with other agencies

Co-ordinated working with the social work department was not evident in some cases (*). For example, in one case the Care Commission did not communicate to the social work department that it had received a report of an internal enquiry from the care home (*), nor did it inform them of how it was proceeding. Such a communication, while not specifically cited as required in the Care Commission's adult protection interim procedure[22] for Care Commission staff, would seem to be desirable with respect to the overall collaboration with local authorities noted in the procedure (*Responding to allegations*, p.10). In a second case (*), the Care Commission implicitly assumed that the social work department was the lead agency with respect to the allegation, though in the absence of a clearly stated

adult protection strategy by that social work department this led to criticisms of failures in actions and communication by the social work department. For example, Care Commission staff assumed that it was the social work department's role to report one case to the police, though at the time its own policy in this respect clearly permitted such direct reporting[23]. It also saw the social work department's role to keep the commission informed regarding the outcome of police investigations – a view not held by the social work department. In another case the Care Commission proposed a joint investigation with the social work department but effectively took the initiative in progressing the investigation (which was accepted by the social work department). In this and a second case (*) there was also evidence of confusion between the two agencies regarding responsibility for decision making and communication. In a further case the Care Commission did not pass on information from the care home's inquiry or its own subsequent actions (*).

4.1.3 National Health Service

The cases in the present study were of allegations of abuse in non-NHS settings. Clearly where abuse is alleged to have occurred in an NHS facility or NHS community service, the involvement of health service workers and compliance with that agency's own adult protection procedures would become central to any consideration of NHS adult protectionactivity, e.g. responding in line with local NHS procedures[24]. In the present study the involvement of NHS staff stemmed either from direct referral of an alleged victim for clinical reasons by the social work department or provider, or as a result of direct healthcare engagement with the alleged victim, a relative or alleged perpetrator (*).

4.1.3.1. Own role

NHS involvement was highly dependent upon the nature of the case. It could be very peripheral (*) with inspection of injuries by a GP to determine the possibility of abuse in one case, or involvement in an adult protection case conference (*). A GP was called in by one family member to review her relative's medication which she considered was being mis-administered (*), implicitly bringing the GP into her own adult protection efforts. This type of involvement did not, however, preclude more direct intervention by GPs in expressing views to the social work department or to a family member making the allegation of abuse (*).

In other cases detailed psychological/psychiatric assessments were undertaken by a community psychiatric nurse (*), psychologist or psychiatrist (*), sometimes located in a CLDT. Here the referral entailed a request to determine capacity. The principal reasons for such assessments from the perspective of the social work department were to establish: (a) capacity to determine if guardianship was an option as a means of ensuring protection (*); (b) in two cases to determine competence to appear in court (*); (c) to facilitate the individual's understanding of her/his own potentially abusive behaviour (*); (d) psychological therapy and/or behavioural management (*), or (e) the possibility of sectioning under the *Mental Health and Treatment (Scotland) Act 2003* (*). Clearly in applying professional skills to these specific issues NHS staff contributed to, but was somewhat external to, the detailed process of adult protection.

4.1.3.2 Working with other agencies

THRESHOLD FOR DIRECT ADULT PROTECTION INTERVENTION

The principal point of NHS contact for both the social work department and alleged victims in managed settings was the GP. GPs had a clear understanding of the role the social work department with respect to its protective remit and the possible strategies that might be employed. For example, GPs looked to deal with self-neglect through relocation (*), urging the social work department to pursue this line of action. The issue of confidentiality surfaced particularly in one case, with the social work department feeling compromised in how it dealt with a situation which was, in retrospect, deteriorating dangerously, due in part to lack of information sharing on the part of the GP (*).

As noted above, with respect to direct intervention to ensure adult protection, NHS staff frequently had a lower threshold than social work staff, a finding which recurs in the case of allegations of abuse in the family.

4.1.4 Police

Twenty seven incidents were notified to the police across all of cases, 19 of which occurred in managed settings. In eight managed setting cases the police were notified of a single incident/set of circumstances over the course of the case (*). In four managed setting cases (*) there was more than one incident/set of circumstances reported to the police over the course of the case. On five occasions a report about the concerns was submitted to the procurator fiscal (*). In only one case involving a managed setting was a perpetrator charged, convicted and imprisoned (*). In a second, an alleged perpetrator was charged but ill health resulted in the case not coming to court (*).

4.1.4.1. Own role

POLICE PROCESSES

From the perspective of the present authors, there was great clarity in the ability of the police to report the process by which the allegation was investigated and the outcomes, reflecting their clear mandate to investigate allegations of criminal behaviour. (In one case a police interviewee suggested that the police were better placed to deal with investigations of abuse than social work departments because of their investigatory competence.)

The police interviewed were clear that their role was to investigate allegations of criminal behaviour, though one police constable framed the police role as consisting of a wider remit to protect vulnerable adults. The procedures followed did not differ from those undertaken in any criminal investigation, though clearly the capacity of the alleged victim or victims had a significant bearing on the collection of evidence. In the one case in which the perpetrator was prosecuted and gaoled, police moved swiftly on allegations by the social work department searching the perpetrator's premises and interviewing a number of people with intellectual disabilities (*). In a further case, police while expressing concern regarding the reliability, capacity and understanding of the alleged victim (*),

nevertheless proceeded to a report to the procurator fiscal. In line with this view background checks were conducted on the alleged perpetrator(s) and where relevant on the whistle blower whether staff or victim, though this course was not invariably pursued (*). Statements were taken from witnesses or those potentially in a position to provide relevant information, while interviews were conducted with the alleged perpetrators unless it was judged that they lacked capacity (*). Police were too willing to accept providers' opinions regarding capacity and failed to explore the alleged victim's competence more fully and drawn their own conclusions. Such an approach would require confidence to relate to individuals who communicate in different ways which in turn is dependent on specialist training. The procurator fiscal conducted interviews with several alleged victims in two cases (*) taking precognition statements, concluding some, but not all alleged victims would be credible witnesses in court.

Against the rigour of most investigations, some examples of relatively superficial investigations were noted. In one case the police abandoned an investigation after interviewing the alleged perpetrator and manager of a care home but not the whistleblower or other staff. No attempt was made to interview the alleged victim who had dementia (*). In one setting where multiple allegations of abuse were thoroughly investigated police chose, on advice, not to interview alleged victims, a number of whom may have had competence to contribute to the investigation (*). In the former case the social work department held the view that the police were not fully committed to investigating allegations of abuse against older people.

REPORTING TO THE POLICE

Reports to the police were usually by social work departments or councils, care homes (*) or the alleged victims themselves (*). The threshold for reporting to the police by agencies was unclear, though appeared to be related to the specificity and seriousness of the allegation, i.e. an allegation of an assault or rape (*) immediately placed the report in the context of a criminal investigation. Reports by four alleged victims were explicitly in response to what would have constituted criminal actions against them (assault and also robbery) (*) and rape (*). In one case, however, in which there was no dispute that a physical assault resulting in injury had occurred, no referral to the police was made because the perpetrator was a fellow care home resident and neither the social work assistant, his manager, the victim's family, nor the manager of the facility in which the assault took place, considered a police report to be appropriate and/or within their role (*).

ABUSE IN THE COMMUNITY

In the context of potential abuse occurring *in* the community, as distinct from in the managed setting, the community police and police units involved in family protection were prepared to engage in collaborative work with the at risk individual, care agencies and/or the social work department in developing a protective strategy (*) or maintaining a watching brief on an individual at risk of abuse from members of the community (*), as well as advising on protective strategies (*).

POLICE COMMENT ON CARE PRACTICES

On two occasions the police explicitly made reference to the quality of care practices in the managed setting in reports on their investigations (*). In one case police enquired regarding staff qualifications (*), while in the second recommendations were offered on care practices (*). As interagency training and working develop, police should become increasingly well informed on care standards and practices, and such judgements may become more frequent. However the status of such comments in the overall process of investigation of an allegation needs to be explicit and understood by all agencies.

OUTCOME OF POLICE INVESTIGATIONS

Only two prosecutions resulted from the 17 cases in which alleged abuse was reported to the police (in 11 cases a report of a single incident and in six cases multiple reports). In one case the perpetrator incriminated himself (*) and was prosecuted for unlawful sexual intercourse, masturbation, fondling, oral sex, indecent behaviour, indecent exposure and taking indecent photographs. A prison sentence resulted. In the other case the alleged perpetrator was claimed to be seriously ill and was not brought to court within the timescale of the study (*). Several police investigations did not lead to prosecutions. One investigation was abandoned at an early stage because of conflicting evidence (*). It was not possible to determine why in this particular case this was a reason for abandonment given that conflicting evidence is hardly unique to adult protection cases. The alleged victim was not interviewed because of reported lack of capacity, though this had not been formally assessed. In a second case the police responded to a call from the alleged victim but allowed themselves to be obstructed from interviewing him by the care home, while in four other cases police were diverted from interviewing the alleged victim by care workers (*). In a comparable situation police abandoned pursuit of an investigation on the assurance of the provider that what had occurred was poor practice, not abuse (*). In these cases an issue is raised regarding who controls police involvement in the case following the initial report. Interview comments draw an analogy between an alleged victim in the family home indicating they do not wish the case to proceed, and the provider acting in the same way – a patently false analogy.

In one case there was extensive direct contact between the victim and the police (*) while in four cases (*) the victim was interviewed with a staff member or social worker present, and in one case the victim was interviewed in the presence of an appropriate adult (*). Statements were taken from staff and family, and police checks and interviews were undertaken with the alleged perpetrators. Medical advice was not sought. In the cases of alleged abuse by care workers, in only one case was an alleged perpetrator found to have served a prison sentence for a comparable crime (*). Despite an extensive and thorough investigation of the alleged fraudster and a strong belief on the part of the police that he was guilty, they did not pursue the case.

4.1.4.2 Working with other agencies

SOCIAL WORK DEPARTMENTS

Aspects of social work-police interagency working are dealt with in Section 4.1.1.2 above.

DELAYS IN REPORTING ALLEGATIONS TO POLICE

Police investigations of allegations of abuse of an adult may be initiated by any of the agencies noted here or indeed by the victim, his or her family, or a member of the public. Reporting a serious allegation to the police was immediate in some cases (*). Where delays in reporting the original allegation occurred (*), these ranged from 9 and 19 days, delays which potentially could have had an adverse impact on the collection of evidence. In one case involving multiple allegations of abuse, several months to over a year elapsed between the provider's internal investigations and notification to the social work department and reporting to the police (*).

Two of the care home or community cases resulted in prosecution of the perpetrator (*). No prosecution ensued in three other cases though the police might themselves have believed that a serious incident had occurred (*). Only in the transparent case of the self-incriminated perpetrator working in a day centre (*) and committing the abuse in a variety of settings was a successful prosecution mounted resulting in a prison sentence. Five cases were referred to the procurator fiscal (*). Following two police investigations (*) the case was not referred to the procurator fiscal. The grounds for non-referral as reported in the police interviews were obscure: (i) lack of a formal complainant (*); (ii) not to overburden the procurator fiscal's office (*); (iii) interview with alleged victim not carried out (on advice of care worker) (*).

THE RELATION BETWEEN POLICE & PROVIDER INVESTIGATIONS

Though not invariably positive (see following section) the views of other agencies regarding police involvement was generally approving. In one case, the provider referred to the sensitivity of the police in interviewing an alleged victim (*). Police procedure invited particular criticism from the Care Commission staff in one case, however, for making their own investigation contingent on the outcome of the provider's internal enquiry (*). Given dissatisfaction with the provider's own inquiry, the Care Commission's frustration was doubly felt as it considered police acceptance of this enquiry pre-empted further investigation.

POLICE FEEDBACK ON CASE OUTCOMES

Despite the generally willing involvement of the police in cases of alleged abuse, a persistent criticism from social workers and other involved agencies, including the Care Commission in one case (*), was lack of feedback on the investigation and its outcome. Indeed, in two cases (*) the designated social worker did not know that the investigation had taken place, or thought it had taken place when it had not (*), while in a third (*) police interacted with the home supporter who reported the allegation and only reported the outcome of the investigation to him.

The outcome of this case was conveyed to the social work department by the housing department which, it is inferred, got the information from the home support worker 15 days after the police investigation was initiated. Feedback on outcomes of investigations was most likely to come through a social worker informally contacting the police, though in the latter case, it was the housing department which notified the social work department 12 days after the decision not to prosecuted. In one case this feedback was elicited by a social worker seven months after the police investigation (*).

In four cases (*) the outcome of the investigation was not reported to the alleged victim, regardless of the individual's capacity. A provider made a similar criticism of lack of feedback (*). This lack of feedback may be seen as one component of the wider absence of any summative review of cases by the involved agencies. However, it would be incorrect to say that the police totally failed to communicate with other agencies. There were many positive examples of effective communication. In one case police notified the Care Commission and asked it to put its own investigation on hold while they investigated, as well as providing information on the outcome of the case (*). In the same case a joint interview with the alleged victim by a social worker and police officer took place.

In the one case in which a successful prosecution was mounted, the procurator fiscal's office maintained excellent communication with victims before and during legal proceedings and after the perpetrator was sentenced. Regular communication was also maintained between the procurator fiscal's office and the victim in the prosecution which was latterly abandoned due to the perpetrator's ill health (*).

4.1.5 Private providers

4.1.5.1 Own role

ADULT PROTECTION IN RESIDENTIAL SETTINGS

All agencies providing frontline support for individuals saw protection of the individual as an element of their role. All care home private/voluntary sector agencies had adult protection guidelines and were committed to safeguarding residents. Parallels with social workers' views of adult protection guidelines were noted, with guidelines having little bearing on the perception of the agency's role with respect to a service user. One respondent referred to the aim as being to respect the individual and promote community involvement, *not to work to guidelines* (*).

REPORTING ALLEGATIONS OF ALLEGED ABUSE

Reporting alleged abuse was most likely to be by care staff (*), though victims and particularly family members were also involved (*). With respect to staff reports, all care providers had specific whistle blowing guidelines and some form of adult protection procedures. However obstacles to whistle blowing (*) were noted, including: lack of clarity as to what constitutes abuse, fear of anonymity not being guaranteed, as well as fear of repercussions (*). Prior to reporting, the first

line of action by the whistle blower was on occasion to deal with alleged abusive behaviour directly with the observed perpetrator (*).

RESPONDING TO ALLEGATIONS OF ABUSE

In only one case did a care home manager respond comprehensively to an allegation of physical assault (*). Here the social work department (*) and police (*) were immediately notified and the GP called to examine the alleged victim (*). The manager also ensured that family members were told about the incident (*). Good communication with the social work department was generally maintained (*). The agency's senior management and legal department were contacted and an internal investigation carried out and brought to a conclusion (*). In a second case occurring in a supported living setting parallel appropriate communication and follow through were found, though the specifics of the response differed in several respects (*). In a third, a supported living setting, the manager informed the police of possible financial exploitation of a resident (*).

Elsewhere there was significant confusion on the part of management and staff in seven managed settings (including, predominantly, care homes) regarding the appropriate procedures to follow in responding to allegations (*). It was assumed in these cases that this was an internal matter to be dealt with initially within the care home, possibly in consultation with senior agency management. In one case a report was made to the police as a matter of protocol, not because a police investigation was judged to be required by the care home manager (*). The preliminary assessment as to whether the allegation was to be pursued was conditioned by various assumptions. First, the allegation if true was not considered of a sufficiently serious nature to warrant a formal adult protection investigation, e.g. alleged abuse might be construed as "only" poor care practices (*). Only "*serious*" incidents merited such treatment, "*seriousness*" being defined as an abusive act by a staff member or sexual abuse (*). Second, past experience of the resident in two cases (*) could lead to the allegation not explicitly raising adult protection concerns. In one case the alleged victim's allegation was dismissed out of hand and the victim's own wish to report it to the police was obstructed on a number of occasions (*). Even a view of the alleged perpetrator could influence the seriousness with which the allegation was taken: *"He's never been violent; he was solicitor!"* (*). In this case there was a clear, inconsistent and diverse attempt to discredit the alleged victim. With respect to internal investigations, there was confusion evident in the recording of the incident and documentation of the steps taken, sometimes with evident inconsistency in claims as to what had occurred (*).

At a more general level, a failure on the part of management to understand the implications of interagency guidelines or specific requirements regarding reporting was noted (*), typically through ignorance of those requirements. Such confusions extended in one case to *internal* communications within the agency, i.e. care home management and agency management having different understanding of their own internal guidelines (*).

Nevertheless, investigations were undertaken with one perpetrator being dismissed (*), one resigning prior to a decision (*), and three who were not found culpable were moved to an alternative care settings. We have already noted the

prosecution and imprisonment of one, multiple perpetrator (*). One accused perpetrator responded by taking a civil action against both the whistle blower and manager (*), which moved to an employment tribunal case (*). In one case there was no formal investigation, though a senior manager from elsewhere in the organisation thoroughly investigated the delay in reporting the incident to the family, their complaint actually being that their relative was unsupervised at the time of the incident (*). In a second case the outcome of an internal investigation was reported to the social work department and the police (*). In both the complaints were upheld and internal procedures with respect to adult protection and staff responsibilities implemented, with findings notified to family and the social work department. In three cases the outcome entailed protective arrangements within the managed setting (*). In a further case staff were reported to have been disciplined in an unspecific way following what appeared to be informal internal investigations which neither the complainant nor the social work department considered acceptable (*).

In one case immediate reporting of the alleged assault to the GP resulted in rapid medical attention (*). In three other cases of physical assaults or serious negligence with physical consequences, the injuries were not construed by care home staff as requiring medical attention, though subsequently one resident required hospital treatment and two, GP interventions (*). In all three cases care home staff considered that referral for medical treatment was unnecessary, in contrast to the views of family members and in one case a qualified nurse (herself a member of staff who intervened on behalf of the resident). None of these cases were construed as adult protection cases.

Though the present study has focussed on individual cases, as noted above (section 1.2.2) in several settings from which these cases were selected there were in reality multiple cases of abuse being investigated at, or around, the same time. There is, then, a wider context of the culture and practice in which our cases are located which has an important bearing on the response to an individual allegation. We discuss this point more fully below.

4.1.5.2 Working with other agencies

PRIVATE AND LOCAL AUTHORITY PROVIDERS AND THE SOCIAL WORK DEPARTMENT

Good quality working relations between providers and social work departments were noted in two cases in particular, entailing timeous reporting and good communication (*). However, in other cases lack of awareness of adult protection procedures led to delays in reporting to the appropriate social work department, 19 days (*), 18 days (*), 1 day (*), and at least 60, but possibly 120 days (*). In one case notification of the alleged victim's family by the care home led it to inform the Care Commission which in turn notified the social work department (*). In a second case it was again the family that reported the incident to the social work department (*). In two cases the care homes' reports of complaints to the social work department were, in fact, complaints about the family complainants who were deemed "...*aggressive*..." to staff members (*).

The relationship between the social work departments and providers could become severely strained when an allegation of abuse was made (*), or when

differing pragmatic and ideological perspectives led to disagreements on how the case should dealt with (*). In the last case the relationship was worsened by a view on both sides that information on the service user had not been shared. There is clearly a significant issue here regarding confidentiality and ensuring that interagency working is optimised as effectively as possible. (In this instance the provider also did not consider the NHS had shared information sufficiently.)

THE PRIVATE PROVIDER AND THE POLICE

While in three cases a police referral was made in the absence of any external prompting to the care home or home support agency (*), in the majority of cases no such referral was made. In one case of multiple allegations of abuse, including financial abuse, no report was made to the police by the providers, the social work department, or indeed, representatives of the service user who in several incidents were the originators of the allegation (*). The police, however, did become involved in several of these cases through reports by others. In two of these cases the view of the manager was that decisions regarding reporting to the police should be left to family members (*), clearly a misconception regarding management responsibilities.

THE CARE CULTURE AND ADULT PROTECTION

The literature on adult protection has drawn attention to the way in which service design and the staff culture may increase or decrease the likelihood of abusive practices[25,26]. Interviewees raised such issues explicitly or implicitly. For example one senior manager investigating the implementation of adult protection procedures in his own agency commented on: *"...a culture of laxity - not negligence – involving lack of training, poor communication, absence of documentation – a culture of lack of leadership, a failure to adhere to agreed and national standards."* (*). Deterioration in a second care home documented by the Care Commission led to a culture of neglect stemming from poor management (*). A service in which staff were poorly inducted, trained and managed encountered multiple allegations of abuse readily attributable to these deficits, with several allegations upheld through internal enquiries (*).

Factors adversely influencing the implementation of effective adult protection measures in managed settings or leading directly to allegations of abuse were identified in several cases, notably:

i. Inadequate initial staff induction and training (*), with training only being introduced after readily anticipated difficulties associated with adult support and protection had occurred. The way in which these shortcomings can act as setting conditions increasing the likelihood of abuse operates at several levels. For example, challenging behaviour which is not managed appropriately may be dealt with in a confrontational and abusive manner by staff. Failure to assimilate values concerned with individual dignity may lead to overtly abusive treatment as in the reference to one service user as "*...a fucking cripple..*" (*) or "*...spasi Jim...*" (*)
ii. Failure to follow agency procedures either on the part of management or staff (*)
iii. Appointment of unsuitable staff because of recruitment difficulties (*)

iv. Poor leadership by management (*) "*lack of staff being supported to use their judgement*" (*)
v. Division in staff group ("*cliques*" *; "*Factions*" (*) arising from a past history of personal antagonism (*) referred to by one senior manager as: "*... major cultural issues...*" and possibly including poor relationships between the manager and alleged perpetrator (*)
vi. Disaffected staff not committed to the service philosophy (*)
vii. Disaffected family members not committed to service philosophy (*)

We would suggest that there is an inextricable link between the overall care culture and the likelihood of abuse. Shortcomings in overall quality of care and the probability of abusive behaviour by staff are likely to be found together. This is not to say that an individual working within a high quality service may not act abusively, only that the probability of this is lowered (*).

A further facet of agency, as against facility, culture is worth noting. There is a strong sense in the cases analysed that blame is passed from the top downwards to the service manager and ultimately the alleged perpetrator. There is no evidence that responsibility is accepted throughout the organisation with, ultimately, senior management having responsibility for abusive behaviour at the service level. In one case involving extensive documentation this passing down is vividly illustrated with no evidence that senior management at any time considered it had responsibility for the state of affairs that had arisen. This is quite distinct from accepting responsibility for remedying the situation once it had arisen, which in this case was rigourously but at times ineffectually undertaken (*). The defence of one staff member that she simply acted as other staff did was rejected as no excuse without management seeing the implications of her defence for their own share of responsibility (*).

4.1.6 Mental Welfare Commission

Reference was made to the MWC in only one managed setting case (*). Here a relative alleging abuse in a care home but, from his perspective, not satisfied with the social work department's investigations, contacted the commission for advice. We did not have access to MWC's response though subsequently MWC contacted the social work department (*) which responded with the case information requested (*).

4.1.7 The role of the alleged victims and family members in managed setting cases

4.1.7.1 The alleged victim: putting oneself at risk?

Alleged victims, family members or alleged perpetrators were not interviewed in the study. The information available, therefore, comes from the same sources on which other sections of this report are based, i.e. case record analysis and interviews with professionals involved in the cases.

The ecological perspective[27] on individuals acknowledges that they themselves may bring something to the immediate situation that puts them at increased risk of abuse. This is not in any sense to blame the victim, but is acknowledgement

that behaviour has a bearing on how potential perpetrators interact with the individual. Nor does such a view in any way justify or excuse the abusive behaviour, though it was thought to do so by the police in one case (*), a view criticised by the Care Commission staff as showing a "*wrong attitude*". However, dealing with the alleged victim's abuse-enducing behaviour was implicit in the protective strategies in a number of cases (*). Four examples from cases in the present study dealt with below will illustrate this point further.

All cases studied were identified because allegations of abuse had come to the attention of an agency, and in due course, to the social work department. The extent to which the victim's own behaviour increased the risk of abuse was highly variable. In one extreme case (*) inappropriate sexual behaviour towards children and adults put him at risk of physical abuse from outraged members of the community, these actions in turn becoming the abusive behaviour from which the individual required protection. In another case (*), the overt possession of large amounts of money led to repeated muggings and financial exploitation. In both cases the individuals were uncooperative with service providers, not considering their own behaviour to be problematical or leading to abuse. In both cases superficial consideration was given to guardianship, effectively to gain control over the individual. However the only available strategies in these and one further case involved complex interventions with the individual including supervision and monitoring in the community, though with attention also given to training the alleged victim in self-protective strategies (*). Given that all three of these individuals had capacity in some if not all respects, issues of human rights and autonomy were raised of which service providers were acutely aware. With respect to a woman with intellectual disabilities who was probably being prostituted and who was allegedly raped, it was considered that she put herself at risk by socialising with sexually exploitive individuals: *"She is extremely vulnerable to unwelcome advances and exploitation by unscrupulous people and finds it very difficult to say 'no'."* (*). In all three cases, part of the support and protection strategy was to develop the skills and/or opportunities of the at risk individuals that would increase self-protection. Evidence of the systematic monitoring of the outcomes of these interventions was not found.

In contrast, in the context of a care home, the behaviour that set the scene for abuse may be basically passive, e.g. lack of co-operation in self-care tasks (*) or may entail verbal exchanges not welcomed by care staff, or more significantly challenging behaviour (*) leading to an entirely inappropriate and unacceptable responses by staff. Resident on resident physical assaults may occur against a background of interpersonal friction (*). At the further extreme some at risk individuals bring nothing actively to the situation but are at risk because of their powerlessness (*).

A small sub-group of alleged victims were of particular concern and interest with respect to the characteristics that put them at risk. They were fundamentally unable to understand and socially mediate relationships in such a way that they acted in a self-protective fashion. Historically, however, they had not been regarded as falling within any of the traditional client groups, though they were viewed as *possibly* having "*learning disabilities?*". In the managed settings, one such case was noted (*) while in the family setting two individuals could be considered from this perspective and are discussed in section 4.2.

4.1.7.2 The family

Families were closely involved in the managed settings and with social work departments in the process of investigating and responding to the alleged abuse (*). With respect to the specific adult protection process the initial concern or allegation could come from a family member (*). This reflects both the acknowledgement of the legitimate interest and concern families have with respect to a family member, even when in care. In extreme cases family members working in concert were able to bring about radical changes in the management of the service (*). A more specific family intervention is exemplified in a case (*) in which the care home did not consider medical attention necessary after an alleged assault. The family disagreed and brought in their own GP. Typically it was the alleged victim's children or siblings who were centrally involved, notably daughters or sisters (*). In one case it was a wife (*). Given the potent influence of family members, consideration also has to be given to the balance between their and the service user's expressed views. In one case reference was made to service users' voices "*...simply being drowned out...*" by those of relatives (*).

The failure to inform the spouse of an alleged victim by either the social work department or her children in order to avoid her distress was reported in a single case (*). Such a decision taken without reference to an adult who clearly had capacity must be questioned, particularly when the spouse was involved in post-case reviews in which this issue might well have surfaced.

As a background to the significant contribution to adult protection that may be made by family members, it must be emphasised that from the outset the process of making complaints and their right to do so without prejudice must be made clear to them. This was not so in one case in which several months of complaining about negligence to care home staff only came to an end when advice was provided regarding formal complaints to relevant statutory bodies (*). Even here there was confusion on the part of the statutory bodies (the social work department and the Care Commission) as to what constituted a formal and an informal complaint. In this case the social work department considered that it was the care home's responsibility to make the family member aware of the complaints procedure.

It should be noted, too, that family members may use allegations of abuse or poor care to support their own agenda, e.g. as a justification for a move from the care home (*) or for a return to the family home (*).

Families were reported to be typically satisfied with the outcomes of the investigations (*), though in three cases (*), they expressed unhappiness about the quality of communication during the investigation of the case.

4.2 Allegations of abuse in family homes

We analysed 11 cases of allegations of abuse in family settings. Though concerns for the individual began in the family home, relocation to a managed setting, usually as part of the permanent protective strategy, occurred in eight cases (*). Some cases have already been dealt with in the context of managed settings, but relevant findings are also considered here with respect to the earlier home phase of the case.

With respect to family relationships there was a wide range of relatives about whom allegations of abuse were made (see figure 4). Additional allegations were made against a range of non-family members in many of these cases e.g. local children, a range of male acquaintances, a support worker and a fellow patient during a hospital stay.

Figure 8 shows the duration of the home cases excluding cases in which allegations of abuse started in a family setting but continued and have been dealt with in section 4.1. These contrast markedly with those for managed setting cases (figure 6). Here adult protection concerns remain active for as long as 15 years. The reasons for the length of time that adult protection is under consideration will be dealt with in the following sections.

Concerns regarding allegations of abuse came from different sources, including the alleged victim (*) and/or service providers in contact with the person (*), a home support worker (*), as well as other family members (*) and neighbours (*). Allegations in several cases were a cause of anger and resentment on the part of alleged victims' families (*). Allegations of abuse by a family member by someone in the alleged victim's service had, not unexpectedly, serious consequences for family-staff relationships (*). In one case this led to counter allegations of abuse against staff and fellow service users (*), allegations that proved demonstrably without foundation (*). A more extreme response was noted in a second case in which a parent threatened to kill two workers involved in adult protection proceedings regarding her adult child (*). Senior management here recommended this be reported to the police (*). (The parent was in due course cautioned by the police (*)).

We discussed in section 4.1.7.1 with respect to managed settings how the behaviour of an individual could put her or him at risk of abuse. Clearly family dynamics in which the stress of caring provided a setting condition for interactions influenced the probability of abuse in some cases. Challenging behaviour, for example, led to a confrontational relationship between a parent and a daughter (*) resulting in the family carer reaching the limit of coping (*). Nor were the consequences of the (alleged) behaviour limited to the perpetrator-victim dyad. Other family members across the generations could be drawn into dysfunctional behaviour, with children's behaviour and marital relationships adversely influenced (*). In one case social workers speculated that difficulty leading to abusive behaviour of a mother to her son was possibly the consequence of abusive behaviour by her husband (*). Thus, the complexity of wider family relationships may set the scene for putting an individual at risk of abuse.

Figure 8: Duration of cases and protective interventions in family homes from initial recording of concerns regarding possible abuse

	Abuse/ protection issues pre-dating entry to adult services	**Period from first concerns as adult to resolution of protection issues**	**Main protective intervention(s)**
1	No	**2 years 5 months**	Support and monitoring in family environment Relocation of victim (after 2 years 5 months)
2	No	**1 year 9 months**	Support and monitoring in family environment Relocation of victim (after 1 year 9 months)
3	**Yes** (disclosed by victim)	**6 years 7 months** ***and ongoing***	Relocation (immediately prior to first agency involvement; resolves first abusive situation) Support and monitoring in community setting
4	No	**5 years 11 months**	Relocation (after 3 months) Support and monitoring in community setting Relocation & guardianship (after 5 years 8 months)
5	**Yes** (documented child protection proceedings)	**3 years 8 months** ***and ongoing***	Relocation (after 3+ years) Support and monitoring in community setting
6	No	**15 years** ***and ongoing***	Support and monitoring in family environment Planning for relocation
7	No	**4+ years**	Support and monitoring in family environment
8	**Potentially** (but childhood files not seen)	**7 years** ***and ongoing***	Support & monitoring in family environment Temporary relocation of victim (after 6+ years of adult services) Guardianship
9	No	**3 years 9 months**	Monitoring & support in family environment Guardianship Relocation (after 3 years 9 months)

Against this background the need for support in care management was clear, though professionals' perspectives on what would ameliorate the situation did not necessarily accord with that of family members'. One parent decisively rejected support from a clinical psychologist who designed a behavioural programme for her to manage her adult child's challenging behaviour (*). Similarly, relocation of an adult child was rejected (*).

Alleged victims sometimes took decisions which put them at risk or maintained themselves in the situation in which abuse was allegedly occurring. This was evident in several of the family cases. Continued contact with an allegedly sexual abusive relative (*) was one example of a woman who frequently made decisions

that increased risk to herself, at least from the perspectives of professionals and other family members (*).

In the context of a family, implementing adult protection procedures was impeded by a number of factors. Lack of capacity on the part of the alleged victim made the collection of evidence extremely difficult, while obstruction by the alleged perpetrator could severely limit any intervention by social workers or other professionals (*). The latter was achieved by simply refusing admission (*), coercion, or influence on, the alleged victim (*), or directly undermining protective strategies, e.g. blocking appointments for assessment of capacity (*), care needs (*) or other appointments (*), including health appointments (*). The wish to maintain control over the alleged victim and his or her life also led to serious tensions with professionals who sometimes saw the person's needs from an entirely different perspective (*). Inconsistency with respect to allegations on the part of the alleged victim also put up barriers to protective measures (*). This reflected ambivalence towards the perpetrator and social workers were fully aware of the emotional bonds that bound victim and perpetrator in some circumstances (*). Equally difficult was the need to maintain a protective strategy through monitoring due to several clear risk factors/warning signs and sustained serious allegations by several family members, when not only did the alleged victim reject any suggestion she was being abused, but all possible objective signs of abuse were found to have alternative, acceptable explanations (*).

Unsurprisingly the intervention of the social work department and/or police led to serious tensions within some families and relationships, particularly when the allegation came from another family member (*).

4.2.1. Interpretation and implementation of agencies' own and other's roles in family cases

We have already commented on the complexity of the family and the professional situation confronting social workers responding to allegations of abuse of adults. Here we detail the finer grain of social work interventions and their interface with the activity of other agencies.

4.2.1.1 Social work

As in the case of managed settings, social work departments had responsibility to support and protect individuals living in their family home who were at risk of abuse. Social work departments more often functioned as the lead agency with respect to adult protection than in managed setting cases, drawing on the input of other agencies to variable extents. However, the co-ordination of reviews and monitoring was deemed the responsibility of a consultant by certain professionals and at certain points in one case (*), whilst at other points in other cases, health professionals led or shaped protective interventions (*) (see below). As in the case of managed settings, the effectiveness of multi-agency working was variable. There were some examples of sustained communication and collaboration between the involved agencies throughout the course of a case (*), while in others protective strategies might well have been hampered by failures to communicate and collaborate. In one case there were no meetings or case conferences convened to bring together all key agencies, despite several

professionals from outside social work departments suggesting these would have helped, and several agencies having potentially vital protective contributions to offer, notably housing (see below) (*). In another case, staff of the day centre provided substantial levels of care to the adult and while reporting the majority of the concerns, felt excluded from the protection process by the social work department (*).

As noted above, concerns regarding abuse of the family member came to the attention of social work departments through reports from a variety of individuals. In one case, however, several allegations made by the victim were not followed up, though throughout support for the family as a unit was continued, with some allegations being investigated (*). The range of allegations made in this case, from those with clear foundations to those which were demonstrably unfounded, complicated proceedings; however it was not possible for us fully to determine why some allegations were responded to and others not.

4.2.1.1.1 Own role

Evidence of extensive support for alleged victims was clear in most cases (*) with a very high level of commitment to protect the at risk individual. Such support was both instrumental and emotional and could extend to legal support. In contrast to care in managed settings, however, allegations of abuse in family homes raised wider issues of social work support, not only for the alleged victim, but also for the alleged perpetrator and other family members. This state of affairs was not unique to the family as against the managed setting, but the answer to the question: "*Who is the client?*" became considerably less evident (*). For example, following serious allegations of physical abuse by a frail individual against his daughter with whose family he lived (*), it was the family who became the focus of social work activity. No adult protection procedure was initiated because "*...the family accepted social work support...*", despite the fact that previous and subsequent events indicated that this was a seriously unsafe environment. In a second case allegations by both the alleged victim and neighbours against a mother were not viewed as triggering an adult protection case but as one meriting family support because of the reciprocal nature of the aggression (*). Curiously the occurrence of mutual aggression precluded the mother against whom allegations had been made being considered an abuser. In a third case a social work department worked closely with the alleged perpetrator's daughter to ensure protection for the alleged family victim (*), with the daughter contributing significantly to support both mother and brother (*). Intervention in a further case was based on long term planning for relocation of the alleged family victim (*), with maintenance of the family unit in the interim being such a priority that when the alleged victim indicated she did not wish to return to the family home, she was returned nonetheless on the advice of the social work team leader (*), albeit accompanied by two workers under instruction to assess the alleged victim's reactions in situ and negotiate with the alleged perpetrator.

Sometimes particular incidents, subsequently judged to require no specific additional intervention beyond ongoing support and longer-term planning, caused a case to enter and exit the initial stages of formal adult protection procedures, often repeatedly. Protective strategies could also be conducted through intensive

family support coupled with on-going risk assessment, without the case ever formally entering such procedures. In one case, despite allegations against a male partner of a woman who was regarded as being at risk, social workers worked assiduously to maintain the relationship which was highly valued by the woman, at the same time intensively and intrusively visiting the couple to provide support and monitoring (*). Here the degree of intrusion was resented by the alleged victim and impaired the relationship with the social worker (*), illustrating the complexity of ensuring protection and maintaining family support. This case raised a wide range of ethical and procedural issues regarding intrusion into the lives of people who did not wish for such contact (*), as well as responding in a responsible way to a number of potential warning signs and to other family members' concerns who were the source of allegations regarding the male partner (*).

The point at which a protective strategy aimed specifically at the alleged victim with a shift away from overall family support was difficult to determine. Reference was made to such a shift occurring: "....*if the abuse was extreme...*" (*), comparable to the references to: *"...serious abuse..."* in managed settings. However, what was viewed as "*...serious abuse...*" was not defined in this case or others in which there was direct evidence of assault (*). However, it was also clear that the decision making of an individual social worker could lead to decisive intervention both to support struggling carers and initiate genuinely protective measures for the adult at risk. This is illustrated in a case in which serious neglect had continued for several years until a new social worker took on the case and began to deal directly and explicitly with the allegations of abuse with the family, as well as ensuring a much higher level of practical family support (*).

This family support strategy was acknowledged by social workers involved, with the question: "*Who is the client?*" explicitly articulated (*). In one case (*) the alleged perpetrator, a mother, was thought possibly to have intellectual disabilities like her son, and also thought to be abused by her husband. However her situation was never construed as an adult protection case. This raises the question as to whether there are special difficulties related to practice in coping with the alleged abuse of multiple family members or related to the threshold for construing a case as involving adult protection (*). In a second case in which an intensive level of monitoring of a domestic situation was highly intrusive over a number of years, formal adult protection procedures were not adopted (*). While adult protection was clearly one aim of the intervention, social work aims extended to a consideration of family relationships that was never formally justified (*). In this case the social work department explicitly attempted to bring the alleged victim into contact with a close relative from whom she was not only overtly alienated, but who was opposed to and demonstrably damaging the central relationship in her life. This relationship was itself a source of some concern but was valued by the alleged victim. This line of action was in many ways counterproductive to the adult protection aim, i.e. it also alienated the woman from the social workers (*). It was particularly interesting to note that some involved professionals shared the adult-at risk's own wariness of this relative's intentions despite the sustained attempt to effect a reconciliation (*).

The broadly based care management approach to the family as the means of protecting the alleged victim meant that formal adult protection action was

delayed for some time, and usually required a specific trigger often in conjunction with a substantial accumulation of evidence before such action was taken. Observations of family carers slapping their adult children contributed directly to consideration of two cases becoming adult protection cases (*). In these cases these events occurred respectively eight months and at least five years after the first expressions of concern (*). In one case it was nevertheless a further 12 months before the case was formally designated an adult protection case (*). In addition, at the eight month point there was confusion as to how to proceed as an assessment of capacity was judged necessary for adult protection proceedings to be initiated, though the adult protection guidelines did not require this (*). Despite physical abuse being the trigger to adult protection measures, neglect was noted in the adult protection recording form as the only abuse of concern, though physical abuse was subsequently noted as a risk factor (*). A second case also involved direct observation of verbal abuse and extensive evidence of physical abuse and neglect, supported by the adult's own repeated allegations; the care manager nevertheless did not follow through on a promised case conference (*). In a two further case, physical abuse was observed to occur but no formal adult protection action taken (*).

Protective strategies were typically multi-element interventions in which consideration of relocation usually figured from an early stage (*), though with a variety of other supportive practical and emotional measures (*) including counselling (*), respite provision (*) and arranging training in behavioural management skills for the adult's carer (*).

In cases in which there was a child in the family, social workers were fully aware of their child protection responsibilities and acted accordingly (*), reporting concerns regarding children's wellbeing to Children and Families services. In one case a report by a social worker of concerns regarding a child in the family led to a deterioration in relations with the alleged (family) perpetrator (*). In a second case, communication and collaboration between the adult victim's social worker and the social worker of a child in the same family contributed substantially to the eventual protection of the adult (*). However in a further case, a social work team attempting to protect an adult was critical of Children and Families social workers involved with the same family, for not involving themselves in adult protection processes and meetings (*).

Though physical or sexual abuse clearly triggered a variety of adult protection interventions, a more subtle and contentious situation arose with respect to adult protection measures when the abuse perceived by professionals related to excessive control over the adult's behaviour by family members (*). Here disagreement could arise between professionals with some construing the abuse presumed to be done to the individual as requiring adult protection and others judging this stemmed from the ideological stance of social workers and advocates regarding adult autonomy (*).

Lest this report suggests that "social work" provided a monolithically consistent input to all cases, it is important to note that disagreements on practice did occur and had potentially radical implications for outcomes (*). Such disagreements dealt with appropriately provided an important system of checks and balances on the exercise of power by social work departments. Conversely, unacknowledged

and/or unaddressed, differences in approach within social work could confuse proceedings, potentially impeding adult protection. For instance in one case a senior manager directed a social worker to convene an adult protection case conference. The case conference was never convened, with no explanation apparently given or sought, including by a senior with whom the social worker was in more regular contact (*).

WHEN DO INFORMAL MEASURES BECOME ADULT PROTECTION MEASURES?

In the context of attempting to deal with allegations of abuse through family support, a point could nevertheless be reached at which formal adult protection procedures would be introduced (*). This did not lead inevitably to decisive protective action, however, as on some occasions the family focus still blurred the need for clear cut decisions that were timeously implemented (*). In a second case in which formal adult protection recording was carried out, this had no bearing on the subsequent protective intervention (*). The function of such recording given the lack of action was entirely unclear. Suspected physical abuse was knowingly tolerated in one case in the interest of support for both alleged victim and perpetrator (*). As noted above, this approach would only have been changed with the alleged victim becoming the principal concern "*if abuse was extreme*" (*). One example of on going abuse being judged "*extreme*" was the observation by a social worker of a young person being slapped twice by a parent coupled with significant physical deterioration possibly linked to serious neglect (*). Here the first vulnerable adult meeting was convened by the social worker with coordination of input by a GP (*), psychiatrist, neurologist (*) speech and language therapist and dietician (*). In addition, a decision was taken to take the first steps to guardianship by the local authority (*). This was a rare example in the family home cases of a social worker judging it appropriate to prioritise adult protection responsibilities over family support responsibilities, and taking comprehensive and decisive leadership to ensure protection of the individual at risk. During the course of these developments there were further reports of both parents slapping and pulling the hair of the individual (*).

The delays arising from no decision being taken regarding adult protection accounted in part for the considerable length of some of the family cases already noted and illustrated in figure 8. However, though the seriousness of allegations may not have changed over time (*), accumulating evidence could result in increased concern with respect to adult protection (*) or decisive action, including removal of the alleged victim to a place of safety (*). Changes in the judgement of risk were also influenced by deteriorating conditions or behaviour in the at risk individual (*;) and/or in the alleged perpetrator (*). In such cases long term monitoring and support by social workers was sensitive to changing conditions and their implications for risk, illustrating the key role of family support in situations in which evidence of abuse was lacking. We have also noted the impact of a single social worker taking the case forward with a direct focus on adult protection (*).

OUTCOME OF ADULT PROTECTION IN FAMILY CASES

Against a background of sometimes extensive case work and support, the final outcome was of relocation to a care home; (*) or tenancy (*). However in two of

these cases it was the victim's own decision, entirely independently of interagency protection processes, which facilitated relocation (*), whilst in a third the progression of a deteriorating illness was the primary instigator of the move, as opposed to protection concerns (*). The relocation and/or supportive and protective measures in that setting were underpinned in three cases by local authority guardianship (*). Temporary relocation to a residential setting of one individual because of serious concerns regarding neglect at home was judged to have led to an improvement in care at home when the person returned (*), though this view did not go uncontested within the social work department (*). This improvement was supported by intensive social work and therapeutic support to the family. Nevertheless, at this point, despite on going concerns, no adult protection plan was in place (*). Relocation could, however, have the effect of simply changing the locus of abuse and/or who the perpetrators were.

In one case the social work department's tolerance of on an ongoing situation in which physical abuse and neglect were becoming increasingly evident was challenged by another interagency team which identified risk through information on joint electronic records following an unrelated health referral, responding immediately by putting in intensive, protective support (*). The team manager also insisted that this case should be viewed as a vulnerable adult case and responded to accordingly. Internal disagreement on procedures was evident in this case. In a further case, following significant internal disagreements about whether denial of choice and control by the family constituted an adult protection concern and grounds for guardianship, the MHO concluded that this was not the case and drew protection proceedings to a close, despite the major ongoing concerns of the social worker and some other professionals (*).

OTHER COUNCIL DEPARTMENTS

Since relocation of the alleged victim from the family home was, after the attempt to resolve family issues through social work support, one of the principal protective strategies (*), housing departments had a key role in such strategies, including concerns over both self neglect and housing conditions (*). A further contributor to the length of these cases was the time taken to find a suitable place to which to relocate the individual (*). The quality of joint working between social work departments and housing departments varied. Reports of good collaborative relationships in some cases were noted (*) but were not optimal in others. In one the housing department was unaware that adult protection was involved, and though the social worker had assisted the individual to apply for re-housing with the explicit intention of addressing protection issues, the alleged victim remained in the potentially abusive environment, having been accorded low priority for re-housing (*). In another case there was clearly some degree of conflict with housing department staff recommending a greater degree of support than that which they assumed the social work department deemed appropriate (*), a situation directly comparable to one noted in managed settings (*).

4.2.1.1.2 Other agencies' roles in relation to social work

NATIONAL HEALTH SERVICE

The coordinating role of the social work department with respect to the involvement of NHS staff was explicitly articulated by one social worker who stated that it was their role to ensure joint social work-health cooperation (*). Apart from the GP, communication between health staff and social work was usually initiated by the latter with health staff subsequently informing the social work department of the outcome of assessment or treatment, though not necessarily of ongoing progress (*). Concerns regarding the impact of neglect by the family on the health of one individual resulted in the social work department involving a health visitor with the family and in the development of adult protection measures (*). As in the managed settings, clinical input from psychiatrists and clinical psychologists played a specific, but not necessarily central role to adult protection strategies (*).

Examples of genuine collaborative working were noted, e.g. a joint initiative to develop a formal risk assessment to protect a woman subjected to abuse from multiple sources (*) through collaborative reviews (*). A social work department and CLDT staff worked closely to monitor the well-being of a woman considered to be at risk from her partner, both engaging in regular scheduled home visits (*). However, fundamental disagreements could also occur and were illustrative of the fact that there was no cohesive interagency plan in place (*), while a lack of co-ordination through self-imposed rigid separation of roles was also noted (*). In this last example NHS staff saw their role as assessing capacity and social work's as dealing with risk and welfare, with no joint meeting to integrate these areas being undertaken.

POLICE

In the context of attempting to manage allegations of abuse through social work support for the family, with its inevitable concomitant of tolerating possible abuse for long periods, there was an intrinsic reluctance in some cases to report allegations to the police. It was considered that to do so would undermine both relationships within the family and the relationship between social workers and family members (*). For example, in addition to allegations of physical abuse, financial exploitation of one family member by another for which there was clear evidence did not lead to the theft being reported to the police (*). In an allegation of physical abuse by a female relative, the social work department deferred to the alleged victim's wish not to report this to the police (*). Here it was considered more important to work with the individual to improve her quality of life than deal with her allegations directly. However, when the alleged victim reported sexual and financial abuse by a more distant male relative, reporting to the police followed immediately (*). A suspicion of rape leading to abortion in a family was not pursued because social workers incorrectly believed they required the alleged victim's permission to report this to the police. In this case it was also believed by social work that the GP could provide evidence of the rape; s(he) had not done so however, and without such evidence social workers incorrectly again felt constrained from seeking police advice (*). Disclosure of familial sexual abuse by a woman known to be at risk for a variety of types of abuse was not judged as a

good enough reason to report to the police because social workers did not consider they had sufficient evidence (*). However, when precisely the same allegation was made by the alleged victim in a subsequent case conference two years later, this was immediately reported to the police (*).

As in the managed setting cases, concern was expressed regarding the failure of the police to report the outcome of an investigation to either the alleged victim or the social work department (*), leading again to a social worker having to track down the information.

4.2.1.2. National Health Service

With respect to the present cases, NHS staff were involved in diverse ways in community settings with alleged victims and partner agencies. In only one case was an individual who temporarily entered hospital subject to abuse in an NHS facility (*). Here the NHS (and indeed social workers) considered that investigation of the allegation was entirely its responsibility and that interagency guidelines were not applicable.

4.2.1.2.1 Own role

As with cases in managed settings, GPs occupied a key role in the lives of some alleged victims, but this role differed in that they were typically dealing with the health and well-being of other family members, including the alleged perpetrator. Their principal role was, of course, to deliver healthcare to their patients regardless of abuse-related concerns (*). Inevitably, however, in cases in which a patient was at risk, GPs could become involved in protective measures. When an alleged victim reported the abuse to a GP, he immediately referred this on to the social work department (*). The GPs of one surgery were the primary professional contacts trusted by a family carer, leading to them becoming involved in advocating on behalf of the carer. Adoption of this role in turn led to some degree of conflict with the social work department, a meeting with the family having to be held in the surgery as a "neutral setting" (*). One GP, however, invoked new contractual arrangements and associated time pressures as necessitating only a (medical) professional input to the case, refusing to attend reviews and only agreeing to discuss the case on the 'phone (*), while another responded to invitations to case conferences with written information but did not attend in person (*).

Exchange of information between the social work department and the GP was sometimes constrained by confidentiality. One GP, dealing with both alleged victim and perpetrator felt compromised by the fact that the social work department had given him no indication of its concerns regarded allegations of abuse within the family (*). Two further GPs were felt by the social work department to have key information about adult protection concerns, but had not been fully involved themselves in adult protection proceedings, case conferences and meetings (*). The need for close communication and information sharing between the social work department and the GP is further illustrated by a case in which the alleged perpetrator lied about visits to the GP and the outcome of these consultations. Active involvement in specifically protective measures by the GP was rare but not unknown (*). In one such case the recorded plan to approach

the GP in relation to possible over medication of a person with intellectual disabilities was twice agreed by a psychiatrist but never followed through (*).

As with health input to managed settings, the involvement of other health professionals reflected their specific roles. A variety of allied health professions (AHPs) contributed to these cases, including dieticians and speech and language therapists. The extent to which family carers can assimilate and act on the advice of such professionals is affected by a variety of influences, including in one case the ethnic background of the family. Here professionals allied to medicine interviewed reported that cultural factors could act as barriers to advice being followed, while communications might be unclear because politeness influenced apparent compliance (*).

Occupational therapists (OTs) (though employed by the local authority) had a particularly significant opportunity to comment on adult protection concerns. They had a unique opportunity to spend time with the family working on constructive issues to do with the functional capacity of the individual and possible modifications to the home, as well as observing interactions within the family (*). Where family members had become alienated from social workers, the OT was likely to be seen as independent of social work, and OTs reported concerns back directly to social workers in a number of the cases (*). Given the practical nature of OTs' input, it was also likely that they would identify cultural barriers to improving the family's environment. One specific example involved the refusal of a family to consider use of orthotic shoes for their son because family members were expected to be barefoot in the home (*).

Health input was also critical where abuse resulting from over or under medication or inappropriate use of medication (*) was suspected, a feature of neglect also noted in managed settings (*). Community psychiatric nurses (CPNs), and to a lesser extent GPs (*), occupied an important role in dealing with these issues within the home setting (*). Although not directly confirmed, it is likely that CPNs, like OTs, had privileged access to families who saw them as less of a threat than social workers whose obligations inevitably led to a more intrusive, interventionist relationship at times. Interestingly one CPN commented on the lack of clarity in her role vis-à-vis a family and the social work department's wish to dictate her role. Clearly this raised issues regarding the nature of team work in relation to agreed goals (*), suggesting lack of clarity in planning.

The role of CLDTs, psychiatrists and clinical psychologists, was comparable to that in managed setting cases. In particular, requests from social work departments for assessments of capacity with a view to pursuing guardianship were noted in several cases (*). These requests were sometimes not pursued because of changes in circumstances (*), while in others they were followed through to the extent that qualified medical staff undertook formal assessments of capacity (*). In one case the psychiatrist involved saw his role as restricted to a relevant professional contribution, and did not see that role as extending to wider adult protection activity, e.g. collecting information from fellow health professionals (*), this being the responsibility of the social work department. While contributing to the risk assessment undertaken, the same psychiatrist "*...stood back...*" from involvement as this was seen again as the social work department's responsibility (*). Elsewhere psychiatrists took a more active role,

including contributing to the monitoring of adults in community settings and advising on the use of mental health legislation for protective purposes (*). It should be added that though social workers are dependent on psychiatrists for assessment of capacity, they could not depend on complete agreement among their medical colleagues (*), leading to adjustments in their own decision making when alternative perspectives came to light from within health (*).

Therapeutic support for the at risk individual was also requested by social work (*) as was the specific advice of a gynaecologist in relation mood swings (*), and health input in relation to encouraging safe sexual behaviour (*).

In the home cases, as in the managed settings, NHS staff, including GPs, often had a lower threshold for decisive protective action (*), as did other health professionals such as nurses (*) and psychiatrists (*). The last case presents a stark contrast. Here the MHO invoked "*...social work values...*" to maintain an individual in the family home on a shared care basis, when several other professionals considered the individual to be seriously at risk (*). The psychiatrist involved raised, at a case conference (*), the question of the family's inability to maintain the person at home. This view was also taken by a consultant when the at risk person entered hospital. He refused to discharge the person back into the care of the family, insisting that discharge had to be to a residential facility (*). However, it should be noted that though this was a *fait accompli* by health, the care manager considered it entirely appropriate given her concerns over long term inaction by social work colleagues (*). Her only reservation was that the status of a medical professional had made the implementation of this decision possible in a way that could not have occurred had it been made by a social worker.

4.2.1.2.2 Other agencies' roles in relation to health

Individual health care staff with relatively well defined areas of expertise saw social work departments as responsible for progressing adult protection cases, though the case may not have been construed specifically in these terms (*). Nevertheless, as noted in the preceding section, this did not preclude direct attempts by GPs (*) and OTs urging more decisive protective action (*). Psychiatrists strongly advised a 24 hour care package in two cases. In one instance the protective strategy grew out of accretions of additional support over a 14 month period with no specific resolution of any of the multiple concerns (*). In the second, there was disagreement between the social work department and medical staff because in a senior social worker's view the latter did not understand the nature of community care and were not competent to advise about the level of community care support required. In a further case health staff formally requested the social work department to increase protective support for an individual, an approach viewed by the involved social workers as intended to "*...cover (health's) backs...*" (*). From the standpoint of health staff, the request did not imply criticism, but was intended to put on record that protective action was proceeding too slowly (*).

4.2.1.3 Police

In the family cases, eight allegations of incidents of abuse and or sets of potentially abusive circumstances were reported to the police involving five families (*), with two individuals also allegedly abused outwith the family home though included here as family cases (*). Report to the police came from social workers (*) and the alleged victims (*). Two cases were submitted to the procurator fiscal (*). No prosecutions were made.

The duties of the police when allegations of criminal behaviour were made do not differ between the two categories of settings under consideration, though the wider requirement of family support comes into play. Parallels between the two situations include the difficulty of securing evidence and concerns regarding the capacity of alleged victims to appear in court. In a real sense, however, the family situation is an essentially closed environment in which typically only family members, rather than independent staff members, are party to the allegations, making police investigations that much more difficult.

This applied even in cases in which the alleged victim him or herself reported the alleged abuse (*). In cases of serious allegations such as rape by a family member, the police took statements from the alleged victims involving an appropriate adult, as they would have for anyone else (*).

Though cases were passed to the procurator fiscal, absence of corroborating evidence and obstructive family solidarity could preclude any prosecution (*).

4.2.1.3.1 Own role

The role of the police does not change between managed and family home settings. The collection of evidence of abuse with a view to referral to the procurator fiscal remained paramount (*). Nevertheless, the police could be drawn into wider supporting action, e.g. picking up and returning to her home a woman who put herself at risk by leaving her supported accommodation without staff or essential medication (*). Such activity was questioned internally within the police with respect to legality (*) and use of police time (*).

4.2.1.3.2 Other agencies' roles in relation to the police

Working relations between police and the social work departments was generally regarded by both parties as good (*) and considered to have improved in recent years. An allegation of rape was immediately passed on to the social work department by the police prior to their investigation, while the social work department passed relevant information regarding the individual on to the police (*). The police willingly became involved when a serious situation arose regarding parents' behaviour which was considered to endanger an adult at risk (*).

As in cases in managed settings, lack of feedback on the progress of cases was reported by social workers (*). In a case of allegations of sexual abuse the police worked closely with the home supporter but did not communicate with social workers (*). Nor did they provide feedback to the social work department or

alleged victim on the course of their investigation, their report to the procurator fiscal, or the outcome of the case (*). In relation to one case the police considered they did not have the right to pass such information on to the social work department (*).

Nevertheless, individual police officers expressed some reservations with respect to their relationship with social workers. In one case the police considered that social workers did not have a full understanding of the range of conditions under which reporting to them would be appropriate (*). Nor did social workers always understand the limits of police powers, particularly where there was no legal basis for constraining an adult's choices (*). In a second case, a police officer expressed reservations with respect to sharing information with the social work department in some circumstances (*).

4.2.1.4 Other community agencies

Day services, whether for older people or those with intellectual or physical disabilities are a key point of contact for those living with their families. Indeed, they may be the *only* point of contact outside of the home. To staff in such facilities must be added escorts who witnessed and reported abusive behaviour on the part of family members in two cases involving people with intellectual disabilities (*) They therefore have a particular responsibility when suspicions or allegations of abuse come to their attention through reports by the alleged victim of evidence of injuries (*). Colleges attended by the alleged victim also served this function by reporting concerns to the social work department (*).

Close and positive collaboration between social workers and day care staff was evidenced in some cases (*), including joint home visits with social work (*). The independent setting of a service away from home could provide the opportunity for joint interviews involving the alleged victim, staff and social worker (*). More importantly, however, was the opportunity provided in the secure environment of a day service to observe and monitor the alleged victim's physical and mental state (*), with this information fed back to the social work department. While such collaborative working provided an important input into cases, it also raised some ethical issues that need to be addressed. Is it legitimate, for example to use bathing as a covert means to investigate signs of physical or sexual abuse? If so, what guidelines are in place stating the limits on such observation? What are the rights of the alleged victim in such situations?

The response by social work staff to day service concerns could fall short of expectations in some cases (*). For example, a report of allegations of physical abuse by a day service manager did not from his perspective influence social work interventions with the family (*). There was concern that there were no case conferences held as a result on these reports (*), though an early report did lead to a review meeting (*). Requests by a day service for a review with the relevant care manager were not responded to (*).

In addition, day services could contribute to the protective strategy though in the absence of co-ordinated working this could fail to be integral to the wider care management strategy (*). In one case a new social worker proactively initiated increased day service input to mitigate evident neglect, the service willingly

cooperating in this (*). In addition, in the same case, day service staff noted many occasions on which despite their communication of concerns, no action appeared to be taken (*). However, the same day centre officers were excluded from involvement in preparing a formal risk assessment though subsequently invited to comment on selected sections of it (*) (See Section 3.5).

Respite services were seen as one means of contributing to the social work department's strategy of relieving pressures on the family, including the suspected abuser (*).

4.2.1.5 Care Commission

The Care Commission was involved in only one case in which an adult had been taken into residential accommodation as a protective measure (*). Parental dissatisfaction with the service was reported to the Care Commission. The complaint was partially upheld.

5 CONCLUSIONS

We have emphasised in this report the complexity and sensitivity of adult protection cases. Professionals involved are faced with conflicting interests, lack of evidence and a wide range of barriers that preclude simple solutions, and indeed at times preclude complicated solutions. We have found among all agencies, disciplines and with respect to all types of abuse examples of excellent practice. Some of these have been highly consistent such as social work support for alleged victims and family members or careful and sensitive interviewing by the police. The expertise of the many health care professionals involved in cases was evident, as was the seriousness with which they took their roles. That good practice in adult protection is possible is clearly evidenced in the cases reviewed.

It is equally clear that however well intentioned, much adult protective practice falls short of being as effective as it should be. In emphasising areas of possible improvement we are focusing on such shortcomings rather than suggesting that poor performance is the norm. Some of the recommendations we make in Volume 2 of this report[28] will be seen in some authorities as having already been implemented, and indeed the good practice noted has informed these.

The cases studied in this report all occurred before the implementation of the *Adult Support & Protection (Scotland) Act 2007* in October 2008. We would argue, however, that though comparable cases might, post-implementation, take a different form if the provisions of the Act are utilised, there is nothing observed that in principle could not happen even with the Act now implemented – *unless effective operating procedures and practices are in put place and are maintained and monitored.* This is not to say that the Act and its significant training and awareness raising programme will not improve practice, outcomes and enhance support for adults at risk of abuse. However, basic operational errors, e.g. failure of a care home manager to notify statutory authorities, may still occur, while fundamental professional attitudes and cultural influences will remain pervasive.

The work of individual agencies and interagency collaboration described in this report may be considered at a number of interrelated levels, namely, the wider cultural context which informs the way in which agencies work, the processes which shape how a given case is conceptualised as a formal adult protection case or otherwise, and finally the contingent procedural or operational actions through which the professionals engage and deal with the case.

The implications of our findings for these three levels differ both in kind and in the ease with which they translate into recommendations in Volume 2. Issues to do with cultural determinants of the approach to adult protection, which in turn help to shape how a case is framed, are highly complex and do not lend themselves to any simplistic statement regarding changed practice. Nevertheless, we regard these as critical to improving both agency and interagency working and will in volume 2 suggest areas of development as well as making more specific recommendations related to operational issues.

5.1 Occupational Cultures

The three principal agencies involved in the present cases other than those providing a direct day, residential or respite service to adults were social work, health and the police. The agencies noted have distinctive cultures which are reflected in their practices which may impose constraints on true interagency working generally, and adult protection specifically. In the English and Welsh context attention has been drawn to a view held by social workers that because of an emphasis on relatively narrow treatments or interventions, NHS staff are not committed to the holistic care of the individual in the way that social services are[29]. While evidence for such a distinction was found in the present study, it cannot be maintained if we disaggregate "health" into its various components. Professionally, health provision is multifaceted with widely different modes of interaction in adult protection cases by health care professionals. GPs, for example, within the limits of their working practices, i.e. patient consultations and attendance at adult protection reviews, *did* exhibit concern for individuals' overall wellbeing and that of the family. Community psychiatric nurses while undertaking professional assessments were fully engaged with individuals at risk. With respect to other health professionals, e.g. psychiatrists and clinical psychologists, the input required reflected expertise in assessment or treatment usually requested by social workers but sometimes by other colleagues. Specific examples were respectively the many cases where requests for assessment of capacity or psychosexual counseling were made. This expertise differs from that of social workers and what is critical is the way in which the very diverse types of health intervention are integrated into the process of adult protection, not that healthcare professionals somehow become a parallel stream with the same adult protection culture and practice as social work. However, a shared value system with respect to the prevention of adult abuse should be regarded as essential.

We have described in some detail the family-orientated case management approach which was adopted by social work departments in a number of cases, particularly where allegations of abuse related to domestic settings (section 4.2). Here social work culture led to a variety of responses to allegations of abuse, in some cases leading them not to be construed or framed as adult protection cases.

(We comment on such frames in the following section 5.2.) The treatment approach of healthcare professionals deriving from a medical culture was at times at odds with social workers' case management approaches in which the issue of abuse was de-emphasised in the interest of holistic support for individuals and also of families. This resulted in a far more decisive advocacy of protective intervention at an earlier stage by health staff, indicating that they had a lower threshold for intervening explicitly to protect.

Attention may here be drawn to parallels with research findings in child protection regarding thresholds for action in situations of alleged child abuse and neglect. A number of studies based on judgements of the seriousness of maltreatment portrayed in a series of vignettes suggested that child protection social workers had higher thresholds for action than other professional groups as well as the general public[30,31,32]. This does not necessarily mean that social workers fail to appreciate the impact of abuse. For example, it has been suggested that the judgements may in part be influenced by knowledge about the potential abuse that can be caused by removing a child from home[33]. Such findings may explain some of the multi-disciplinary tensions that can underlie both child and adult protection decision-making.

With respect to comparative thresholds for action by social workers and the police, the issue is essentially one of a judgement as to whether a criminal act has been perpetrated. Where what was described as a "serious" action, e.g. rape, was alleged, social workers responded immediately by reporting the allegation to the police. However, in what were judged less serious actions, such reports were not made as social workers' thresholds for reporting were higher, though the police might well have been prepared to investigate on the basis of available evidence. The higher social work threshold was also maintained by inappropriate decisions regarding the feasibility of the police acting on the available evidence, i.e. social workers took decisions that should have been made by the police following reporting.

The issue of thresholds in the interdisciplinary context remains one of the most difficult in this field. We suggest here that differences in thresholds relate to the culture of an agency or profession where culture refers to a complex of explicit and implicit values and roles historically determined by social and legislative requirements. To illustrate in simple terms: if a social worker's principle aim is to deal with protection through work with the family, under certain conditions the threshold will be high with respect formally to construing the case as an adult protection case and acting upon this. The health service worker who more narrowly sees protection in terms of a direct intervention to protect the at risk individual outwith this wider context, will advocate protective action at a lower threshold. Similarly the police where there is evidence of a criminal act will have a threshold lower than that of a social worker confronting the same act.

However, this characterisation of thresholds fails to take into account either the nature of the alleged abuse or other contextual factors. In the interviews here the "seriousness" of the allegation was often invoked as a determinant of thresholds for action. Child protection workers have noted informally that following a serious failure of child protection thresholds for intervention are significantly lowered.

Arriving at a consensus regarding thresholds for initiation of adult protection procedures requires the development of a common framework of risk assessment and clarity on what actions should follow; this, against a background of shared values and aspirations with respect to protecting at risk individuals. Since it is highly unlikely that the overarching culture of different professional groupings will be significantly modified in the context of adult protection proceedings, we suggest that convergence of thresholds can only be achieved through clarity of risk assessment and the actions then required. Clearly even agreement on risks will leave room for disagreement on how these risks will be managed. In terms of the *Adult Support & Protection (Scotland) Act 2007*, the threshold for council officers regarding implementing an inquiry may be relatively clearly mandated. However, as this report shows, the sources of allegations are extremely diverse, and the passing on of allegations to social work departments will be influenced by threshold decisions.

Issues of agency and facility culture were considered in section 4.1.5.2. The close link between a good quality service based on effective management and leadership coupled with appropriate training, on the one hand, and an ethos that precludes the abuse of service users, on the other, was described. The development of such services is fundamental to adult protection in managed settings and effectively provides the environment in which specific protective measures come into play. Responsibility for the design and maintenance of such service quality rests with *all agencies* concerned with establishing, running and monitoring them. Among these are commissioners, service providing agencies and the Care Commission.

5.2 How cases are conceptualised

During the course of the study and in the immediate years leading up to the *Adult Support & Protection (Scotland) Act 2007,* there had been a rapidly accelerating formalisation of the operational procedures and agency responsibilities to respond to concerns regarding identified risks of abuse of adults. These took several forms including procedural guidelines sometimes reified into complex flow charts. While such approaches helpfully raised the profile of adult protection issues in some of our cases, it was equally clear that a majority of professionals, including social workers, did not follow them, and indeed in some cases considered them irrelevant to the protective process as they conceptualise it. In the case of social workers, this was at least in part because the guidelines were not considered flexible enough to be relevant, but in addition, were not consistent with social work values that were viewed as fundamental to case work. These were expressed in terms of maintaining the integrity of the family and family relationships with the focus on the needs of the adult considered at risk forming but one objective of family support.

Further, formalised guidelines did not take into account sufficiently the range of competing frames in which many of the cases could be conceptualised and responded to. Several of the cases reported here may be construed in more than one way, e.g:

i. a case of abuse requiring adult protection procedures

ii. a case of entrenched family difficulties requiring family support

iii. service quality and/or compliance issues setting the scene for abuse

iv. passive neglect as a consequence of inadequate staffing

v. unintended abuse in the context of a loving but strained caregiving relationship

It is to be anticipated that the Act may also be underused when the case is construed in such a way that the use of the Act's provisions are judged to be inappropriate, as in the situation envisaged in v. above.

In all these frames (and the list is neither exhaustive nor are the various frames mutually exclusive) protection of the adult at risk is paramount and the abuse inflicted totally unacceptable. In the present cases good professional (and particularly, social work) practice was dependent on the ability to understand and move between the different ways a situation might be framed. The adult abuse/protection frame does not of itself take automatic precedence over other ways a situation might be understood and responded to. This was certainly the case in the practice studied here. Adult protection is a complex concept and the means to achieve it are varied. Hence good professional judgements about the most appropriate frame(s) to adopt and intervention(s) to employ will be more important to improved practice than increasingly detailed flowcharts and protocols. Importantly, good professional judgements entail a full consideration of alternative ways a situation might be framed and the implications of these perspectives. There also needs to be clear judgement on when circumstances require movement between frames, e.g. when evidence of abuse becomes clearer or when a fundamental change in the situation becomes apparent. What is required here is that these considerations regarding choice of frames are explicitly formulated and recorded. Nor should "Adult Protection" be seen with respect to intervention as isolated from other ostensibly non- "adult protection" approaches.

The implication of this position is that adult protection is a much wider concept than that narrowly formulated in typical guidelines which may exclude cases which involve *de facto* protection, but which were never recorded as such. A further consequence is that if within all these frames adult protection remains a central, explicit objective, then the tolerance of protracted alleged abuse over several years reported here will become less of a risk. To deal with (ii), above, (a case of entrenched family difficulties requiring family support) entirely within this frame will be less likely and continued chronic, alleged abuse will be confronted more constructively.

Nevertheless, it cannot be assumed that every frame chosen will have equal value in protecting the adult at risk. We have seen in both managed settings and family homes considerable delays over the formal introduction of explicit adult protection measures during which concerns regarding abuse were maintained or increased. Here we would suggest that rather than chronic adherence to a particular line of action, the way in which a case is going to be construed and individuals supported needs to be explicit and justified. It should be added that there was considerable evidence such deliberations had taken place, though these were revealed in interviews in which care management was being justified rather than as formal decision in case notes. Increased clarity in decision making in order to give the best chance of curtailing chronic abuse is called for.

Training and education to equip professionals to engage with the complex, contextual determinants of adult support and protection should begin at first degree level and progress through reflective learning in the context of continuing professional development frameworks. Parallels exist in child protection. An audit of social work courses in Scotland suggested that it was possible for social work students on some courses to avoid electives that covered child protection. To rectify this social work courses have now been required to include and be assessed against *Key Capabilities in Child Care & Protection*[34] with the aim of ensuring that those working in adult settings will be aware of their responsibilities towards children. Further, the post-registration training and learning requirements for registered social workers require that five days be dedicated to assessing and managing risk to at risk groups.

All social work qualifying courses will incorporate attention to the adult support and protection legislation. However, the present study suggests that knowledge of the legislation will not be sufficient without attention to the wider issues involved in making the required fine judgements. Education and training for other relevant professionals will also need to address the detailed implications of practice within the context of their specific professional responsibilities.

5.3 Operational considerations

We have drawn attention on a number of occasions to the complexity of adult protection cases. Here we will simply reiterate the diversity of the characteristics of people abused or allegedly abused (figure 1), the range of settings and the complex patterns of abuse, including multiple and serial abuse (figure 3, 4 & 5). Cases defined by these patterns of variables are then engaged with in a variety of different ways by multiple agencies (figure 7) in varying permutations. Clearly in broadening the concept of adult protection by acknowledging that adult protection frames are multiple and complex (section 5.2), we do not advocate guidelines being abandoned or that operating procedures are too pervasive. We would suggest this is not the case. Despite the limited manner in which available guidelines were adhered to (section 3.3), shortcomings in many cases were attributable to either a lack of understanding on the part of professionals of what was required or a failure to follow procedures, or, an absence of procedures where they would have been desirable. Here we note some areas of principal concerns that were identified through the research.

5.3.1 Reporting abuse

It is critical that those in frontline services are clear on their responsibility to report suspicions of, or allegations of, abuse and the process involved. There was some confusion among care home mangers in this respect, with significant delays in reporting occurring (section 4.1.5.2). While provider agencies generally had adult protection guidelines, these are of little relevance unless accompanied by intensive training in which staff internalise the adult protection message as well as knowing how to act when such situations arise. Obstacles to whistle blowing were noted, including: lack of clarity as to what constitutes abuse, fear of anonymity not being guaranteed, as well as fear of repercussions.

The context in which alleged abuse is reported and to whom it is reported had an important bearing on the response (section 4.1.1.1). A family complaining of the treatment of their relative in a care home elicited a complaint about their attitude and behaviour from the care home manager to the social work department. A complaint by a relative regarding treatment of his father never entered adult protection considerations because his motivation was suspect. All allegations necessarily go through some form of pre-screening, but awareness of how the status of the reporter affects responses is important. In the first example above, if the same complaint had been made by a GP it is less likely that social work would not have been approached. If in the second example a visiting therapist had made the complaint, it is unlikely that the allegation would have been dealt with informally.

The issue here is ensuring that reports of alleged abuse are considered in their own right with the status and credibility of the reporter not automatically overriding the message. Clearly there can be good historical reasons why a reporter may lack credibility, e.g. repeated false accusation, mental health status etc. We suggest here that in evaluating the credibility of a reporter, the reasons for responding to the allegation (or not) should be clearly stated, as any audit of cases in which no response was made would lead to exposure to criticism, may be incompatible with requirements under the Act, and most importantly, fail to take protective action where it is required.

We drew attention to significant delays in reporting allegations of possible criminal acts to the police (section 4.1.5.2). We also noted that such delays may compromise investigations. There are many reasons for such delays, some based on assumptions about police procedures or conditioned by the desirability of dealing with the allegations through other means. The circumstances in which referral to the police is appropriate need to be clearly stated and equally available to all to whom the allegation is made know.

5.3.2 Investigating allegations of abuse

The investigation of allegations was variously undertaken by social work departments, commissioners, internally in service settings, the Care Commission, and where the possibility of criminal behaviour was alleged, the police. At times there was lack of clarity regarding the relationship between different investigations and the status that they had in the adult protection process. The assumption that an internal investigation by a provider agency removed the responsibility from, for

example, a social work department to conducting its own investigation has to be questioned. It is assumed that under the *Adult Support & Protection (Scotland) Act 2007* this would not be acceptable.

With respect to police investigations, we noted first that officers were sometimes influenced by input from staff in the care setting, i.e. accepting information in a way that precluded fuller investigation. An example is acceptance of the view that the alleged victim lacked capacity and could therefore not be interviewed. Second, the police in some cases commented on the standard of care in the service setting. The status of their knowledge and expertise to do so was unclear, as was the bearing this had on the case.

5.3.3 Reviews and case conferences

Over the time course of the research, procedures with respect to interagency meetings were diverse. Reference was made to "case reviews", "case conferences", "vulnerable adult reviews" and so on. There were examples of effective meetings called timeously by social work departments, well attended, properly documented and with clear actions specified. Many were however unclear in their focus and outcome with no evidence of minutes having been taken. Often they included repetitive reviews of the case involving protracted and detailed summaries. The necessity for such meetings in the context of interdisciplinary work is self evident, as is the need to integrate relevant information, agree risk assessments and specify actions and reviews of their implementation.

It is clearly acceptable for adults at risk to choose to absent themselves from case conferences and reviews or to exclude certain family members. However, for relatives or professionals to exclude an adult from the process is much more questionable, particularly in the absence of clear evidence of incapacity. The assumption should be that the adult at risk will be given the opportunity to be fully involved. The ability of relatives and/or professionals to exclude other people from the process to whom it might be relevant, such as other interested relatives, should also be questioned. In addition, independent advocacy support should be available to the individual at such meetings as well as more widely.

5.3.4 Interagency communication

The detailed documentation of the present cases as analysed in the integrated chronologies on which this report is based (see section 2, figure 2) clearly illustrates how extensive is the network of communications with respect to the principal agencies as well as a range of other significant agencies that contribute to the case, not to mention the alleged victim, the alleged perpetrator, and family members. Examples of good, reactive and anticipatory communication from initial reporting to resolution of the case were identified, though equally numerous failures were also found.

The facilitation of effective communication has in the context of implementation of the *Adult Support & Protection (Scotland) Act 2007* recently received detailed attention. *The National Practice Forum* has reviewed data sharing requirements in the light of the Act and made a wide range of recommendations based on

stakeholders' views and its own analysis[35]. In our view, these recommendations go some way to providing a communicative context in which deficits in interagency communication may be dealt with.

Clarity is particularly called for with respect to communication regarding the framing of the case as one involving "adult protection". For example, the involvement by a social work department or a housing department needs to ensure that the latter understands that the reason for the request for re-housing arises from adult protection concerns.

One clear exception to this rule is when such communication might jeopardise an on-going enquiry, whether by the police or others.

5.3.5 Risk assessment

We have already drawn attention to the importance of the criteria to be used in risk assessment for attaining a convergence of thresholds across professions with respect to adult protection action. This implies some uniformity of risk assessment format and process which contrasts with the wide range of formal and informal formats and processes in the cases reviewed (section 3.5). Indeed, a national initiative would be welcome to achieve some degree of uniformity in risk assessment.

5.3.6 Legal considerations in cases of alleged abuse

We have seen that a wide range of legal actions to effect protection were considered in the present cases (section 3.6), though it was the *Adults with Incapacity (Scotland) Act 2000* that was mainly considered with guardianship sought following an assessment of capacity. Social workers were on occasions pursuing legal options without a clear view of the provision of the legislation, depending ultimately and appropriately on input from council solicitors and/or MHOs. However, even when guardianship was achieved by the local authority, there was evidence that it was unclear how this was to be acted on in the context of the protective strategy. With the addition to legal provision of the *Adult Support & Protection (Scotland) Act 2007*, this position becomes an even more complex situation for non-legal professionals.

5.3.7 Independent advocacy

In the present cases independence advocacy was thin on the ground (section 3.7). Comment has already been made regarding the availability of independent advocacy at adult protection meetings to adults who have been, or have allegedly been, abused. However, the potential role of advocacy, as acknowledged in the Act, is more wide ranging. Such representation is required outside such formal settings and indeed beyond the conclusion of formal adult protection activity.

There are funding and capacity-building implications for independent advocacy support services and the model of adult protection advocacy that should be adopted. It would be preferable for independent advocates to be consistently involved in adult protection processes as a consequence of the greater availability and use of such services overall, rather than independent advocacy involvement

being triggered by a crisis. Nevertheless, such crisis advocacy will also be called for.

5.3.8 Reflective learning

We have seen that in a minority of cases social work departments took a decisive lead in convening meetings and monitoring the protective strategy (section 4.1.1). It is to be expected that the *Adult Support & Protection (Scotland) Act 2007* which formalises this role of councils will improve the effectiveness of leadership decisively. However, given the frequent lack of transparency in defining a leadership role a statement of leadership plan following initial inquiries would be highly desirable.

Less obvious, however, is the absence of any attempt to draw together agencies' experiences of the cases and learn from them. In only a small minority of cases was any attempt made to get closure. The importance of such closing reviews cannot be overemphasised. First, there is the opportunity in an interdisciplinary setting to identify processes that were and were not successful in protection and in resolving the case. These processes will have occurred both within agencies and between agencies providing in the latter the opportunity to review operating practices and communications. Second, they provide an ideal opportunity for agencies to evaluate differences in approach that bear directly on increasing understanding of cultural and procedural differences to which we referred above in section 5.1.

In the heavily pressurised context of human services, the motivation to undertake such reviews may often take second place to engagement with new cases and (wrongly) be viewed as inefficient use of time. Such reviews should be built into the overall process of adult protection and conducted as a matter of course, while Adult Protection Committees should include in their programmes of work reviews of a subset of cases that the involved professional judgements to illuminate strengths and weaknesses in adult protection processes. Such information will inform both the committee's development of protective processes and indicate areas for training and staff development.

5.4 Adults at risk, their families and the perpetrators

In the inner circle of adult protection cases sit adults at risk, their family members and the alleged and actual perpetrators. In the present study we did not have the opportunity to interview these protagonists, as this would have gone beyond the project remit. A considerable amount of information, however, was gathered on them, and here we are particularly concerned with their part in the process of adult support and protection as reflected in case records and interviews with professionals.

5.4.1 Alleged victims and victims of abuse

As we noted in section 1.2.2 (figure 1), the victims and alleged victims were extremely diverse. How they were approached and dealt with in the cases was obviously conditioned by their needs and characteristics both with respect to their capacity and personality as well as the circumstances in which they lived. The

pervasive feeling in reading the case files and listening to the interviewees was that though abuse remained unproven in most cases, there was significant cause for concern and a high likelihood that abuse had been perpetrated. There is considerable ambiguity in this situation. The cases were typically dealt with *as if* abuse had occurred or was occurring, and on the evidence of the case files and interviews this was entirely justified. Here *risk* was the key consideration. Better to make a Type 1 rather than a Type 2 error, i.e. accept that there is a risk when there is not, rather than reject the suggestion that there is no risk when there is.

In section 4.1.7.1 we drew attention to the way in which the behaviour of an individual could lead to an increased risk of abuse, while making clear that such an analysis in no way implied blame of that individual. Though the person may lack insight into how their own behaviour might put them at risk, consideration has to be given to how, through training and support, such behaviour may be modified. More broadly, increasing awareness though education and training is a further dimension of adult support and protection that should be implemented.

Acceptance of the risk that individuals have been exposed to abuse has important implications for follow up and support for the at risk individual. Examples were found of excellent follow up treatment and support, both individually and to groups (section 4.1.1.1), generally through social work support, but also occasionally through health service counselling and treatment. In some cases continued care management sufficed while in others an intervention focused on the consequences of the abuse through counselling or therapy. Explicit consideration should be given to the victim's or alleged victim's therapeutic needs in the aftermath of adult protection cases whether the allegations were supported or not.

5.4.2 Family members

Policy and legislation are now directed explicitly at providing individual choice to encourage autonomy and to ensure the least restrictive circumstances for the individual. Where an individual has capacity this can bring the at risk person and his or her family into conflict. Despite the emphasis in social work practice on facilitating improved family relationships, the autonomy of the at risk individual should be paramount. This should not be obscured because of confusion as to whom within the family is the client. For instance, where an adult at risk wishes to move out of a particular situation, or might wish to move out if their views were explored, professionals should not grant the right of veto to family member or continue with their own aim of maintaining the family's physical integrity at all costs.

Family members remained closely engaged with and concerned about their relative in managed settings including care homes. They might also be the source of complaints regarding the treatment of their relative. For them to contribute to the protective process, it is essential that they are given clear information on the process by which they can make their concerns known. This applied whether the complaint related to the general quality of care or specifically to an allegation of abuse. When complaints are made, this information should be reiterated and support given to them in the reporting process.

5.4.3 Alleged perpetrators and perpetrators of abuse

We noted (sections 3.2.2 & 3.2.4) the extent to which alleged perpetrators had continued access to at risk adults or where information was lacking as to the access they did have. In such situations though an adult protection case may be closed, and despite the fact that abuse was alleged and not proven, there remains an issue as to the status of such alleged perpetrators with respect to the varying risks they may be judged to present. How information regarding earlier allegations and future risk is handled will depend on the status of the individual and their relationship with the at risk adult. A clearly articulated policy should be developed that states how statutory agencies in interagency partnerships should, or should not, monitor alleged perpetrators. Such a policy will have to be framed in the light of individuals' human rights, employment status, professional codes of practice and relevant legislation.

6 CONCLUDING COMMENT

The close analysis of the cases reported has been effective in identifying both strengths and weaknesses in interagency adult protection practice, and a wide range of complementary issues. The study cannot, however, lay claim to having some form of statistical validity in relation to the many cases dealt with in Scotland over a given period of time. As with most qualitative research, the emphasis has been on depth of analysis rather than breadth and generalisability. The findings, however, have now been reported in a wide range of local and national forums to those working in this field. We were encouraged by the extent to which our findings were judged to reflect practice at the time, and in a sense to validate practitioners' own experience.

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