The Regulation and Quality Improvement Authority

Criminal Justice Inspection Northern Ireland
a better justice system for all

Joint Review by RQIA and CJI of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults

February 2012

informing and improving health and social care
www.rqia.org.uk

Contents Page

List of Abbreviations

ABE	Achieving Best Evidence
AJP1	Adult Joint Protection Form 1 – Appendix 6 from the Protocol
AJP2	Adult Joint Protection Form 2 – Appendix 7 from the Protocol
AJP3	Adult Joint Protection Form 3 – Appendix 8 from the Protocol
AVA&C	Abuse of Vulnerable Adults and Children
Belfast Trust	Belfast Health and Social Care Trust
CJI	Criminal Justice Inspection Northern Ireland
DHSSPS	Department of Health Social Services and Public Safety
HSC	Health and Social Care
LASP	Local Adult Safeguarding Partnership
MARAC	Multi-Agency Risk Assessment Conference
MVPO	Missing and Vulnerable Person Officer
NIASP	Northern Ireland Adult Safeguarding Partnership
Northern Trust	Northern Health and Social Care Trust
PPANI	Public Protection Arrangements Northern Ireland
PPU	Public Protection Unit
PSNI	Police Service of Northern Ireland
RCU	Rape Crime Unit
RQIA	Regulation and Quality Improvement Authority
South Eastern Trust	South Eastern Health and Social Care Trust
Southern Trust	Southern Health and Social Care Trust
Western Trust	Western Health and Social Care Trust

Foreword

In recent years significant efforts have been made within health and social care services and the Police Service of Northern Ireland (PSNI) to establish procedures and operational arrangements in order to respond effectively to the abuse or exploitation of vulnerable adults. A considerable degree of interagency liaison was necessary to develop effective partnership working arrangements, to help prevent abuse and to respond appropriately when it is alleged, suspected or occurs.

In May 2011 a joint review was carried out by the Regulation and Quality Improvement Authority (RQIA) and Criminal Justice Inspection Northern Ireland (CJI) of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (the Protocol), introduced in July 2009. The Protocol outlines the role and responsibilities of the respective agencies and provides guidance about joint working arrangements and investigation. It was developed in partnership between the PSNI, the health and social care (HSC) trusts, the HSC Board, RQIA and the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland.

The purpose of this review was to assess the progress made by HSC trusts, HSC Board, PSNI officers and RQIA in the implementation of the Protocol since 2009.

The review team found that since the introduction of the Protocol, much progress has been made in establishing and maintaining effective and improved working relationships at an operational and strategic level, involving colleagues across all agencies. Trust social services staff and PSNI officers interviewed as part of this review demonstrated knowledge of their role and function. They stated that the Protocol has assisted them in developing a multidisciplinary approach to the protection of vulnerable adults in Northern Ireland. Social services and PSNI staff indicated they are working more closely together in sharing information, although some aspects of communication and recording of information requires further improvement. Some best practice exemplars of joint training were evident in a number of HSC trusts e.g. the deployment of dedicated social services personnel to work more closely with the PSNI by the Belfast, South Eastern and Southern HSC trusts.

A number of staff reported that the Protocol had assisted them in the exercise of their professional judgement and in the consideration of their legal responsibilities. The majority of those interviewed believed that it was beneficial that RQIA was a joint signatory to the Protocol in that RQIA had access to intelligence regarding the services associated with vulnerable adult cases and that RQIA had enforcement powers, particularly in relation to regulated services that could not be used by other agencies.

The review team considered that the Protocol represents a good example of how public services can find effective ways of working for the benefit of citizens.

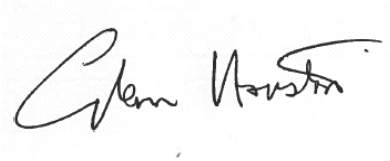
Local Adult Safeguarding Partnerships (LASPs) have been established in each trust area which have fundamentally changed the governance of adult protection services at a local level. A number of workstreams have also been established regionally under the Northern Ireland Adult Safeguarding Partnership (NIASP) to help safeguard and protect vulnerable adults. No significant difficulty was noted with regard to the recruitment of staff with most social services posts being filled or about to be filled. However, some operational pressures regarding the staffing of PSNI districts require to be addressed, in order for PSNI officers to develop specialist knowledge and retain skills of officers involved in responding and working with vulnerable adults.

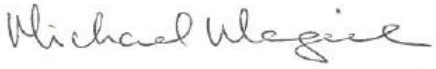
The review team had concerns about the lack of consideration given across the region to the completion of the human rights forms set out in the Protocol and particularly noted a varied approach by HSC trusts in the expected completion of the suite of forms set out in the Protocol. This was evident in the recording of joint agency consultations or in situations where an agreement was made with the PSNI to undertake a strategy for investigation. The appropriateness and use of the current forms requires further review by all the agencies involved to ensure the effectiveness of their implementation. The delay caused by the time it takes for investigations to be directed upon by the Public Prosecution Service (up to 18 months in some cases), was raised as a frustration by social services staff. This was of, particular concern where an employee has been suspended as a consequence of an allegation leading to a police investigation.

This review demonstrated that, whilst much has been done, the treatment of vulnerable adults needs to remain agenda priority for both health and justice sectors. All staff require recognition and support from a senior level in their agencies to continue to build on the positive work completed to date and to enable the required improvements agreed by NIASP and other agencies to be implemented in the future.

The review team suggest that the Protocol is reviewed by all agencies involved in view of the new legislative requirements introduced since 2009 and the issues raised for agencies as a result of this review.

The review team commends all those involved in this crucial and demanding area of work and wishes to thank all the staff who contributed to this review.





Glenn Houston
Chief Executive, RQIA

23 November 2011

Michael Maguire
Chief Inspector of Criminal Justice Inspection for Northern Ireland

23 November 2011

Section 1: Introduction

1.1 The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent regulator for health and social care in Northern Ireland.

RQIA was established in 2005 as a non-departmental public body under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

The vision of RQIA is to be a driving force for positive change in health and social care in Northern Ireland through four core activities:

- Improving Care: we encourage and promote improvements in the safety and quality of services through the regulation and review of health and social care.
- Informing the Population: we publicly report on the safety, quality and availability of health and social care.
- Safeguarding Rights: we act to protect the rights of all people using health and social care services.
- Influencing Policy: we influence policy and standards in health and social care.

RQIA operates within a value system that supports the belief that learning is at the heart of improvement. To ensure a clear focus on improvement, organisations need to have effective systems which can identify performance standards and support the learning necessary for improvement. The review was undertaken in accordance with the guidance contained in the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (July 2009).

1.2 Criminal Justice Inspection Northern Ireland

Criminal Justice Inspection, Northern Ireland (CJI) is an independent, statutory inspectorate established in 2003 under section 45 of the Justice (Northern Ireland) Act 2002.

CJI inspects a range of agencies which include the police, prison, prosecution, probation, and youth justice services and the courts.

The strategic aim of CJI is to promote the effectiveness, efficiency and even-handedness of the criminal justice system in Northern Ireland.
The strategic objectives of CJI are to:

- Promote efficiency and effectiveness through assessment and inspection to facilitate performance improvement.

- Provide an independent assessment to Ministers and the wider community on the working of the criminal justice system.

- Provide independent scrutiny of the conditions for and treatment of, users of the criminal justice system, in particular victims and witnesses, children and young people, prisoners and detainees; and work in partnership to deliver a high quality, independent and impartial inspection programme.

This allows CJI to identify issues that are common to some or all agencies and to promote inter-organisational learning and best practice in the sector.

1.3 Context for the Review

RQIA's Three Year Review Programme 2009-12 identified issues relating to vulnerable adults as an area requiring review. In July 2009 guidance and standards regarding the protection of vulnerable adults were published in a protocol, known as The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults. This was developed in partnership by the PSNI, DHSSPS, HSC Board, RQIA and HSC trusts and the former Health and Social Services Boards.

At the time of the launch of the Protocol in September 2009, it was suggested by the respective chief executives of the HSC Board and RQIA and the Chief Constable of the PSNI, that the Protocol should be closely monitored, reviewed and revised at an appropriate time in the light of experience.

RQIA and CJI agreed with DHSSPS and the Department of Justice (DOJ) respectively in May 2011 to undertake a joint review of the implementation of the Protocol. It was agreed that the joint review should examine:

- the governance and staff arrangements regarding the safeguarding of vulnerable adults
- the nature and type of interagency training provided to the PSNI and HSC staff
- the extent of partnership and interagency working between the HSC trusts, HSC Board, PSNI and RQIA staff, to support the implementation of the Protocol

1.4 The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults

The Protocol requires all staff to report suspected, alleged or confirmed instances of abuse of vulnerable adults. It sets out the role and responsibilities of the respective agencies and provides guidance about joint working arrangements and investigation. The main aim of the protocol is in protecting vulnerable adults from abuse, by promoting an interagency approach to their protection. It also aims to ensure vulnerable adults receive equitable access to justice in a way that promotes their rights and wellbeing.

The Protocol provides a framework within which staff exercise their professional judgement and discharge their legal responsibility to ensure that

all cases are appropriately screened. The Protocol is supported by an on-going programme of interagency training.

1.5 The Oversight Role of HSC Trust, PSNI and RQIA

The alleged and suspected abuse of vulnerable adults in Northern Ireland is overseen by three separate bodies – the HSC trusts, the PSNI and the RQIA.

Where an alleged instance of abuse of a vulnerable adult takes place the primary responsibility for protection rests with the relevant HSC trust. If an investigation indicates a criminal issue is evident, it is dealt with by the PSNI. Where it relates to individual care the HSC trust leads the investigation. RQIA will become involved where a potential breach of regulations governing the care and protection of vulnerable adults has occurred. HSC trusts and the PSNI are expected to comply with regional procedures and the guidance contained in the Protocol.

The Human Rights Act 1998 was adopted in Northern Ireland in October 2000. It incorporates the European Convention for the Protection of Human Rights and Fundamental Freedoms into United Kingdom domestic law. This makes it unlawful for public authorities to act in a manner which is incompatible with the rights and freedoms guaranteed by the convention. Appendix 1 of the Protocol sets out the main convention rights enshrined in the 1998 Act. A list of human rights considerations are set out in Appendix 2 of the Protocol, the application of which was examined by the review team.

Victims/survivors were not directly involved in this review as the team was concerned that further interviews with victims/survivors may cause unnecessary stress. An adult protection form is contained in the Protocol, which provides space for the recording of any discussions with victims/survivors. To assess and report on the extent of user participation in the process, the review team audited the completion of adult protection forms.

This overview report summarises the findings from the review of the implementation of the Protocol by RQIA and CJI, to ensure the effectiveness and quality of safeguarding of vulnerable adults. It makes recommendations which the review team considers necessary for all bodies reviewed. The overview report and five individual trust reports are available on RQIA's website www.rqia.org.uk.

As part of this review RQIA invited Mr David Wiseman a former inspector and Deputy Chief Executive with the former Care Commission, Scotland, to undertake an audit of RQIA's role in relation to the Protocol. Mr Wiseman's conclusions and recommendations are set out in appendix 7.

1.6 Review Methodology

The methodology for the review comprised the following stages:

1 Completion and submission to RQIA of a self-assessment from the five health and social care HSC trusts, together with supporting evidence. The self-assessment questionnaire was developed from the principles and guidance set out in the Protocol.

2 An audit was undertaken of 12 files per trust to review the implementation of the Protocol in terms of the consideration given to the:

- human rights of the those thought to be subject to abuse
- completion of the Adult Protection Form AJP1, to record details of joint agency consultations
- completion of the Adult Protection Form AJP2,to record the strategy agreed for investigation
- completion of the Adult Protection Form AJP3, to record the nature of discussion and the consideration of the adults willingness and ability to engage in an interview.

3 Joint validation visits involving RQIA inspectors and the Deputy Chief Inspector for CJI were undertaken, and involved meeting with staff and senior management within HSC trusts and with the PSNI officers responsible for the operational management of vulnerable adults' cases. The format for each meeting with the trust was to validate information supplied in the profile and the self-assessment questionnaire. Discussions were held with a number of PSNI officers responsible for processing vulnerable adult referrals who commented on the liaison arrangements with HSC trusts.

The review team audited a number of PSNI forms that corresponded to the forms selected from the HSC trust files.

4 RQIA held a meeting with the HSC Board to review its oversight arrangements for monitoring the implementation of the Protocol by HSC trusts and the HSC Board's planning and commissioning of services for safeguarding vulnerable adults.

5 RQIA also commissioned an independent reviewer to examine how RQIA discharged its functions in relation to the implementation of the protocol. This focused on RQIA staff's awareness of their responsibility in respect of the protocol. It also examined the effectiveness of the liaison arrangements between RQIA, HSC trusts and PSNI, and the appropriateness of RQIA being a signatory to the Protocol.

6 Preparation of a feedback report for each trust by RQIA and for the PSNI by CJI.

7 Preparation of an Overview Report of the findings of the review across Northern Ireland.

1.7 Membership of the Review Team

Theresa Nixon	Director of Quality Assurance and Chief Social Work Advisor, RQIA
Brendan McGuigan	Deputy Chief Inspector CJI
John Black	Head of Residential and Day Care Regulation, RQIA
David Philpot	Project Manager, RQIA
Janine Campbell	Project Administrator, RQIA

Section 2: Findings of the Review Team of the HSC Trusts

2.1 Profile of the HSC Trusts

Five health and social care HSC trusts have been operational in Northern Ireland since HSC trusts were established on 1 April 2007, following the merger of the legacy HSC trusts as a result of the Review of Public Administration. In 2011 the HSC trusts provided services to a total population of 1,776,613.

Figure 1: HSC Trust Geographical Boundaries

2.2 Number of Vulnerable Adult Referrals

Figures provided by the HSC Board obtained from the Delegated Statutory Functions Statistical Report (31 March 2011) indicate that there were 1,936 vulnerable adult referrals within Northern Ireland during 2010-11.

Table 1 Number of Vulnerable Adult Referrals

HSC Trust	Number of Referrals
Belfast	643
Northern	396
South Eastern	441
Southern	251
Western	205
Total	**1,936**

The review team noted that all the agencies involved in responding to referrals are not recording information in a similar manner. These figures may represent an under recording of vulnerable adult referrals across Northern Ireland. NIASP should review the reporting arrangements by the HSC trusts to make sure that all new referrals are appropriately recorded.

2.3 Governance

In all five HSC trusts there were clear lines of management accountability and professional responsibility from front line staff through to the chief executive and the trust board for services provided to vulnerable adults.

In each trust an appointed director was in place having clear responsibility for the development of systems and processes to discharge the responsibilities of the trust. Each trust's strategy for adult safeguarding has been determined in accordance with the DHSSPS Regional Adult Protection Policy and Procedural Guidance (September 2006) and the DHSSPS Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (July 2009). This has been further supported by the introduction of Local Adult Safeguarding Partnerships (LASP) and by the development of a Northern Ireland Adult Safeguarding Partnership (NIASP), which was managed by the HSC Board since March 2010.

The review team considered that the integrated assurance structures in each trust provide a good framework for the monitoring of compliance in relation to organisational assurance processes, including accountability for the implementation of the Protocol.

All HSC trusts had developed good working relationships with the Chair of LASP and Chair of NIASP at the HSC Board which was robust in monitoring and in drawing up reporting mechanisms.

All HSC trusts were able to demonstrate how they report information on the discharge of their statutory functions when reporting to their trust board and the HSC Board. Opportunity to communicate information and outcomes in relation to vulnerable adults is provided through the HSC trusts' annual delegated statutory function reports to the HSC Board. Here, performance returns and significant issues regarding the management of cases are highlighted. The review team noted that this continues to be a developing area of practice across HSC trusts.

The review team considered that the discharge of statutory functions and governance oversight arrangements in respect of vulnerable adults, including risk management, were generally well discharged by HSC trusts. However, processes varied from trust to trust. Each trust provides the following details to the HSC Board in their annual discharge of Delegated Statutory Functions Report:

- number of vulnerable adult referrals received each year
- how many were received from acute settings
- number of investigations commenced within the year
- the number of investigation completed within the year
- how many require a multi-agency risk assessment conference (MARAC)
- number of adult protection plans in place on 31st March.

HSC trusts reported clearly on processes for reporting and escalation of challenges in meeting their statutory functions to the HSC Board and DHSSPS. The review team noted that liaison and performance management arrangements were in place between the HSC Board and each of the five HSC trusts. These aim to ensure the effective management of vulnerable adult issues.

Some guidance has been issued by NIASP in respect of sharing outcomes and learning from investigations of abuse of vulnerable adults across Northern Ireland.

The roles of the designated officers was clear in all HSC trusts. The importance of these posts in the development of vulnerable adult services was acknowledged by all trust staff, although some were at different or differing stages of the progression of their work plans.

Each trust has an incident reporting policy and indicated that all vulnerable adult issues are reported through the adverse incident reporting mechanisms within the HSC trusts. This provides a framework to evidence and report on situations where near misses have occurred and assist in the review of trend data by senior managers. These include incident reports about regulated services which have been sent to RQIA. This framework allows managers to review practice and identify trends, enabling learning and development to occur where it is deemed appropriate. A monthly meeting is held by the five trust adult safeguarding specialists which the review team believe has been helpful in the sharing of learning and the promotion of consistency of approach across the five trust areas.

In reviewing the implementation and overall delivery of the Protocol across the five HSC trusts, the review team found that the adult protection services were responsive to allegations of abuse to vulnerable adults, whilst conforming to the regulations, policies and procedures.

The review team had concerns about the lack of consideration given to the completion of the human rights forms as set out in the Protocol. The review team noted, in particular, a varied approach across the HSC trusts in the completion of these forms. A number of HSC trusts are using old adult joint protection (AJP) forms, while others are adding additional information to the forms.

The review team considered that the appropriateness and use of the current forms requires further review by all the agencies involved in order to ensure the effectiveness of their implementation.

The delay caused by the time it takes for investigations to be directed upon by the Public Prosecution Service (up to 18 months in some cases), was raised as a concern and a frustration by many social services staff. This was particularly the case when health and social care staff have been suspended (often on full pay) or deployed on other duties.

The review team was advised that social services staff have on occasions initiated their own investigations in an attempt to respond to incidents or allegations, before involving the PSNI. This presents a risk of the loss of forensic information or evidential opportunities and should be emphasised to all staff during in service training.

2.4 Staffing

No difficulties were noted across the five HSC trusts in workforce planning and recruitment although staff vacancies existed in some teams. Each trust indicated they had taken steps to minimise the impact of any vacancies by operating a vacancy control system.

Designated officers indicated that the volume of work and responsibilities of the role are increasing as a result of evolving policy development and the increased need to raise awareness of vulnerable adult issues across the range of staff in the trust.

The review team was advised that workforce planning to address any potential gaps, was a continuing priority to ensure the trust could deliver an appropriate service.

2.5 Training

To provide safe and effective services to vulnerable adults, staff should be fully supported, regularly supervised and appropriately trained and educated.

Every trust is required to provide in service training and development opportunities for staff in order that they can undertake the roles and responsibilities required by their job, including compliance with:

- DHSSPS policy and guidance
- professional and other codes of practice; and
- employment legislation

A key element of this review was the examination of how the five HSC trusts co-ordinated the training of the staff involved in the Protocol and associated adult protection and safeguarding procedures, and how this is monitored by the HSC Board.

The review team examined the issue of training and makes reference to the responses received from each trust in relation to:

- the key objectives of the training provided
- feedback mechanisms regarding the quality and benefit of training
- suggestions regarding any improvements needed to the training
- interagency cooperation during and post training.

The findings below include, an overview of responses received from each trust arising from the discussions with the review team, alongside any specific

information provided in the self-assessment forms returned. Further detail on training provided is contained in the individual trust reports.

General Commentary

The review team noted two consistent themes regarding training, these were:

1. HSC trusts reported the significant benefit derived from any joint training undertaken by trust staff with colleagues from the PSNI. Joint training facilitates a greater understanding and respect for each services role and responsibilities when it comes to safeguarding vulnerable adults. It also establishes greater trust and liaison between colleagues from each organisation.

2. One issue identified concerned the awareness and understanding of all staff working within the acute sector and in adult psychiatric/learning disability facilities, and the need for HSC trusts to promote and ensure training in, and awareness of, vulnerable adult issues.

2.5.1 Health and Social Care HSC Trusts

Overview of Number of Staff Trained

All five HSC trusts were able to identify the number of staff who have received training in the Protocol and associated procedures. Specific information regarding numbers of staff trained in the Protocol and associated processes is available in the individual HSC trusts' report. Whenever possible this training is joint and includes social services and PSNI staff. A number of HSC trusts have indicated they had plans underway to train further staff through joint training initiatives involving the PSNI.

Key Objectives of Training

All five HSC trusts confirmed that each training session is underpinned by clearly defined aims and each trust specified the objectives for the particular training and the desired outcomes.

The Belfast Trust indicated that the training provides guidance to staff on how to help if the vulnerable person does not want to complain; the ethics related to a situation when a person does not consent to have an allegation investigated, and how, such situations are to be managed. The training programme uses a variety of approaches including videos and role play which specifically cover areas such as gathering evidence, decision making and strategy planning.

The South Eastern Trust representatives described the development of an e-learning tool for use by its domiciliary care service. The trust also made this available to independent sector providers with whom it had service contracts. In addition, the trust representatives advised that a DVD which highlights

issues regarding the safeguarding of vulnerable adults is available to trust staff teams.

The Western Trust aims to ensure that the right person, with the right skills, is dealing with the right case, so that cases are managed properly and risks are minimised. In meeting this target the trust has developed a comprehensive guide for its staff. This includes the actions they should take from an initial referral through to the management of strategy meetings and when cases should be closed. This is an approach other HSC trusts may wish to follow and may be helpful in the future development of regional guidance.

Feedback Mechanisms Regarding the Quality and Benefit of Training

The Northern Trust representatives described how training is coordinated through the regional social services training department, supported by the regional nurse education and development centre.

The Southern Trust has a designated training officer with responsibility for all vulnerable adult training.

The Belfast Trust gathers feedback from the training programmes and reported that the comments from those attending noted attendees appreciate the quality and content of the training received. The trust representatives described the establishment of a practice support group which receives feedback regarding both the training and practice issues. This group is responsible for ensuring that examples of good practice are shared across the trust. Difficult or contentious issues, for example when a vulnerable service user declines assistance from either the trust or PSNI, are also shared.

The Northern Trust stated that the evaluation of training is captured using a specific software package called Evaluator 6. This provides a detailed report covering both quantitative and qualitative feedback from those attending training.

Other informal mechanisms were described as being a source of information about the quality and benefits of training. These included social work forums and operational interface groups, as well as individual and group supervision processes. The Northern Trust also uses a quality review process to examine the long-term impact of training on practice. This practice includes sampling training courses provided, contacting attendees and seeking their views, through use of a questionnaire, about the impact of the training they have received on their practice and knowledge and skills. The review team considered this to a very proactive approach to ensuring that the learning from training was being applied in practice.

The Southern Trust highlighted a need for greater joint working with PSNI and managing cases where service users were not willing to make a disclosure. In order to address these issues, trust representatives described how these matters are discussed further through directorate and staff team meetings to ensure that all staff fully understand their obligations regarding vulnerable

adult issues. In these forums trust staff are able to ask questions to help clarify roles in the process of safeguarding vulnerable adults and to ensure they are aware of who to contact when they have any concerns.

The South Eastern Trust described how training is evaluated through individual staff supervision and an audit of vulnerable adult cases to identify that they are managed properly. In addition, the trust ensures the on-going relevance of training provided or where, in light of experience, amendments to the training are needed this is brought within its adult protection forum which considers the broad range of issues regarding adult safeguarding and protection.

An example of how this forum can promote change and benefit the approach to vulnerable adult issues was highlighted and this concerned the availability of staff from the trust with appropriate Achieving Best Evidence (ABE) skills. Whilst not a unique issue for this trust, the same was described by other HSC trusts, in that staff trained in ABE were not gaining any experience in using these skills because of a lack of referrals in their particular area of work. At the same time others trained in ABE, had to use these skills very frequently because of the higher number of referrals they were receiving. The trust made a decision to establish a rota that spanned across directorates which means that those trained in ABE are able to keep their skills up to date and there is a more equitable allocation of resources within the trust to what can be a very time consuming and resource intensive area of work.

Suggestions Regarding any Improvements Needed to the Training

The Belfast Trust reflected many positive improvements in the outworking of the Protocol but suggested some scope for improvement, mainly regarding the use of the AJP1 forms and in the transfer of information between the trust and PSNI.

The Southern Trust described how each training session is audited to ensure that skills and knowledge are kept fully up to date. The review team was informed of a proposal by the trust to establish a specific training programme for staff working with complex families and that this would form part of a masters level course in family therapy for which staff would be credited. The review team considered this to be a potentially positive development and one that might encourage staff working in the area of family therapy.

The overview of responses from each trust arising from the discussions with the review team concerning partnership and interagency cooperation during and post training are described in section 3.

Section 3: Partnership and Interagency Working across all Agencies

3.1 Partnership

"The essence of partnership is sharing. It is marked by respect for one another, role divisions, rights to information, accountability, competence, and value accorded to individual input. In short, each partner is seen as having something to contribute, power is shared, decisions are made jointly and roles are not only respected but are also backed by legal and moral rights.,."(Jo Tunnard,1991, cited in Jackson and Morris, 1994 p1[1]).

RQIA and CJI sought to examine the extent of interagency and partnership working across the agencies referenced in the Protocol and involved in safeguarding and protection of vulnerable adults.

Health and Social Care agencies, together with Criminal Justice agencies, have a lead role to play in preventing and detecting abuse, and in providing protection to adults at risk of harm. Specifically, they seek to ensure that adults receive protection, support and equitable access to the Criminal Justice System. The review team noted that key representatives with a knowledge of vulnerable adult issues have been nominated to NIASP from all agencies apart from RQIA, as RQIA wish to retain their independence as a regulator.

The Protocol is based on the recognition of the need for a more coordinated interagency working approach to ensure that vulnerable adults who are at risk of abuse, receive protection, support and equitable access to the criminal justice system. Effective adult safeguarding and protection requires to be firmly based on co-operation and commitment between staff and agencies and shared decision making.

The review team examined information sharing and the linkages and structures in place to enable the progression of safeguarding between relevant agencies.

3.2 Information Sharing between Agencies

The review team noted that significant energy has been invested in sharing information, in improving managerial oversight of the arrangements and many areas of good practice were noted.

The review team was advised that the transfer of documents between social services and police has been problematic. Further consideration is required regarding the appropriateness of electronic transmission of documentation and the PSNI is urged to find a solution to allow the better flow of information between agencies.

[1] Jackson, S. and Morris, K. (1994) Looking at Partnership Teaching in Social Work Qualifying Programmes, London: CCETSW

The review team considered that that the use of existing forms requires review by both social services and the PSNI in the light of operational practice, to ensure that all parties to the Protocol have access to the necessary information.

HSC trusts and PSNI staff reported some lengthy delays in concluding investigations which require to be directed upon by the Public Prosecution Service. Some social services staff stated that on occasions it has been difficult to follow up issues due to a number of reasons. These include the absence of key personnel because of rota arrangements in the PSNI or difficulties in agreeing follow-up meeting dates with social services officers to enable joint investigations to proceed. HSC trusts also reported that securing the services of an advocate to support the vulnerable adult has been a challenge at times. In some instances these have added to the delay in gathering information and closing cases.

3.3 Linkages and Structures

The review team found that the formation of the LASPS and NIASP in September 2010 has helped to create the necessary linkages and structures to enable the progression of the range of activity, in adult safeguarding matters between criminal justice agencies and public protection arrangements.

Since September 2010 the LASPS and NIASP have worked closely together to develop connections to the criminal justice agencies and public protection arrangements. The review team noted that much time and effort has been invested by the HSC trusts and HSC Board staff in the development of processes and procedures for reporting and escalation of challenges in meeting the statutory functions of HSC trusts. This includes the discharge of their arrangements under the Protocol.

Each LASP had also established a number of internal multi-agency working groups in conjunction with NIASP to enhance multi-agency working. There was evidence of robust sharing of information between social services and the PSNI. The review team is of the view that dedicated PSNI officers for vulnerable adults would help to lead to a more efficient decision making process.

A high level of collaboration, cooperation and communication regarding agreed areas was evident between the five HSC trusts, HSC Board, PSNI and RQIA. The review team considered that the NIASP work plan reflected a range of activity across the full spectrum of adult safeguarding in respect of prevention, protection and partnership working.

The review team considered that each priority area identified for action in the NIASP work plan will require further detailed planning and the development of individual action plans. These will need to be monitored by NIASP for effective implementation at its quarterly meetings.

The review team also noted that much work has centred on streamlining processes related to the multiagency risk assessment conferences (MARAC). NIASP has sought to clarify the relationship of the MARAC processes to adult safeguarding procedures to ensure there is for example, a consistent response for victims of domestic violence or abuse.

Public Protection Arrangements in Northern Ireland (PPANI) has issued revised guidance for the management in the community of sexual/dangerous offenders which makes specific reference to adult safeguarding.

3.4 Partnership Arrangements and Interagency Working by the HSC Board

The HSC Board is one of the signatories to the Protocol. Since its launch in July 2009, procedural and strategic arrangements have been established to assist HSC trusts and other agencies to respond effectively to any abuse or exploitation of vulnerable adults. The review team considered that the HSC Board has used the Protocol as a basis for improving interagency working and that its introduction was supported by a programme of interagency training.

The UK government has developed policy frameworks which aim to improve safeguarding and protection outcomes for adults who are at risk of abuse, exploitation or neglect. The Northern Ireland Adult Safeguarding Partnership (NIASP) led by the HSC Board has key areas of responsibility in relation to adult safeguarding activity. The establishment of NIASP has helped to change the governance of adult protection services through the development of a range of workstreams. These aim to address consistency, integration and co-ordination of services across each of the HSC trusts, focusing on the following areas:

a) operational policy and procedures
b) training
c) information management
d) communication and user engagement

The review team noted, in addition to the workstreams outlined above, the development of Safeguarding Adults at Risk Information Hub (SAaRIH) - an online resource for local researchers and practitioners. Formal links have been established with the Health Service Executive (HSE), Dublin, and the National Centre for the Protection of Older People, based in University College, Dublin.

The review team considered that the progression of a range of policies and initiatives has significantly improved working relationships and mutual understanding between the agencies involved in the implementation of the Protocol.

The review team commended the work of the HSC Board in establishing the NIASP. Without the work of the NIASP, the coordination and standardisation

of service delivery for vulnerable adults by all agencies would have been more difficult to achieve.

3.5 RQIA's Liaison Arrangements between HSC Trusts and PSNI

The majority of staff interviewed believed that it was beneficial for RQIA to be a joint signatory to the Protocol, RQIA has access to intelligence regarding the services associated with vulnerable adult cases and enforcement powers, in relation to regulated services that could not be used by other agencies.

Further detail on the independent review of the effectiveness of RQIAs liaison arrangements between HSC trusts and PSNI is included at Appendix 7.

3.6 PSNI Partnership Arrangements and Interagency Working

Members of the review team met with a number of PSNI officers to obtain their views on partnership and interagency working.

PSNI officers reported increasing levels of respect, trust and mutual understanding achieved through operational experience. Cases dealt with vary in complexity, however, communication has improved significantly between social services and PSNI. This has led to a clearer agreement on which investigations should be dealt with on a single agency or joint agency basis.

A key benefit for partnership arrangements with social services cited by the PSNI is the level of support and guidance offered by them in negotiating often difficult and complex cases involving vulnerable adults. This is particularly important for residents of care homes which require a shared understanding of medication and treatment programmes and the thresholds between acceptable health and social care standards and incidents, particularly of neglect or abuse. However, a number of challenges also exist in relation to staff absences from the Public Protection Unit when no back-up arrangements are in place for screening of incidents until they return to work.

The review team suggested that the PPU review this matter particularly for long term absence. Reviewers were advised that police officers are not confident that all vulnerable adult referrals from social services are being made through them and, therefore, not recorded on its districts' databases.

The review team recommended that PSNI design and deliver a training package for all operational police officers and those staff involved in classification calls to the police.

Concerns about any under reporting of incidents are being addressed also through the LASPS and by participation by police in social services training events.

Further details of the review team's views in respect of the PSNI regarding partnership and interagency working is outlined in section 6.2.4.

3.7 Interagency Working in Respect of Joint Training by HSC Trusts and PSNI

The review team considered that all HSC trusts had established effective working arrangements with the PSNI and other agencies to promote, enhance and support interagency working. This included joint training with the PSNI in five trust areas. This served to develop a mutual understanding of the relevant responsibilities of the agencies and helped to inform and improve the awareness of the systems and processes required by staff to be follow up in relation to the safeguarding of vulnerable adults.

The Belfast Trust training team advised that it has established close working relationship with the police training unit and works closely with them in any joint training initiatives. This has helped foster a greater understanding of each service's role and responsibilities and raised awareness that there are similar issues for both parties. The trust indicated that liaison with the PSNI has improved significantly, due to stronger working relationships and a better understanding of the focus of each organisations work.

The Western Trust described the improvements in arrangements for adult safeguarding since it established an operational team linked across all trust service areas. This has also helped the development of improved liaison and communication with the PSNI when issues of concern arise.

The Western Trust highlighted the improved levels of communication that were now apparent between their staff and the PSNI. Not only through telephone and e-mail contacts but also through the facility provided to the Public Protection Arrangements Northern Ireland (PPANI) of staff having of a secure network link to the e-mail system of PSNI. In addition a PPANI representative from the trust works from and is based at a PSNI station one day per week.

When considering multi-disciplinary liaison, the Western Trust was able to describe how one hospital based social worker, is a designated ABE interviewer. This social worker liaises with medical staff appropriately in respect of alleged or suspected cases of domestic violence.

The Belfast Trust representatives described how the working relationship between trust staff and the PSNI was helpful in applying the Protocol. This is reflected in the way that staff know each other can make initial informal enquiries regarding issues of concern. Trust staff know the PPU specialist interviewers and now have experience of working with them in a structured way.

A further development described by the South Eastern Trust concerns training in the presentation of evidence to a court, which is a joint initiative being undertaken with colleagues from the PSNI. In addition, the trust's 'Emergency duty team' has received specific joint training with PSNI colleagues to ensure clarity about specific roles and responsibilities.

Trust officers who have availed of joint training with the PSNI described how this had enhanced their skills and enabled participants to learn from each other's experiences. Both trust and PSNI staff indicated that their working relationships have improved considerably, based on their experience of conducting joint investigations. Staff stated that this has enabled them to be more effective in their decision making and communication.

The review team commended the initiative shown by the Belfast Trust which had organised familiarisation courses for PSNI response officers. The review team considers this model of good practice could be replicated in other HSC trusts.

In general, the review team considered that much improvement was evident by both social services and PSNI staff working in partnership and facilitating interagency working. Each agency will continue to take a strategic overview of the planning, delivery and evaluation of the training strategy and works together to promote and develop effective interagency co-operation.

Section 4: Findings of the Joint File Audit of HSC Trusts/PSNI Files Regarding the use of Forms Contained in the Protocol

4.1 Audit of Files

An audit tool used by the reviewers to examine the HSC and PSNI records of reviewed incidents is contained at Appendix 6 of this overview report.

The review team developed the tool, which was used to review trust and PSNI files, based on the standards set out in the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults:

- Appendix 2: Human Rights - list of considerations
- Appendix 6: Adult Joint Protection Form 1 (AJP1) – which is a record of the Joint Agency Consultation
- Appendix 7: Adult Joint Protection Form 2 (AJP2) – which is a record of the Strategy for Investigation
- Appendix 8: Adult Joint Protection Form 3 (AJP3) – which is a record of the Clarification Discussion.

These appendices were used by the review team to audit compliance with the Protocol.

The file audit team comprised three RQIA staff and a Deputy Chief Inspector from the CJI, who visited all eight PSNI districts across Northern Ireland. The team met with vulnerable adult officers and their line managers, which included sergeants and inspectors. The file audit team carried out an audit of 60 randomly selected records of vulnerable adult referrals known to both trust and PSNI officers. Twelve were selected from each of the five HSC trusts known to have contained incidents that were reported either to RQIA or PSNI. To allow time for implementation of the Protocol and associated training, the incident reports selected were dated at least six months after the issue of the Protocol in July 2009.

The team checked to determine whether an initial referral form was present in the HSC records. They also examined the application of the process, including the timeliness and quality of communication at the point of referral between social services officers, and PSNI in line with the Protocol guidance. The findings of the file audit of records in the eight PSNI districts, conducted by CJI are included in Section 6 of this report.

To establish that an incident had been recorded, it was agreed that reviewers would locate the initial referral form in the vulnerable adult's HSC file, before conducting an audit of the files selected from each trust. The presence of an initial referral form confirmed an incident had been recorded in the file. The reviewers compared the original PSNI forms with the HSC forms, to see if the HSC form was a photocopy of the PSNI form, and contained identical information.

4.2 Findings of the Review Team

Initial Referral Forms

Table 2: Number of Initial Referral Forms

HSC Trust	Number of Initial Referral Forms present in 12 files
Belfast	12 referrals present
Northern	12 referrals present
Southern	12 referrals present
South Eastern	12 referrals present
Western	12 referrals present

Every trust had an initial referral fully completed for each of the 12 files audited.

Human Rights Forms – Appendix 2 in the Protocol

Table 3: Number of Human Rights Forms Completed

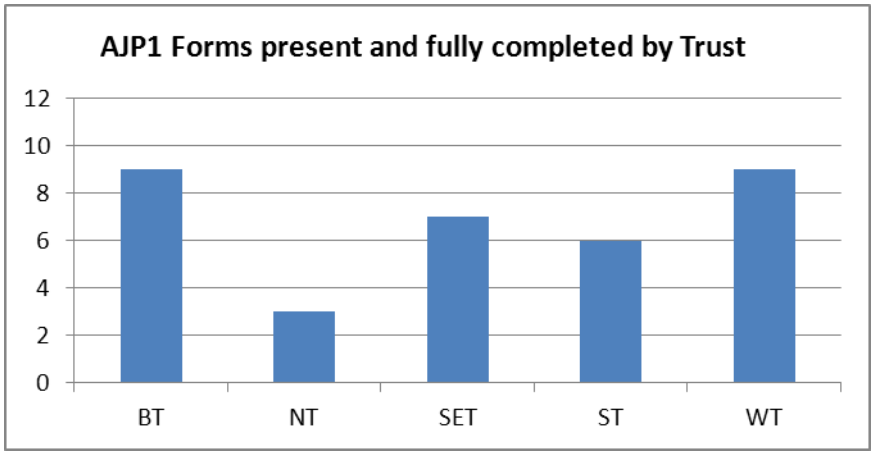
HSC Trust	Number of Human Rights forms present in 12 files
Belfast	One trust form present
Northern	No forms present
Southern	No forms present
South Eastern	One trust form present
Western	One Protocol form present

The Protocol is committed to ensuring that the rights of the vulnerable adult are upheld. The Protocol contains a Human Rights form which should be used for each vulnerable adult referral, demonstrating that the relevant human rights principles have been applied when making any decision.

Amongst the 60 files audited the review team found only one Human Rights form completed as set out in Appendix 2 of the Protocol. Without completing the forms, HSC trusts are not able to demonstrate that they had afforded the necessary consideration to the rights of vulnerable adults. As forms were not completed, it was not clear to the reviewers if the HSC trusts had applied the Human Rights principles as stated in the Protocol.

Adult Joint Protection (AJP) Forms

Graph 1: AJP1 Forms Present and Fully Completed by the Trust Appendix 6 in the Protocol



The abbreviations used in the above graph refer to the name of each trust.

If the trust files did not contain an AJP1 form, RQIA found that sometimes an alternative version was being used. In some cases no documentation was found in the file. If no documentation was present in the file this does not indicate that the trust failed to progress the investigation.

Table 4: List of Alternative Versions for each of the AJP Forms

HSC Trust	AJP1 Form Appendix 6	AJP2 Form Appendix 7	AJP3 Form Appendix 8
Belfast	Older unknown versions; PB 09/09; PB 09/05.	PB 09/09.	
Northern	Appendix B.	Appendix C;	PB 09/09; Appendix D.
South Eastern	Older unknown versions; Appendix B; Page 35; 09/05.	09/05.	PB 09/09.
Southern	Older unknown versions; PB9/05; Appendix B.	Appendix C.	Appendix D.
Western	Appendix C; PB 09/05.	PB 09/09.	Appendix D; PB 09/09; PB 09/05.

The AJP forms present within most of the files examined for the five HSC trusts were found to be fully completed and contained the required

information. However, the review team noted that a variety of additional forms had been developed by some HSC trusts, which were used to report incidents and record discussions. Some of the files audited contained older versions of the AJP forms, which should have been replaced with the new protocol forms - AJP1, AJP2 and AJP3.

The review team noted that two files were poorly organised and lacked structure. After examining the entire content of the files, reviewers could not confirm that the cases had actually been closed.

In one case record, the reviewer noted that trust staff had contacted the PSNI for advice. No AJP forms were completed or retained in the HSC file although the PSNI recorded this as a consultation, in accordance with the Protocol.

One file contained a restricted document, a custody report concerning a service user who had been detained in custody. This report, from the PSNI, had been printed and inserted into the service user's HSC file. This was inappropriate and should not have been present in the HSC file.

The reviewers found that three files were illegible in parts, as the form had been completed by hand. This could make the information unavailable to other professionals who may need to consult the notes. DHSSPS regional policy states that "ideally, all such records should be typed. Where records are hand-written, they must be legible, with each record written in black ink"[2i].

Another concern identified by the reviewers was the difficulty in distinguishing between the question and the answer on the re-typed trust versions of the form.

In conclusion, the review team found variation across the HSC trusts in respect of the completion of the AJP forms, as set out in the Protocol. A number of HSC trusts are using old AJP forms, while others are adding additional information to the forms. This matter requires to be reviewed to ensure consistency in recording relevant information.

4.3 Review of Stakeholder Participation in the Clarification Discussion

The involvement of the victims/survivors in this review was considered. However, the review team concluded that further interviews with vulnerable adults who have already been interviewed about alleged or suspected abuse may cause them unnecessary stress.

The review team, however, reviewed the completion of Appendix 8 (Adult Joint Protection Form 3 (AJP3) by HSC trusts or PSNI. This form must be completed to record the clarification discussion held with the vulnerable adult

[2] Administrative Systems, Recording Policy, Standards, and Criteria. September 2010. DHSSPS. http://www.dhsspsni.gov.uk/admin_policyfinalmay2011.pdf

and provides space for the recording of the participation of the vulnerable adults.

Table 5: Number of AJP3 forms completed in the 60 files audited

Not every incident progresses to the stage of the process to require completion of the AJP3 form. In cases where the process reaches the requirement for a Clarification Discussion the AJP3 form is completed. This AJP3 form records the vulnerable adult's willingness and ability to the process.

Three questions are asked on the AJP3 form as follows:

- Is the adult willing to engage in an interview?
- Is the adult able to engage in an interview?
- Has the purpose of the interview been explained to the adult?

HSC Trust	Belfast	Northern	South Eastern	Southern	Western
AJP3 form in file	3	5	2	3	4
Fully and appropriately completed	3	5	2	3	4
Vulnerable adult was willing to engage	2*	5	2	3	4
Vulnerable adult was able to engage	2*	5	2	3	4
The process was explained to the Vulnerable Adult	2*	5	2	3	4

The service user's involvement in any discussion about future action or investigations is essential.

There is one recorded incident* on file in the Belfast Trust where the vulnerable adult left the room and choose not to engage with HSC staff and PSNI. The file records state that the vulnerable adult did not remain in the meeting long enough to have the process explained to them.

Findings of Audit of AJP forms.

The review team considered the variation in compliance with the AJP documentation set out in the Protocol and suggest that this matter is reviewed by NIASP as a priority.

Section 5: Findings of the Review Team of the Health and Social Care (HSC) Board

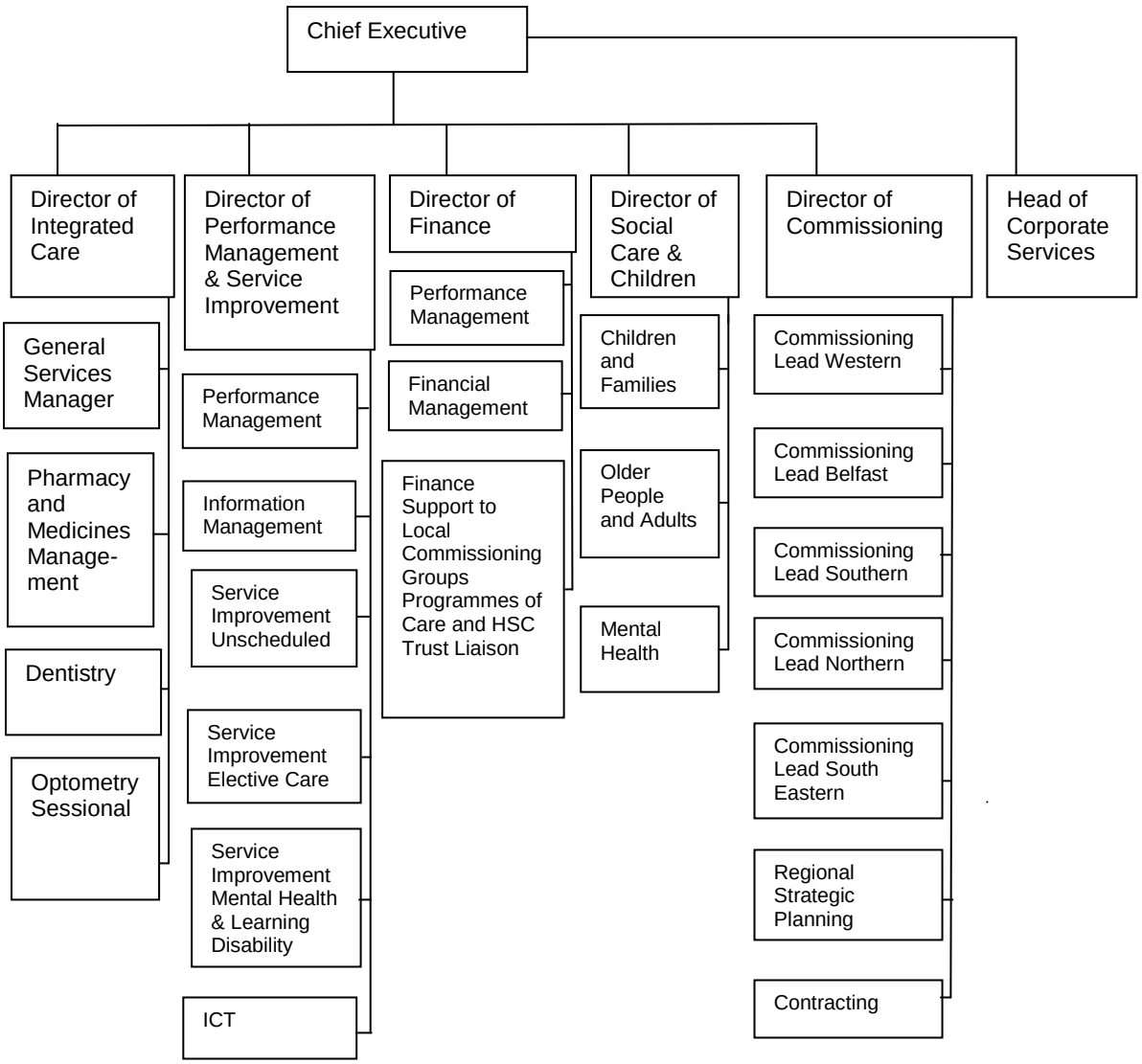
This section of the report presents the findings of the review team regarding the HSC Board.

5.1 Profile of the HSC Board

The HSC Board was established on 1 April 2009, to commission and develop health and social care services across Northern Ireland. The role of the HSC Board is to:

- Work with the HSC trusts to ensure that services meet the needs of people in Northern Ireland
- Deploy and manage funding to ensure that all services are safe and sustainable

Table 6 Health and Social Care Board Organisational Chart



The Director of Social Care and Children, supported by an Assistant Director and a Regional Adult Safeguarding Officer is responsible for monitoring all activities in respect of safeguarding adults.

A successful safeguarding agenda requires the support of a wide network of agencies, organisations, bodies and communities of interest, across the statutory, voluntary, community, independent and faith communities.

The review team met with officers of the HSC Board In May 2011. The review team examined governance and quality assurance arrangements in respect of both the monitoring of the Protocol and the collection of information on vulnerable adults activity from across the five HSC trusts. The review team also examined the funding provided for additional staff to support the work of the local adult safeguarding partnerships in each trust; the monitoring and development of training commissioned by the HSC Board; and the progress made since the launch of the Protocol in the development of partnership and interagency working arrangements.

5.2 Governance

The review team found that there were clear lines of management accountability and professional responsibility from the HSC Board Chief Executive through to staff responsible for vulnerable adults services.

There are clear liaison and performance management arrangements in place between the HSC Board and each of the five HSC trusts to ensure the effective management of services to vulnerable adults.

The HSC Board indicated that it has ensured, through its scheme of delegation, that it quality assures, monitors and verifies the accuracy of information provided by the HSC trusts through their Annual Discharge of Statutory Functions reports.

5.3 Staffing

A dedicated officer was appointed by the HSC Board to coordinate all information relating to the Protocol, including: reviewing its implementation by HSC trusts; and the progression of new regional policy on adult safeguarding. The HSC Board indicated it had provided funding for additional staff in HSC trusts in order that the Local Adult Safeguarding Partnerships (LASPs) could implement the NIASP guidance, policies and procedures at local level.

The review team considered that the additional commissioning of five adult safeguarding specialists in HSC trusts by the HSC Board has provided an important support to HSC trusts in the development of vulnerable adult services.

The review team commended those involved in setting up the NIASP. Without the work of this group the development of a coherent regional

interagency approach to the implementation of action plans would be difficult to progress.

5.4 Findings of the Review Team

The review team found that the Regional Adult Safeguarding Officer, on behalf of NIASP, meets with the chairs of the LASPs on a quarterly basis, and with the Trust Adult Safeguarding Specialists every month. The purpose of these meetings is to:

- ensure consistency of approach and developments within adult safeguarding throughout Northern Ireland
- facilitate communication across and between safeguarding systems
- identify and, where possible, address emerging practice issues

The Regional Adult Safeguarding Officer also meets with DHSSPS on a regular basis to contribute to the development of a new regional policy on adult safeguarding. The review team commended the HSC Board on this appointment. The benefits of this coordinator were seen in the improved communication across agencies and the agreement to an interagency improvement plan.

5.5 Training

A workstream has been set up under NIASP to review the regional training.

The review team was advised that significant benefits have been derived from the commissioning of joint training with colleagues from PSNI. This has helped to increase the understanding of each other's role and has resulted in greater trust and liaison between staff from each organisation.

The review team noted that NIASP has ensured that HSC trust adult safeguarding specialists are included in regional initiatives for the Public Protection Arrangements Northern Ireland (PPANI) arrangements.

The review team noted that further training is required in relation to staff who work in both acute and psychiatric services to ensure that they are alert to the signs and symptoms of abuse; are clear about the referral process to adult safeguarding teams; and are fully engaged in the management of any risks identified within the protection plan. The review team was informed that NIASP will ensure that the Electronic Care Record (ECR), which incorporates information from the Social Services Client Administration and Retrieval Environment (SOSCARE) is able to identify adults at risk of harm, or in need of protection, from attendances at accident and emergency departments.

The review team considered that the correct use of the AJP forms is as set out in the Protocol, but noted a lack of recorded consideration by HSC trusts of the Human Rights of Vulnerable Adults. This is an area which requires further review and attention by NIASP to ensure the effective adherence to the Protocol.

Section 6: The Review of the Role of the Police Service of Northern Ireland (PSNI) in Relation to the Protocol

Figure 2: PSNI 8 Districts

6.1 The Police Service of Northern Ireland (PSNI)

The PSNI is a single regional service organised into eight districts.

In March 2006 the PSNI issued service procedures entitled Vulnerable and Intimidated Witnesses - Implementation of the Criminal Evidence (NI) Order 1999 and the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults and Children. The guidance is lengthy and primarily deals with the options that should be considered to enable vulnerable and intimidated witnesses to give evidence in court. The service procedure also includes the PSNI recognition of the need to engage with health and social services to ensure that all cases involving suspected or alleged abuse of vulnerable adults are receiving the appropriate level of investigation.

The service procedures were reviewed and reissued in January 2008 and again in September 2008. There was no update to the original guidance following the signing of the protocol in 2009. The review team recommend that a specific service procedure on vulnerable adults is prepared to reflect the current operational situation and the prominence that the issue is now given. More detail should also be provided on how the partnership arrangements with social services should be conducted.

CJI inspectors conducted preliminary visits to each of the eight police districts during January and February 2011 to determine how cases

involving Vulnerable Adults were being identified and processed. In addition, discussions were also held with the review team to determine the most effective way of assessing the PSNI performance in this area and integrating the findings with the review being conducted within the five HSC trusts. The review team agreed a fieldwork schedule and conducted joint visits to the PSNI districts in May and June 2011.

6.2 Findings of the Review Team

6.2.1 Governance and Staffing

The strategic and policy lead for the PSNI on vulnerable adults is the Head of Strategic Partnerships branch in the Criminal Justice Department, supported by an inspector based in the same department. The inspector and staff member keep in contact with officers delivering the services. They also arrange regular forums with these officers to bridge the gap between strategy, policy and delivery.

The PSNI established Public Protection Units (PPU) in each of the eight police districts on 31 March 2008. These units brought together child abuse investigators, domestic violence investigators, sexual and violent offender management teams and a missing and vulnerable persons unit. They are regarded as a district resource who will deal with the majority of cases reported locally. Some cases of serious sexual offending are referred to the regional Rape Crime Unit (RCU) for investigation, and on other occasions the local Criminal Investigation Department (CID) will take the lead and seek the support of specialist investigators for allegations of fraud and deception.

The Missing and Vulnerable Adult Units within each of the PPUs consists in the main of only one officer. These officers have been given the title of Missing and Vulnerable Person Officers (MVPO). The PPUs are under the control of a detective inspector who is supported by a number of detective sergeants and constables. The team spoken to by the review team considered that the vulnerable adult issues would not have the same priority as child abuse cases. However, as the number and frequency of referrals continue to rise, the PSNI accept that the prominence of the issue is increasing.

In most districts the day-to-day management and supervision of the MVPOs is conducted by a detective sergeant from within the PPU. Some districts allocate vulnerable adult cases for investigation by other members of the PPU, particularly if there are suspicions of domestic violence or sexual offences. Those sergeants spoken to by reviewers claimed that their interest and involvement in the issue has increased over the last 18 months and is symptomatic of the importance now being attached to this type of case.

The PSNI accepts that the amalgamation of missing persons and vulnerable adult roles, which are quite different and for the most part

unrelated, is not ideal. An internal review of PPUs in 2010 recommended that these roles be separated and the practice of double jobbing ceased. In some areas the MVPOs have also been appointed to act also as the mental health liaison officers for the district. The review team observed that although the recommendations from the internal review report in respect of this role have not yet been endorsed by the Chief Constable's Forum, some districts have already started to react to the increased workload of the MVPOs.

In H district, as set out in Figure 1, there are two officers appointed to the role because of the geographical size of the area to be covered. In D district they have separated the role and have appointed an officer to deal specifically with Vulnerable Adults. Some of the existing MVPOs spoken to by reviewers considered that the vulnerable adult role was in addition to their original portfolio and was not entirely welcomed, however, after relevant training and operational experience they have warmed to the task.

Districts with a number of children's homes generate a high number of missing person reports. Normally a report is made when the young person has stayed out late or failed to return at the expected time. All of these reports require differing levels of investigations. This can add significantly to the workloads of MVPOs. In one district the numbers of missing person reports each year can vary between 500-2,000.

The MVPO role was established in 2008 and most of the existing officers have been in post since that time. All officers confirmed that they had not received any guidance on the records they are expected to keep, other than the forms contained within the Protocol. This has led to a situation where there is no standard approach to record keeping. The review team suggest that, in an effort to establish consistency, guidance should be issued to establish a standard for record keeping and an audit trail for referrals, which can be applied in each police district.

MVPOs have developed spreadsheets in an effort to manage their own workload and to provide an audit trail for referrals. The review team examined the spreadsheets in all police districts, which provided varying degrees of information. Some contained the name, address and age of vulnerable adult, name of social services staff making the referral, nature of the referral and action taken. Others contained the limited information and made auditing difficult. The review team accepts that the spreadsheet is primarily a tool for the local MVPO. However, these could become a key audit mechanism, providing an important point of reference and protection where a referral is disputed.

The MVPOs were appointed into their role from a uniformed policing background and received training to enable them to conduct clarification discussions with social services. MVPOs have now all received further training and are qualified to conduct Achieving Best Evidence (ABE) interviews. Other police officers working within the PPUs, CID and Rape Investigation Units are also ABE trained and in relevant cases conduct the

interviews. The original plan suggested that MVPOs and their local social services staff with whom they conduct joint interviews should undergo this training together. Those officers who have attended joint training with their social services counterparts were entirely supportive of the experience.

6.2.2 Training

Since 2008, 347 police officers have been trained to participate in clarification discussions. One hundred and fifteen police officers have been trained to Achieving Best Evidence (ABE) level and 57 police officers have received refresher ABE training. The training sessions allow for the sharing of experiences and the development of best practice which, in turn, informs future training. Feedback from both the police and social services in relation to the training being provided was very positive, not only in respect of enhancing skills but also for participants learning from each other's experience.

The review team was told that a significant number of those who have been trained to conduct ABE interviews have not sought to participate in the refresher course. This identifies a concern that the skills may not have been used in practice. Trainers believe that it would be more appropriate for police supervisors and social services managers to attend a familiarisation course rather than undergo full ABE training, only to be taught skills that they are unlikely ever to use in the course of their duties.

The training is organised and delivered by PSNI officers who have had operational experience in child abuse, rape enquiry teams and mainstream CID. One police trainer was from a mental health nursing background. This knowledge and understanding of health and social care has helped make the course both relevant and experiential. The officer also provides training advice to the Northern Ireland Safeguarding Partnership.

During 2010, the Belfast Trust provided funding to enable the delivery of a familiarisation course for PSNI response officers operating in Belfast districts. The training was designed to provide these officers with an understanding of how individuals may present as vulnerable. Feedback from participants was very positive.

The review team commended this initiative as an example of best practice which should be replicated in each trust area. A police trainer has also initiated a programme of awareness for members of the Tactical Support Groups (TSG) and Portal Officers (airport and sea port).

6.2.3 Delivery

The MVPOs spoken to claimed that the number of referrals is increasing year-on-year. The officers have maintained local records of the numbers of referrals made, however, these have not yet been subject to analysis across the PSNI. The review team recommends that PSNI collate and analyse this information to establish trends. Fuller documentation is kept

in respect of those cases where clarification discussions have taken place and joint investigations have been conducted.

Referrals which are received from social services are normally entered onto the PSNI Command and Control system, which is the primary means of recording incidents reported to the police. They are usually marked as 'Enquiries Continuing'. Where, after preliminary investigation, the PSNI is satisfied that there has been no criminal act, the case can be closed, marked as 'No Crime'. Where following investigation, a case is likely to be considered for prosecution the relevant details are entered onto the PSNI electronic case file preparation system (NICHE), before the completed file is forwarded through the Criminal Justice System Data Sharing Mechanism (Causeway) to the Public Prosecution Service (PPS).

The review team had access to the records of the eight police districts and five health and social care HSC trusts, and made a random selection of case files to be examined. They found that where there had been a formal referral by social services, the forms were completed and forwarded to the relevant PSNI officer. This was initially recorded on the district spreadsheet and the relevant referral documentation was retained within a file cover relating to the vulnerable adult.

Officers believe that there is still some confusion with social services staff as to what actually constitutes a referral. There were occasions when police had recorded a note of what they believed to be a discussion about an incident, whether it constituted a possible criminal offence, and yet there was no record on the social services file. However, all parties believe that the developing relationships and operational experience will minimise such an occurrence.

Officers were critical of the existing Protocol forms which they considered to lack detail, particularly when a full investigation is unlikely to proceed. In many cases the PSNI were photocopying the initial social services report or copying the minutes of the social services review meetings attended by police. The review team recommend that the existing forms be reviewed in the light of operational practice to ensure that all parties to the Protocol have access to the necessary information.

6.2.4 Partnership Arrangements and Interagency Working

The advent of adult safeguarding and the embedding of partnership working across the HSC trusts and PSNI districts have significantly improved the relationships between police officers and social services staff. The review team received positive comments from both parties in relation to the increasing levels of trust and mutual understanding, achieved through joint operational experience.

A by-product of this new partnership working is an increased awareness of how both the PSNI districts and HSC trusts deliver their respective services. For the police it is an awareness of how the various social care

services and teams are engaged with and deliver services to vulnerable adults. For social care services staff it is an understanding of how the police operate and who within PSNI is best placed to deal with issues involving vulnerable adults.

All MVPOs conducting joint investigations have developed both an understanding and respect for their counterparts in social services. They told reviewers that they find the work challenging and suggest that their professional skills are being enhanced with this investigative experience.

Not all of the officers have completed full investigations; some have acted more in a liaison, gate-keeping role, directing social services to the most appropriate unit or individual to be involved in the joint interviewing and subsequent investigation. In many cases a telephone discussion with relevant social care staff to determine whether any criminal offences have been committed is sufficient. In the absence of a criminal offence the police will suggest that the matter should be dealt with by social services on a single agency basis. These contacts are helping develop relationships with social workers who in turn are building their knowledge of what might constitute a criminal offence.

MVPO's told reviewers that they are being pressed as a result of current timeliness targets to complete their work more quickly and there is little appreciation of the time that it takes to establish trust with a vulnerable adult and the number of decisions that need to be made when dealing with cases of this nature. Officers therefore feel that they are being pressured both internally to meet PSNI targets and externally to meet the needs of health and social care staff who, on occasions, await the outcome of criminal investigations before taking internal disciplinary action.

Cases have varied in complexity and seriousness from care plans not being completed to the inappropriate handling of residents in care homes and hospitals by staff and altercations between patients or residents. At the more extreme end of the scale there are cases involving sexual assault, physical violence, theft, fraud and deception. There have also been a number of allegations from 'whistleblowers' of multiple assaults or neglect by carers or medical staff, which have required extensive and protracted investigation. Vulnerable adults who present with unexplained injuries and who cannot say what has happened to them or who suffer from dementia or other mental impairment also feature regularly amongst referrals.

One of the benefits for the police of the partnership arrangements with social services is the level of support and guidance offered by them in negotiating what are often very difficult and complex situations involving vulnerable adults. Some of the cases relate to care packages, residential care arrangements, medication and treatment programmes and the thresholds between acceptable health and social care standards and incidents of neglect or abuse.

6.2.5 Challenges

Backup Arrangements

At present there are no arrangements to back-fill for MVPOs who are absent. While calls from social services can be responded to by other members of the PPU there is a real risk that cases involving vulnerable adults are not dealt with appropriately. There are no back up arrangements for the 'screening of incidents' role performed by these officers and that on returning to work they have to trawl through thousands of command and control serials to find potential cases involving vulnerable adults. This is a time consuming exercise which creates an unnecessary risk. The review team suggest that PPUs consider back up arrangements to cover for MVPOs long term absence and more accurate use of specific identification codes on the PSNI Command and Control system.

Reporting of Referrals

MVPOs told reviewers that they are not confident that all vulnerable adult referrals from social services are being made through them and therefore not recorded on the district database. In the past, referrals have been made by social services staff directly to Domestic Violence Officers (DVO) Rape Crime Units (RCU) or Criminal Investigation Departments (CID) within districts in the belief that the specialist unit is better equipped to deal with the incident.

MVPOs indicated that there have been occasions when response officers have attended incidents that should have been referred through the protocol. In some cases statements had been taken from vulnerable adults before capacity and consent were determined. In some districts MVPOs have delivered awareness briefings to other front- line staff to reduce the likelihood of such situations. The review team commend this initiative, however this approach is not consistently applied across all districts. We therefore recommend that PSNI design and deliver a training package through district training to include all operational officers and those staff involved in the classification of calls to the PSNI.

Some MVPOs believe that there is an under-reporting of incidents from nursing and residential care homes, however this situation is being addressed through the local adult safeguarding partnerships and through the participation of MVPOs in social services training events.

Communication between Social Services Staff and PSNI

The review team was told that the communication channels between social services staff and MVPOs is improving. The transfer of documents has in the past been problematic, not least in relation to the electronic transfer of information. Some HSC trusts have incurred expense in delivering documents by courier to relevant police stations. With the co-location of social services staff under PPANI arrangements and through access to

social services electronic records, this situation has been alleviated, but is not fully resolved. In relation to delay in cases being investigated MVPOs told reviewers that there were occasions when social services staff have initiated their own investigations and reviews before involving the PSNI. in an attempt to respond to incidents or allegations. There are clear risks in doing so in that any forensic or other evidential opportunities may be lost to trained police investigators.

When cases are reported to police it can be difficult to coordinate preliminary or follow-up meetings to enable the joint investigation to proceed. Coordinating the attendance of all relevant parties and allowing time to interview vulnerable adults or arranging the services of an advocate, can add to the delay.

Delays in Investigations

The PSNI is aware of social services' frustration with the time it takes for investigations to be directed upon by the Public Prosecution Service, particularly when staff have been suspended or deployed on other duties. This situation is more difficult when private nursing homes are involved and staff may be suspended on full pay. Some officers have developed a good relationship with the regional Public Prosecution Service office and have, on some occasions, been able to expedite decisions. Cases which appear to be straightforward cases may take up to 18 months to come to court - there have been instances where the victim has died of natural causes before a case is heard.

Provision of Guidance and Support

The review team assesses that MVPOs are committed to their role and work with the minimum of supervision in a pressured environment. Their role has developed in line with demographic and societal changes. This is placing increasing numbers of adults into the category of vulnerable and in need of care and support.

Mutual respect has developed between MVPOs and their counterparts in HSC trusts. This respect is based on their operational experience, including joint investigations. They are increasingly aware of each other's responsibilities and benefit from effective interagency communication and joint decision making.

The PSNI must recognise the increasing importance of their role and ensure that they have adequate guidance and support to allow them to take forward this important area of police work.

Section 7: Recommendations

7.1 Recommendations for the Health and Social Care Board

1. The NIASP (in consultation with the 5 LASPs and other relevant agencies and DHSSPS) should consider any amendments required to the Protocol in the light of new legislation and the learning from this review and their operational experience, in order to ensure the continued safeguarding of vulnerable adults.

2. NIASP should review the reporting arrangements by the HSC trusts to make sure that all new referrals are appropriately recorded.

7.2 Recommendations for the Health and Social Care HSC Trusts

7.2.1 Governance

3. The HSC trusts should ensure that all relevant professionals with safeguarding responsibilities have a working knowledge of the Protocol and adhere to the guidance agreed in July 2009.

7.2.2 Training

4. The training of staff in the acute sector and in adult psychiatric/learning disability facilities should be reviewed to ensure a high level of awareness of adult protection issues and targeted training programmes should be provided for staff.

7.2.3 Recording and Record Keeping

5. The HSC trusts should review compliance with DHSSPS policy in respect of recording and record keeping in terms of the forms required by the Protocol.

6. The HSC trusts should comply with the current AJP forms set out in the Protocol and cease using historic forms and ensure that no inappropriate documentation is contained within vulnerable adults files.

7. The HSC trusts should bring examples to NIASP of other additional forms which they currently use to supplement the information contained in the AJP forms, to inform any future review of the Protocol.

8. The HSC trusts should ensure that appropriate consideration is given to the application of Appendix 2 of the Protocol in respect of the human rights of vulnerable adults.

7.3 Recommendations for PSNI

9. PSNI should develop and circulate a new service procedure to deal with Adult Safeguarding to include vulnerable adults and a role profile of the officers engaged in this work.

10. PSNI should implement the recommendations of the 2010 internal review of PPUs, in particular the separation of roles and the practice of ‘double and triple jobbing’ should cease.

11. PSNI should review systems and processes designed to identify and record referrals to ensure a corporate approach and should monitor activity on a force wide basis to establish trends.

12. PSNI should develop IT solutions to ensure the free flow of information between PSNI and Health and Social Care HSC trusts.

13. PSNI should develop a training package to ensure that all operational officers are aware of the need to involve specialist assistance when dealing with vulnerable adults.

Section 8: Conclusion and Findings

All staff and agencies interviewed as part of this review demonstrated a working together approach and a commitment to working to safeguard and protect vulnerable adults.

The review of the Protocol took place against a backcloth of much change in the delivery of Adult Safeguarding services in the HSC trusts, the PSNI and the Board. The review team noted improvement created by the appointment of the Trust Adult Safeguarding Specialists and the NIASP Chair and Regional NIASP Working Groups, which is to be commended.

The review team met highly motivated teams of staff working with vulnerable adult service users and noted exemplars of best practice in joint training with the PSNI.

The review team identified common areas in each trust regarding improvements in the area of development of safeguarding policy, protocols and the collation of information for the HSC Board, particularly in respect of the discharge of statutory functions.

The Protocol has been in existence since July 2009. Whilst it is generally working well, the review team is of the view that the NIASP, in consultation with the DHSSPS and LASP, should review the suitability of the AJP and other forms contained within the Protocol to ensure that all parties have access to relevant and necessary information.

A further area requiring urgent consideration is the electronic transfer of confidential information between social services and PSNI and the accurate recording of vulnerable adults referrals by social services and the PSNI in order to establish trend data and analysis of information to inform the LASPs safeguarding plan.

In 59 out of 60 files audited, there was no indication that consideration has been given to the human rights of the service users. A form exists in the Protocol but there was only evidence of this being used in one case. It was not clear to the reviewers if the HSC trusts have applied the Human Rights principles as set out in the Protocol. This should be reviewed by the HSC trusts to ensure that all vulnerable adults are afforded appropriate consideration of their Human Rights, in order to meet the obligations of the United Nation's Convention on the Rights of Persons with Disabilities (UNCRPD) (2009).

Some issues of concern were raised about the PSNI back-up arrangements to cover long-term absence of staff to ensure vulnerable adult referrals are dealt with appropriately. It is suggested that the PSNI use specific identification codes in the PSNI command and control system to record information on the district database appropriately.

Further awareness raising is required with health and social care staff about the importance of early PSNI involvement in investigations, as PSNI indicated that some HSC staff have initiated their own investigations or reviews. The danger in doing so is that forensic or other evidential opportunities may be lost to investigators. This risk should be reinforced by social services managers with their staff.

Delays have been noted in holding meetings to enable joint investigations to proceed due to difficulties in coordination of diaries across staff in social services and PSNI. In addition, further review of the delay in the investigations by the Public Prosecution Service is required in order that the decisions on staff suspended from duty can be taken more expeditiously.

The review team wish to commend all staff involved in this review who were clearly committed to their role. It is critical that they have adequate guidance and support to allow them to fulfil their responsibilities in line with guidance outlined in the Protocol.

The review team wishes to thank the staff from the HSC trusts and PSNI for their co-operation and invaluable contribution to this review.

Section 9: Appendices

Appendix 1: The European Convention for the Protection of Human Rights and Fundamental Freedoms into the UK Domestic Law – The Human Rights Act 1998

Appendix 1

THE EUROPEAN CONVENTION FOR THE PROTECTION OF
HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS INTO THE UK DOMESTIC LAW

THE HUMAN RIGHTS ACT 1998

MAIN CONVENTION RIGHTS:

Article 2	- Right to life
Article 3	- Prohibition of torture
Article 4	- Prohibition of slavery and forced labour
Article 5	- Right to liberty and security of person
Article 6	- Right to a fair trial
Article 7	- No punishment without law
Article 8	- Right to respect for private and family life
Article 9	- Freedom of thought, conscience and religion
Article 10	- Freedom of expression
Article 11	- Freedom of assembly and association
Article 12	- Right to marry
Article 14	- Prohibition of discrimination
Article 16	- Restrictions on political activity of aliens
Article 17	- Prohibition of abuse of rights
Article 18	- Limitation on use of restriction on rights

FIRST PROTOCOL:

Article 1	- Protection of property
Article 2	- Right to education
Article 3	- Right to free elections

SIXTH PROTOCOL:

Article 1	- Abolition of the death penalty

NOTE: The following Articles are omitted from the Act:

Article 1	- Obligation to respect Human Rights
Article 13	- Right to effective remedy
Articles 15 - 59	- Operational provisions for the European Court

Appendix 2: Human Rights - List of Considerations

Appendix 2

HUMAN RIGHTS - List of Considerations

If you cannot answer a question, you cannot proceed to the next question. Only take action when you have completed the list.

1. Is there any necessity to take action?
   What are you doing? Why are you doing it?

2. Is there any legal basis upon which to take action? Is there a statutory/mandatory/discretionary power you are using? If so, state it. If not, on what basis are you taking action? (You should seek legal advice).

3. What are the Human Rights implications of the proposed action? (Go through Convention List and mark the relevant article and the relevant limitation).
   (See Appendix 1)

Specify Article and Limitation

4. Is the proposed action proportionate? Is the scale of the action appropriate to the size of the problem? (i.e. consider whether it is intrusive or invasive). Is there an alternative?

Give reasons for your decision

5. Is there an independent public remedy available? If not, consider what will be the effect of failure to give a remedy i.e. Ombudsman/Judicial Review/other Court action).

Specify all available remedies

6. If action is taken, is there "equality of arms"? Does the person have the same opportunity to gather evidence as you and present it to the Court/Tribunal?

7. Is the action the least possible one? Is it the least intrusive or invasive?

Post-Event Evaluation

Signed: **Dated:**

Print Name:

Position/Rank:

Appendix 3: Adult Joint Protection Form 1 (AJP1) - Record of Joint Agency
This is set out in Appendix 6 of the Protocol.

Appendix 6

ADULT PROTECTION: FORM AJP1 - RECORD OF JOINT AGENCY CONSULTATION

Referral by telephone on _____/_____/_____
To: _____ Designation: _____
Person referring: _____ Designation: _____
Address: _____
Contact Tel No:

Name of Vulnerable Adult: _____ DOB: __/__/___
Home Address: _____
Present Location: _____

_____

Gender*: M ☐ F ☐

Nature of Vulnerability*: ☐ Frail Older Person ☐ Dementia ☐ Learning Disability
☐ Physical/Sensory Disability ☐ Mental Illness ☐ Other (please specify)

Is the Vulnerable Adult subject to any legal/statutory status?*
(e.g. Guardianship, Non-Molestation Order) Yes ☐ No ☐

If yes please provide details: _____

Details of any current or past involvement with Social Services, Police and/or the Regulation and Quality Improvement Authority: _____

_____

Name of Carer/Next of Kin: _____

Address: _____

Contact Tel No: _____

WHAT IS THE MAIN FORM OF SUSPECTED, ADMITTED OR KNOWN ABUSE?*

☐ Physical ☐ Sexual ☐ Psychological/Emotional
☐ Financial ☐ Neglect ☐ Institutional Abuse
☐ Other (please specify)

HAS THERE BEEN PREVIOUS CONCERN OR EVIDENCE OF ABUSE?*

☐ Yes ☐ No ☐ Don't know
If yes, what was the nature of the concern and the outcome?

_____

*Please tick appropriate box/es

ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES

Outcome of Joint Agency Consultation*

Single Agency Investigation by:

Social Services ☐ Police ☐ RQIA ☐

Joint Investigation by:

Social Services ☐ Police ☐ RQIA ☐

OR

Protocol for Joint Investigation of alleged and suspected cases of abuse of vulnerable adults ☐

Please specify if any other follow up will take place.

_____

_____

Signature of person completing form: _____

Print Name: _____

Designation: _____

Date: _____

- Please tick appropriate box/es

ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES

Appendix 4: Adult Joint Protection Form 2 (AJP2) – Strategy for Investigation. This is set out in Appendix 7 of the Protocol.

Appendix 7

ADULT PROTECTION: FORM AJP2 - STRATEGY FOR INVESTIGATION

Name of Vulnerable Adult: _____ DOB: __/___/__

(A) PEOPLE IN ATTENDANCE/INVOLVED (NAME & AGENCY):

_____

_____

OTHERS CONSULTED:

_____

_____

(B) INITIAL STRATEGY: Date: ___/___/___

_____

_____

_____

Next of Kin/Carer to be informed: YES/NO By Whom: _____

(i) Amendments to strategy Date:

_____

_____

_____

Telephone/Meeting*
Persons Involved/Designation:
_____
_____

(ii) Amendments to strategy Date:

(C) PERSONS TO BE INTERVIEWED

_____

_____

_____

Telephone/Meeting*
Persons Involved/Designation:
_____
_____

* Please delete as appropriate

ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES

1 Person making the allegation to clarify all facts about referral

Name: _____

Address: _____

2 Next of kin or other carers:

Name: _____ Relationship to Vulnerable Adult: _____

Address:_____

3 Significant others
(attach separate sheet if necessary)
Name: _____

Relationship: _____

Address: _____

_____

Date & Time: _____
Venue:_____
Who will conduct?
SW:_____
PSNI: _____
Other: _____

4 The Vulnerable Adult
Name: _____

Address: _____

_____

Date & Time: _____
Venue:_____
Who will conduct?
SW:_____
PSNI: _____
Other: _____

5 The Alleged Perpetrator

Name: _____

D.O.B:_____

Address: _____

Date & Time: _____
Venue:_____
Who will conduct?
SW:_____
PSNI: _____
Other: _____

Relationship to Vulnerable Adult: _____

* Please delete as appropriate

ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES

(D) Has a statement of complaint been made? YES/NO*

By Whom: _____

Does the vulnerable adult have the capacity to:

(a) Consent to interview? YES/NO*

b) Consent to medical examination? YES/NO*

On what basis were these decisions made? _____

_____

Signature: _____ Designation: _____

(of Person completing form)

Print Name: _____ Date: _____

* Please delete as appropriate

ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES

Appendix 5: Adult Joint Protection Form 3 (AJP3) – Clarification Discussion. This is set out in Appendix 8 of the Protocol.

Appendix 8

ADULT PROTECTION: FORM AJP3 - CLARIFICATION DISCUSSION

Name: _____ DOB: ____/ ___ / _____

Address:

_____

Date: _____ Time: _____

Venue: _____

CONSIDERATIONS:

1 Has the adult previously made a clear disclosure of abuse or are there substantive grounds for suspecting abuse has occurred?

Comment:

_____

_____

2 Is the adult willing to engage in an interview?

Comment:

_____

_____

3 Is the adult able to engage in an interview?

Comment:

_____

_____

4 Has the purpose of the interview been explained to the adult?

Comment:

_____

_____

5 Which format is the most suitable for the interview? If a video interview appears to be the most appropriate option assess the adult's willingness to be interviewed on video.

Comment:

_____

_____

Decision: VIDEO STATEMENT QUESTION AND ANSWER

(Circle format to be used)

NATURE OF DISCUSSION:

CONTEMPORANEOUS, VERBATIM RECORD OF DISCLOSURE:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Please close with diagonal line)

SIGNATURE OF PERSON MAKING NOTES: _____

PRINT NAME: _____

DESIGNATION: _____ DATE: _____

(NOTE: Responsibility for completion rests with either **Police or Social Services)**

Appendix 6: File Audit Tool

Review of the Implementation of the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults.

File Audit Tool

Full Name		Date of Birth	/ /
Address	Postcode BT _____		
HSC Trust		Date Report rec'd by RQIA	/ / 2010
PSNI Officer Name & Unit		PSNI Station and District	

Was the file available to be reviewed?	HSC File Yes / No	PSNI File Yes / No
Paper or electronic?	Paper/ Electronic/ Both	Paper/ Electronic/ Both

No.	Question	HSC Trust	PSNI
1 a	Is an initial referral form present?	Yes / No	Yes / No
1 b	Please record version or form number.		
1 c	Is initial referral form fully completed?	Yes / No	Yes / No
1 d	Initial referral form, note any omissions.		
1 e	Initial referral form, RQIA held a photocopy?	Yes / No	Yes / No

No.	Human Rights - Appendix 2 Question	HSC Trust	PSNI
2 a	Is Human Rights - Appendix 2 present?	Yes / No	Yes / No
2 b	Is Human Rights - Appendix 2 fully completed?	Yes / No	Yes / No
2 c	Appendix 2, note any omissions.		
2 d	Human Rights - Appendix 2, RQIA held a photocopy?	Yes / No	Yes / No

No.	AJP1 - Record of Joint Agency Consultation	HSC Trust	PSNI
3 a	Is AJP1 (Appendix 6) present?	Yes / No	Yes / No
3 b	Is AJP1 (Appendix 6) current (version July 09)? (If 'NO' state version)	Yes / No ( )	Yes / No ( )
3 c	Is AJP1 (Appendix 6) fully completed?	Yes / No	Yes / No
3 d	AJP1 (Appendix 6), note any omissions.		
3 e	AJP1 (Appendix 6), RQIA held a photocopy?	Yes / No	Yes / No

No.	AJP2 - Strategy for Investigation	HSC Trust	PSNI
4 a	Is AJP2 (Appendix 7) present?	Yes / No	Yes / No
4 b	Is AJP2 (Appendix 7) current (version July 09)? (If 'NO' state version)	Yes / No ( )	Yes / No ( )
4 c	Is AJP2 (Appendix 7) fully completed?	Yes / No	Yes / No
4 d	AJP2 (Appendix 7), note any omissions.		
4 e	AJP2 (Appendix 7), RQIA held a photocopy?	Yes / No	Yes / No

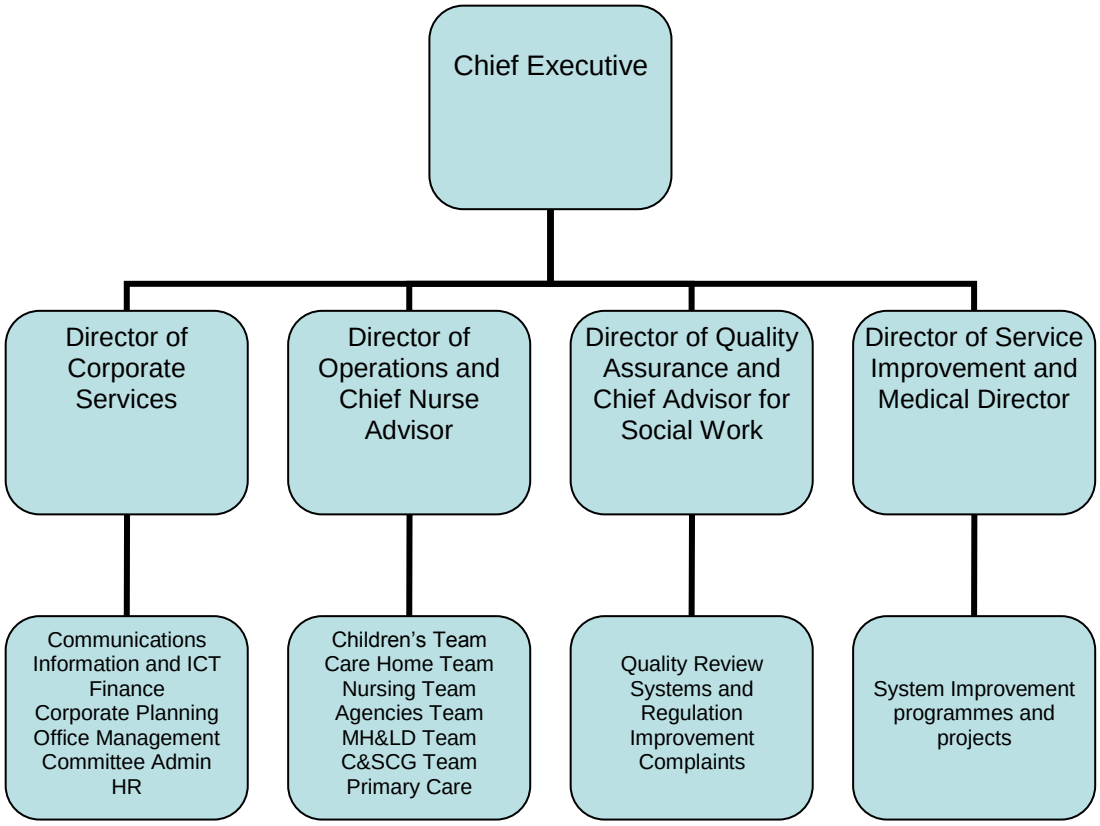
No.	AJP3 - Clarification Discussion	HSC Trust	PSNI
5 a	Is AJP3 (Appendix 8) present?	Yes / No	Yes / No
5 b	Is AJP2 (Appendix 6) current (version July 09)? (If 'NO' state version)	Yes / No ( )	Yes / No ( )
5 c	Is AJP3 (Appendix 8) fully completed?	Yes / No	Yes / No
5 d	AJP3 (Appendix 8), note any omissions.		
5 e	AJP3 (Appendix 8), RQIA held a photocopy?	Yes / No	Yes / No

Question	Continuation of answer	HSC	PSNI

Appendix 7: Review of the implementation of "The Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (July 2009)" in RQIA

This section of the report represents the findings of the independent reviewer regarding RQIA.

Organisational Chart at the time this review was undertaken.



A7.1 Introduction

A review of whether RQIA has appropriately discharged its functions in relation to the implementation of the Protocol was carried out by an independent consultant with experience in regulation from Scotland. The terms of reference set for this review were:

- Reviewed the awareness of RQIA's responsibility in respect of the Protocol,
  a) interviewing a number of inspectors in the regulation team and indicate their awareness of the role of RQIA
  b) reviewing the notifications of Vulnerable Adults incidents where the Protocol was followed and appropriateness of follow-up actions

- Examined the effectiveness of liaison arrangements between RQIA and HSC trusts/PSNI.
- Commented on the appropriateness of RQIA being a joint signatory to the Protocol.

Methodology

The review was carried out using the following methodology:

- Reading of relevant documents including the Protocol itself and the "Policy and Procedure for the Management of Statutory Notifications of Incidents and Deaths".
- Interviews with inspectors from each of the Nursing, Residential and Domiciliary Inspection Teams, in order to ascertain their awareness of the role of RQIA.
- Demonstration of the database used as part of the system for the Management of Statutory Notifications of Incidents and Deaths and discussion with representatives of the Incident Project Team.
- Sampling of files where there has been a reported notification of a vulnerable adult's incident to ascertain whether the Protocol was followed and the appropriateness of follow-up actions.
- Examination of the effectiveness of liaison arrangements between RQIA and HSC trusts/PSNI. By carrying out a series of phone interviews with representatives of the five HSC trusts and 2 PSNI officers.
- A meeting held with a number of the Heads of Programme and the Director of Quality Assurance, and a telephone conversation with the Director of Operations

A7.2 Review of Awareness of RQIA's Responsibility in Respect of the Protocol

Knowledge and understanding of policies and procedures relating to the Joint Investigation of Alleged and Suspected Cases of Vulnerable Adults

The review team interviewed stated they felt secure and confident in their own role. They felt that their role was to assess the notifications received formally through RQIA's Notifiable Events Management System (NEMS) and ensure that the parties involved were following due process. However, two inspectors felt that there was a lack of clarity within RQIA about incident management notification processes.

When asked whether any other guidance (apart from the Protocol) existed some inspectors referred to the "Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance", published in 2006. One inspector also referred to the "Policy and Procedure for the Management of Statutory Notifications of Incidents and Deaths". Some inspectors interviewed initially stated they were not aware of anything specific but later made a reference to the regional guidelines. When asked if they had read this further guidance the majority stated they had. One inspector stated that they had not actually seen the Protocol.

The majority of inspectors felt that the guidance was sufficient and could not identify any gaps. Some inspectors felt that a process map or flowchart might help to clarify the role of different RQIA staff. In specific, some inspectors felt that a review of the role of inspectors and administrative staff might result in a more efficient process.

Recommendation 1: It is recommended that RQIA develop formal systems and processes to confirm that that all relevant staff have read and understood all policies and procedures that cover "Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults", "Safeguarding of vulnerable adults", and the "Management of Statutory Notifications of Incidents and Deaths". It may be worthwhile developing a system for ensuring compliance with all RQIA policies and procedures.

This can be achieved by:
a) RQIA establishing records which can confirm that all relevant staff have been informed about policies and procedures and a process for testing the understanding of those policies and procedures and

b) RQIA conducting an assessment of compliance regularly.

A7.3 Training

All but one of the inspectors interviewed stated that they had received training specifically related to the implementation of the Protocol. However, this training had been about three years ago and no refresher training had been undertaken. One inspector stated that the sessions provided had been more focused on providing information rather than actual training on the use of the Protocol.

Some inspectors believed that new staff would only become aware of their role in respect of the Protocol through a process of experiential learning having been involved in a new case and having been supervised through this by their Head of Programme. The inspectors interviewed were not clear whether this specific Protocol was covered in any induction training and whether this would be sufficient anyway. Reference was made to the role of team meetings being very valuable and the inspectors interviewed felt that they did benefit a lot from sharing their experiences with team colleagues and learning from this process. However, they also pointed out that this was a process undertaken within each individual team and therefore they did not benefit from sharing their experiences and learning from colleagues within the other teams.

Recommendation 2: It is recommended that RQIA, organise jointly with its partner signatories refresher training and training for new inspectors and administrative staff.

Recommendation 3: It is recommended that a mechanism is developed which enables internal guidance and learning to be shared across all the inspection teams.

A7.4 Referrals

The inspectors estimated that about 4-5 cases, per inspector, were handled each month in the Nursing team and 2-3 cases, per inspector, within the two other teams.

Some inspectors also referred to the fact that a significant number of cases were open at any one time. One inspector was holding 16 open cases and the other 24 open cases.

The inspectors suggested that new cases were brought to their attention through a variety of sources including:

- The care service
- HSC trusts
- Informal carers/relatives
- Whistle-blowers
- Having identified something during inspection and looking at care plan

Only one inspector could recall a case being referred to them from the PSNI and this had been a number of years ago.

A7.5 Strategy Planning Meetings

The majority of inspectors stated that they would only be involved in strategy planning meetings where a regulatory issue might need to be considered as part of the process. However, intelligence about the regulated service would be shared by email or through phone conversations. Most inspectors felt that they or their line manager would decide whether they would attend strategy planning meetings on the basis of the intelligence they received about the case and/or the intelligence they held about the regulated service. One inspector suggested that it would be the HSC trust that would determine whether they wanted an RQIA inspector to attend and if an inspector, in consultation with his Head of Programme, agreed to attend, the inspector would have a role in determining if there was a breach of regulations. Some inspectors also felt that the other agencies, particularly the PSNI, had less of an understanding of legislation as it related to domiciliary care and the specific role of RQIA.

Some inspectors raised concerns about the skill and quality of management of the case discussion and chairing of strategy planning meetings. It was also felt that the understanding of the RQIA role varied across HSC trusts – mainly between HSC trusts – but for larger HSC trusts there could also be some variance within a trust. The review team felt that this may be because of the quality of training provided for trust officers. It was also mentioned that some HSC trusts have specialised teams and the

difference in the quality of their understanding and involvement can be seen.

Recommendation 4: It is recommended that the question of who determines the appropriateness and purpose of RQIA attendance at Strategy Planning Meetings is clarified.

Recommendation 5: It is recommended that any further joint training (as per recommendation 2) should address these concerns.

A7.6 Management of Statutory Notifications of Incidents and Deaths

All the inspectors interviewed believed that that the policy and procedure for management of statutory notifications of incidents and deaths adequately covered alleged and suspected cases of abuse of vulnerable adults. However, some inspectors questioned the need for the workbook element when the information recorded in this would already be included in one of the forms (Form 2).

It was also suggested that the layout of the forms could be improved as currently some of the tick boxes were on opposite sides of the written statements. This led to confusion and sometimes meant that the care service ticked the wrong box.

It was suggested that any review of the processes and associated forms should involve inspectors and any IT systems should be adapted so as to support those processes.

During the discussion it was also stated by inspectors that other processes are used to gather information such as:

- Information from questionnaires
- Contact sheets and the buddy system
- Inspection Planning Tool

Members of the Incident Project Team stated that the system could be analysed at provider level because of the link to the register. However at this stage RQIA was not analysing information at service provider level, other than for HSC trusts.

The Incident Project Team was handling about 30 notifiable events referrals a day but the Notifiable Events Management System (NEMS) was not designed in a way which enabled them to determine how many of these were vulnerable adult cases that should be dealt with according to the Protocol. The system had been designed to capture incidents which had to be notified to RQIA in accordance with specific regulations governing service provision and not specifically to capture vulnerable adult cases as a separate entity. Previously allegations of abuse against vulnerable adults (and children) had been captured in an AVA&C database but spine data was transferred into the NEMs system. The current form does not enable RQIA to assess the number of cases that have led to the

application of vulnerable adult procedures.

Recommendation 6: It is recommended that RQIA clearly explain the purpose and importance of all process documentation to relevant staff.

Recommendation 7: It is recommended that, with appropriate stakeholder involvement, the layout of the forms is reviewed.

Recommendation 8: It is recommended that clear criteria/triggers are identified by RQIA to enable recording of the notifiable events which have led to invoking the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults.

A7.7 Other Issues

The length of time of some investigations and the effect that has on suspended staff and for service users, whose memory and recollection of events may diminish over time, was mentioned by some inspectors.

Case Sampling

NEMS was established for the specific purpose of recording statutory notifications of incidents and deaths and not for recording alleged and suspected cases of abuse of vulnerable adults. Therefore without looking at all case files that were recorded as an allegation of misconduct, to ascertain whether they actually related to an alleged and suspected case of abuse of vulnerable adults a sample could not be identified using the database. It was therefore agreed that a sample of cases would be taken from the previously identified sample that had been used when RQIA had looked at HSC trust actions. For these cases11 files and three extracts from files were examined, and, where present, the workbooks, in order to review inspectors' responses and the appropriateness of any follow-up actions. Of these, 11 cases involved inspectors from the Nursing Team, two from the Residential & Day Care Team and one from the Agencies Team.

In all but one case it was recorded that appropriate partner agencies had been notified/involved. There was nothing recorded in for one case file to indicate whether this was the situation.

All of the cases sampled covered a period of time when a separate historical system was being used and therefore an initial notification form should have been completed. This only existed in three of the files examined. However, in two of the files a follow up notification form was included.

Four files contained a reference to strategy planning meetings. In only one case the minutes of the meeting were included. In two of these four files there was reference made to other meetings and in both cases the minutes

of these meetings were included in the file.

None of the files contained a workbook related to the case being examined. One file did contain a workbook but it was related to another case also included in that file.

Only eight of the cases examined gave a clear indication of the outcome of the investigation and what action had been taken.

Recommendation 9: It is recommended that RQIA conduct record keeping audits of files where the Protocol for joint investigation of alleged and suspected cases of abuse of vulnerable adults has been invoked by RQIA.

Effectiveness of Liaison Arrangements Between RQIA and HSC Trusts/PSNI

The representatives of all five HSC trusts and the two representatives of the PSNI stated that they believed the Protocol helped to ensure effective communication and collaboration between HSC trusts, RQIA and PSNI so as to protect vulnerable adults, as long as it is followed.

They felt that it helped in determining whether a single agency or a joint agency investigation was required.

They felt that it helped in defining the roles and responsibilities of PSNI and trust staff in investigations.

They believed it provided a framework for early consultation, cross referral of appropriate cases and joint working arrangements for investigating and interviewing. They also felt that, in most cases, it helped to minimise the number of interviews conducted with the victim. However, some trust representatives felt that there was a need for wider awareness of the Protocol and the two PSNI representatives felt that rank and file PSNI officers needed to be better informed and in some cases, where the incident was picked up at a local level rather than through the PPU, it was possible that the Protocol might not be fully followed and this could result in additional interviews having to take place.

They believed that the Protocol helped to ensure that protective measures are paramount and run in parallel with any criminal inquiry or other lines of enquiry, such as civil action or disciplinary procedures. However, one trust representative qualified this by referring to the fact that there had been some difficulty about managers deciding whether to refer for investigation or to investigate through disciplinary procedure. She mentioned that the trust had recently finalised an agreement within trust with their human resources section which it was hoped would improve this situation.

There were mixed views as to whether they thought that RQIA staff were fully aware of their responsibilities in this area of activity. Some felt that

while most RQIA staff were aware of the need to be informed, the way they then took those responsibilities forward varied.

There were mixed views as to whether RQIA staff were making themselves available to attend Strategy Planning meetings when that is required. It was felt that this was not consistent with some occasions arising when RQIA staff did not attend. It was felt that it was important that RQIA staff attended where RQIA hold the powers in relation to enforcement.

When asked who they felt should make the decision as to whether RQIA should attend a Strategy Planning meeting, some trust representatives felt that the person chairing the strategy planning meeting should have a significant say but recognised that RQIA should make the final decision. They felt that this should depend on whether or not the incident related to a regulated service.

In the main, all the trust and PSNI officers interviewed were clear about why they believed the RQIA needed to be involved in cases. This being that the RQIA, as regulatory body, had a legal obligation in respect of ensuring regulated services are acting appropriately and standards of good practice are maintained. They also felt that the RQIA had access to a wealth of knowledge and that the trust and the RQIA could jointly look at whether care services have adequate and quality procedures in place. It was felt that when regulatory issues are identified in these cases there are often other quality issues as well and while the RQIA may be aware of these the HSC trusts may not be.

One trust representative referred to the NI Adult Safeguarding Partnership and felt that there was a gap here in that RQIA did not sit on the partnership (because they inspect the HSC trusts).

At least one trust suggested that all agencies should take the opportunity to review the Protocol to make it more effective. They felt that in this respect RQIA should seek the views of each partner as to what changes should be considered. They felt that any current shortfalls are managed because of the good relationships that exist and it would be useful to build in any good practice that has been developed by staff and is therefore not currently detailed in the Protocol.

Appropriateness of RQIA Being a Joint Signatory to the Protocol

The majority of those interviewed as part of this review believed that the Protocol was beneficial and that it was beneficial that RQIA was a joint signatory to the Protocol. The main reasons for this being that RQIA often had access to intelligence regarding the services associated with vulnerable adult cases threat was not otherwise available to the other agencies and that RQIA had enforcement powers in relation to regulated services that could not be used by other agencies.

The Independent Reviewer suggested that, if the recommendations above are implemented, it would be appropriate for RQIA to remain as a signatory to the Protocol.

David Wiseman
Independent Consultant

The **Regulation** and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel: (028) 9051 7500
Fax: (028) 9051 7501
Email: info@rqia.org.uk
Web: www.rqia.org.uk