



Kent Academic Repository

Aylett, Jay (2018) *Practitioner Conceptualisation of Vulnerability in Adults at Risk of Abuse*. Doctor of Philosophy (PhD) thesis, University of Kent,.

Downloaded from

<https://kar.kent.ac.uk/71997/> The University of Kent's Academic Repository KAR

The version of record is available from

This document version

Publisher pdf

DOI for this version

Licence for this version

UNSPECIFIED

Additional information

Versions of research works

Versions of Record

If this version is the version of record, it is the same as the published version available on the publisher's web site. Cite as the published version.

Author Accepted Manuscripts

If this document is identified as the Author Accepted Manuscript it is the version after peer review but before type setting, copy editing or publisher branding. Cite as Surname, Initial. (Year) 'Title of article'. To be published in *Title of Journal*, Volume and issue numbers [peer-reviewed accepted version]. Available at: DOI or URL (Accessed: date).

Enquiries

If you have questions about this document contact ResearchSupport@kent.ac.uk. Please include the URL of the record in KAR. If you believe that your, or a third party's rights have been compromised through this document please see our [Take Down policy](https://www.kent.ac.uk/guides/kar-the-kent-academic-repository#policies) (available from <https://www.kent.ac.uk/guides/kar-the-kent-academic-repository#policies>).

Thesis Title: Practitioner Conceptualisation of Vulnerability in Adults at Risk of Abuse

Abstract

The recognition of abuse and neglect of vulnerable adults is a relatively new phenomenon. In the academic community adult protection research has received sparse attention.

A decade of commentary by researchers, practitioners and campaign agencies indicates a general consensus about the confusing and ambiguous nature of the term 'vulnerability'. A few studies have drawn attention to confusion over what constitutes vulnerability, noting the lack of clarity over definitions. Fewer still have sought to elicit the views of staff on applying this concept.

This study explores what signs of vulnerability professionals in human services employ when assessing the risk of abuse/exploitation to adults and what contextual factors or operators have a bearing on their conceptualisation and subsequent responses. Additionally, it explores how the findings and recommendations of Serious Case Reviews (SCRs) could be understood in the light of this.

The study exploits the researcher's insider position, giving voice to practitioners by describing and interpreting the conceptualisation of vulnerability from the perspective of current police officers, health or social care practitioners working in safeguarding adults practice.

A mixed qualitative methods design was used including document analysis, focus group discussions, individual interviews and direct field observations of practice. The demographic and thematic analysis of SCR reports provided another layer of data.

It is argued that professional conceptualisation of vulnerability to abuse is highly differentiated, identifying characteristics which fall into 3 domains. These relate to an adult's personhood (Character), their Circumstance (Context) and the Conduct or Condition of persons who exploit them. Characteristics of these categories included inability to understand, inability to communicate, inability to protect oneself, neediness and reliance on others, lack of relationship skills, and the status of being cared for.

Despite this differentiated concept of vulnerability professionals described constraints acting upon their understanding, and their authority and autonomy to act. These organisational constraints served to reduce the shutter size on the lens of practitioner gaze on vulnerability. With reference to

Lipsky's model of Street Level Bureaucracy and use of discretion, it is argued that the constraints on professional response to vulnerability are a function of criteria in law and policy, and the legitimised work by employers.

This thesis argues that to understand the findings of SCRs and implied criticism of practitioner understanding of vulnerability, there has to be an understanding of the context and other influences on decision making in practice. It suggests description rather than definition of vulnerability to policy makers to liberate professionals from criteria driven decision making. This approach concurs with the views of Judge J Munby (2006) who was careful to avoid a definition of a vulnerable adult and emphasised that the characteristics outlined were 'descriptive, not definitive: indicative rather than prescriptive'.

Word count: 104,257

Pages: 289

Year of Submission: 2018

**Academic School: School of Social Policy, Sociology,
and Social Research**

Candidate Name: Jay Aylett

Award: PhD Social Work

Acknowledgements

This thesis would not have been possible without the support of so many who deserve to be acknowledged here. Dr Jo Warner for her perseverance and insightful supervision. Dr Paul Cambridge for his constant support and encouragement and whose original persuasions started me on this journey.

My thanks must go to my parents, John & Joyce Aylett, who have always encouraged me academically to be the best I could be. Also to my cousin, Jacky Aylett, and close friend Ann Lyons who have consistently believed in me, especially at times when I failed to believe in myself. Huge thanks to my wife, Ann Redman, who has endured years of my absence whilst hidden in our study.

This study required the involvement of a number of professionals from social care and policing services who gave of their time and knowledge to participate in this study. Finally, my thanks to all the professionals and academics I have been privileged to work alongside during my career in social work so far. You are too many to name but your sustained concern for people at risk of abuse has been a source of strength for me.

TABLE OF CONTENTS

	Page
Acknowledgements	2
Abstract	8
List of Appendices	10
List of Tables and Figures	11
List of Abbreviations	12
Chapter 1 - Thesis Introduction	
1.1 Introduction	14
1.1.1 Timeline for Research Activities in Relation to Changes in Law, Policy and Terminology in Safeguarding Adults Practice in England & Wales	14
1.2 Personal Values and Experience and their Influence on the Study	17
1.3 Research Field Context – Two Local Authority Areas	20
1.3.1 Introduction to the Local Authority Areas	21
1.3.2 Evidence and Engagement in Research and Development	22
1.3.3 Inter-Agency Working – Structure and Strategy	23
1.3.4 Multi-Agency Learning & Development for Professionals	25
1.4 Theses Structure – An Overview of the Chapters	27
Chapter 2 - Literature Review	
2.1 Introduction	29
2.2 Methodology of the Literature Review	30
2.3 The Evolution of Safeguarding Adults and the Emancipation of Public Policy – Background and Context	30
2.4 Construction of The Vulnerable Adult in Law	37
2.5 Relevant Research	43
2.5.1 Incidence & Prevalence Studies of Adult Abuse	44
2.5.2 Policy Implementation in Safeguarding Adults	46
2.5.3 Joint Working and Professional Roles in Safeguarding Vulnerable Adults	47
2.5.4 Serious Case Reviews – The Analysis Thus Far	49
2.5.5 Professional Judgement and Decision Making in Adult Safeguarding	54
2.5.6 The Context of Practitioner Judgements and Decision Making	56
2.5.7 Studies on Vulnerability in Adult Safeguarding Practice	57
2.6 Theoretical Frameworks Relevant to the Study	62

	Page
2.6.1. Theories about Approaches to Risk Assessment & Management	63
2.6.1.a. The Problem of Definition	64
2.6.1.b. The Actuarial Model of Risk Assessment	65
2.6.1.c. Risk Versus Uncertainty	67
2.6.1.d. Structured Clinical Judgement	68
2.6.1.e. Risk Taking and Positive Approaches	69
2.6.1.f. Organisational Contexts of Risk Decisions, Professional Difference and the Influence of Resources	72
2.6.2. Street Level Bureaucracy Theory	74
2.6.3. Literature on Judgement and Decision Making – Theoretical Models	78
2.6.4. Social Constructionism and the Social Model of Vulnerability	84
2.6.4.a. Social Construction Theory	84
2.6.4.b. Social Model of Disability and Vulnerability	86
2.7. Concluding Comments	88
 Chapter 3 - Methodology	
3.1. Introduction	90
3.2. Reflexivity – The Role of Researcher in Identifying the Research Problem	90
3.3. The Research Problem and Questions	93
3.4. The Research Design & Rationale - Phenomenological/Interpretivist Methodologies	94
3.5. The Research Design & Rationale – A Mixed Qualitative Methods Approach	97
3.5.1. Case Study/Document Analysis – Serious Case Review (SCR) Thematic Analysis ...	100
3.5.1.a. Rationale for Choice of Method	100
3.5.1.b. Data Collection	100
3.5.1.c. Data Analysis	102
3.5.2. Focus Groups – Single Discipline	102
3.5.2.a. Rationale for Choice of Method	102
3.5.2.b. Sampling and Data Collection	104
3.5.2.c. Data Analysis	107
3.5.3. Direct Observations	108
3.5.3.a. Rationale for Choice of Method	108
3.5.3.b. Sampling and Data Collection	110
3.5.3.c. Data Analysis	112

	Page
3.5.4. Semi-Structured Interviews	113
3.5.4.a. Rationale for Choice of Method	113
3.5.4.b. Sampling and Data Collection	115
3.5.4.c. Data Analysis	116
3.5.5. Document Analysis – Written Referral and Decision Making Records	117
3.5.5.a. Rationale for Choice of Method	117
3.5.5.b. Sampling and Data Collection	118
3.5.5.c. Data Analysis	119
3.6. Ethical Considerations	120
3.6.1. Obligations to Subjects, and their Employers	121
3.8. Concluding Remarks	122

Chapter 4 - Serious Case Reviews – Universal Truths?

4.1 Introduction	123
4.2. What have we Learnt – Serious Case Reviews as Legitimate Mechanisms for Learning Lessons Beyond the Local Context?	124
4.3 Serious Case Review – Thematic Analysis – Commentary	126
4.4. Serious Case Reviews - Thematic Analysis of the Conclusions and Recommendations	128
4.5. Serious Case Review – Thematic Analysis – Case Report Demographics	131
4.5.1. Serious Case Review Report Process and Construction	133
4.5.2. Report Demographics/Case Characteristics – Victim, Perpetrator and Location ...	134
4.5.2.a. Who were the Persons Subject to the Abuse (Victims)	134
4.5.2.b. Who were the Persons Alleged Responsible for the Abuse (Perpetrators or Persons Alleged Responsible)	136
4.5.2.c. Where was the Abuse said to Have Taken Place (Location/Setting)	137
4.6. Summary	138

Chapter 5 - Cues and Clues to Vulnerability – Part 1

5.1. Introduction	140
5.2. Critical Constructs – Characteristics, Themes and Categories Identified in Signs of Vulnerability a) Character, b) Context/Circumstance, c) Conduct or Condition of Others, d) Themes which Occur in more than One Category	141
5.3. Characteristics of Character	145
5.3.1. Mental Disorder and Mental Incapacity	145

	Page
5.3.2. Dependency or Reliance on Others	151
5.3.3. Adult’s Physical Health Condition	154
5.3.4. Lack of Agency – Individual & Situational	156
5.3.5. Nature of Relationship to the Perpetrator	159
5.3.6. Relationship Interpersonal Skills – A Matter of Character and Competence	163
5.3.7. Challenges in Communication for the Adult	165
5.4. Summary	167

Chapter 6 - Cues and Clues to Vulnerability – Part 2

6.1. Introduction	169
6.2. Context or Circumstance of the Victim	170
6.2.1. Social Isolation	171
6.2.2. Status of being a Patient or Client	173
6.2.3. Homelessness	175
6.2.4. Institutional Care Provision	177
6.2.5. Poor Quality Care Service Provision	179
6.3. Conduct or Condition of Others	179
6.4. Dynamic Concept of Vulnerability which considers the Interaction between Signs Identified from a Person’s Condition (Innate Signs) or from their Position (Situational Signs)	181
6.5. Summary	183

Chapter 7 - Cues and Clues to Vulnerability – Part 3

7.1. Introduction	186
7.2. Combining the Signs of Vulnerability – “I’m reluctant to attribute just one...”	187
7.3. Professional Differences in their Victim or Offender Focus for Signs of Vulnerability	190
7.3.1. Offender Focus	190
7.3.1.a. Vulnerable Offenders and the Risk to Others	192
7.3.2. Victim Focus	195
7.4. Commentary/Conclusion	197

Chapter 8 - Recognising Vulnerability is One Thing, Responding Well That's a Different Matter.

	Page
8.1. Introduction	200
8.2. Recognition of Vulnerability and Responses to it – The Former cannot Presume the Latter	201
8.3. Occupational Rules which Influence Professional Response to Vulnerability	202
8.3.1. Job Role, Service Eligibility Criteria and Organisational Priorities	202
8.3.2. Law & Policy – Authority to Intervene	209
8.3.3. Resource Limitations	210
8.3.4. Summary	212
8.4. Methodologies of Approach to Recognising Vulnerability, Information Gathering & Ways of Knowing – Evidence and Intuition	214
8.4.1. Introduction	214
8.4.2. Intuition	214
8.4.3. Information Gathering	219
8.5. Summary	221
 Chapter 9 - Discussion and Conclusion	
9.1. Introduction	222
9.2. Research Question and Methods – Revisited	222
9.3. Conceptual Confusion - Background and Context to the Study	224
9.4. Main Findings and Arguments	225
9.4.1. Serious Case Review Reports –Fallible Findings from Faulty Formulas?	225
9.4.2. Complex Concepts – Combining the Individual (Condition) and Situational (Position) in Signs of Vulnerability_.....	231
9.4.3. Seen Through a Glass Darkly – Eligibility Criteria and other Constraints on Responding to Vulnerability to Abuse	233
9.5. The Argument in Summary	235
9.6. Research Questions Re-visited	236
9.7. Limitations of the Research and Recommendations for Development	238
9.8. Contribution of this Study to Research and Practice	240
References	242
Appendices	271

Appendices

List of Appendices

Appendix 1	Literature Review Search Terms and Sources
Appendix 2	Full Study Participant Profile
Appendix 3	Interview Protocol and Question Schedule
Appendix 4	Participant Profile Written Records
Appendix 5	Research Project Briefing (all Agencies)
Appendix 6	Research Project Brief (Participant Information)
Appendix 7	Consent Form (Direct Observation Participants)
Appendix 8	Focus Group Protocol
Appendix 9	Criteria for Mapping SCR Summaries
Appendix 10	Freedom of Information Request
Appendix 11	Direct Observation Protocol
Appendix 12	Characteristics of Vulnerability - Summary Table
Appendix 13	Thematic Analysis of SCR Conclusions - Summary Table
Appendix 14	Combinations of Signs of Vulnerability - Summary Table

List of Tables and Figures

Table 1	Research Activity Timeline and Changes in Law/Policy/Terminology
Table 2	Summary of Research Activities and Aims
Table 3	Focus Group Participant Profile
Table 4	Direct Observation Participant Profile
Table 5	Interview Participant Profile
Figure 1	Tri-Partite Interactive Conceptual Model of Vulnerability

List of Abbreviations

AAR	Adult at Risk [of abuse]
ADASS	Association of Directors of Social Services
AEA	Action on Elder Abuse
ASB	Anti-Social Behaviour
BASW	British Association of Social Workers
CQC	Care Quality Commission
CRU	Central Referral Unit
DASH RIC	Domestic Abuse Stalking and Harassment Risk Indicator Checklist
DCSF	Department of Children Schools and Families
DoH	Department of Health
DPA	Data Protection Act
FOI	Freedom of Information
GT	Grounded Theory
IMR	Independent Management Reviews
LD	Learning Disability
MASH	Multi-Agency Safeguarding Hub
MH	Mental Health
MHA	Mental Health Act
MSP	Making Safeguarding Personal
NDM	Naturalistic Decision Making
OOH	Out of Hours
OPPD	Older Persons & Physical Disabilities
PAR	Person Alleged Responsible [for the abuse]
PPU	Public Protection Unit
RAM	Risk Assessment Matrices
RiPFA	Research into Practice for Adults
SA1	Safeguarding Adults 1 (Social Services Risk Assessment Tool)
SAB	Safeguarding Adults Boards
SAR	Safeguarding Adults Review
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SJT	Social Judgment Theory

SLB	Street Level Bureaucrat
SLBT	Street Level Bureaucracy Theory
SSI	Social Services Inspectorate
SVA	Safeguarding Vulnerable Adults

Chapter 1

Thesis Introduction

1.1. Introduction

This chapter details the background to the study, and sets the research activities against the changing landscape of law and policy during the lifetime of the study. It locates the researcher within the study, the values and experiences that have framed the study question and the influence of these on the research. It also describes the field context for the study, two local authority areas, and the engagement of partner agencies in the development of safeguarding adults policy and practice which provide the working arrangements and support to the professionals who have been the participants. The anonymity of participating professionals and their employing agencies has been preserved. Each participant was assigned a unique identifier known only to myself. Finally, it sets out the structure of the thesis.

1.1.1 Timeline for Research Activities in Relation to Changes in Law, Policy and Terminology in Safeguarding Adults Practice in England Wales

The legal and policy context of adult safeguarding practice in England & Wales has witnessed considerable change during the lifetime of this study, with accompanying changes in terminology. To support a more coherent narrative in the thesis the table below sets out the timings of the research activities and sets this against the relevant evolving changes in law, policy and terminology.

Table 1 Research Activity Timeline and Changes in Law/Policy/Terminology

Year	Research Activity	Relevant Prevailing Law and policy	Terminology
2000 - 2009		<p>'No Secrets' 2000 – Policy requiring local authorities to develop in partnership multi-agency policy & procedures to protect vulnerable adults from abuse. Term 'Vulnerable Adult' introduced.</p> <p>'No Secrets' review 2009 – report on consultation of review of 'No Secrets' – <i>change in terminology signalled from Vulnerable Adults to Adults at Risk.</i></p>	<p>Vulnerable Adult Serious Case Review Adult Protection Committees.</p>
2010			<p>Vulnerable Adult Serious Case Review Adult Protection Committees.</p>
2011	<p>Literature review including legal and policy context of Safeguarding Adults Practice in UK, develop research proposal and secure ethics approval.</p>		<p>Vulnerable Adult Serious Case Review Adult Protection Committees.</p>
2012	<p>Website search County Councils and Metropolitan Councils websites in England and Wales – SCR Executive Reports published since year 2000.</p>		<p>Vulnerable Adult Serious Case Review Adult Protection Committees.</p>

Year	Research Activity	Relevant Prevailing Law and policy	Terminology
2013	Freedom of Information request to County Councils and Metropolitan Councils in England Wales – about Adults Safeguarding SCRs undertaken since 2000. Request for Full & Executive reports published and unpublished. Data collection for SCR Executive Reports concluded. Thematic analysis of findings and recommendations from SCR Executive Reports.		Vulnerable Adult Serious Case Review Adult Protection Committees.
2014	Focus group discussions with professionals from social care and police. Direct observations of practice decision making regarding adult safeguarding referrals in multi-agency work context.	Care Act 2014 enacted April 2014. Guidance issued under the Care Act 2014 Care and Support Statutory Guidance Chapter 14 October 2014.	Adult at Risk Safeguarding Adults Reviews. Safeguarding Adults Boards.
2015	January 2015 – June 2015 Interviews with participants from the direct observation activity. July 2015 – December 2015 interruptions to research schedule.	Care Act 2014 implemented April 2015. ‘No Secrets’ repealed with the enactment of the Care Act 2014. Introduced statutory duty for Local Authority to make safeguarding enquiries. Change in terminology Adult at Risk NOT Vulnerable Adults. Safeguarding Adults Boards placed on statutory footing with requirement to undertake and publish the findings of Safeguarding Adults Reviews – formally Serious Case Reviews.	Adult at Risk Safeguarding Adults Reviews. Safeguarding Adults Boards.

Year	Research Activity	Relevant Prevailing Law and policy	Terminology
2016	Transcription of Focus Group discussion and Interviews. Data collection of professional written records. Coding and analysis of all data.	Guidance issued under the Care Act 2014 Care and Support Statutory Guidance Chapter 14. Updated 2016.	Adult at Risk Safeguarding Adults Reviews. Safeguarding Adults Boards.
2017	Intermission and final drafting of thesis chapters for submission.	Guidance issued under the Care Act 2014 Care and Support Statutory Guidance Chapter 14. Updated 2017.	Adult at Risk Safeguarding Adults Reviews. Safeguarding Adults Boards.

1.2. Personal Values and Experience and their Influence on the Study

As a current practitioner in the field of safeguarding adults my concern was to explore the 'real world' setting of other professionals in this field of practice and to understand their thinking about vulnerability in the context of day to day practice decision making. Qualitative methods were the natural choice for this study as they adopt approaches which seek to understand phenomena within a real world setting and without manipulating it (Patton 2002). Within qualitative research the paradigm of constructivism values the multiple realities of the various persons involved and the interactions between them that form the basis of their shared understandings. This approach resonated with my own value base and my view of this field of practice in which concepts are evolving through the interactive arrangements of joint working practice. Crotty (1998) defined constructivism as "the view that all knowledge and, therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (Crotty 1998, p.42).

The demands of trustworthiness and credibility of qualitative research can be undermined by the presence of bias. These biases can emerge from the researcher themselves. Mehra (2002) asserts that researcher bias and subjectivity is largely accepted as inevitable in qualitative research and suggests that the researcher's personal values, beliefs and experience will be reflected in the choice of methods, interpretation of findings and the choice of topic. Mehra argues that it is in the

interaction between researcher and researched that knowledge is created making it virtually impossible for the study to be free from subjective influences.

These influences need not be detrimental; in fact they may be highly relevant in interpretative research. However, as Cresswell (1994) points out, the researcher should be explicit in identifying, reporting and elucidating the impact of this throughout the study.

This is pertinent in this study as:-

- 1) The field of study is an area of social work practice in which I have worked as a professional and educator, and am currently a manager of other practitioners.
- 2) The field context for the study is the participant's current workplace.
- 3) Many of the participants in the study are already known to the researcher as workplace colleagues or persons to whom the researcher has delivered practice based training.

I would wish to acknowledge the personal beliefs and influences which supported this choice of study.

I have been practising social work in residential and field settings for 30 years. I qualified in 1992 and subsequently worked in mental health services, initially with older people with mental health problems, mostly with adults of working age with severe and enduring mental health problems, and latterly people with dual diagnosis - learning disability and mental illness. My last full time practice post was as a Senior Social work Practitioner in a Community Mental Health Team where my duties involved complex case work, statutory assessments under the Mental Health Act 1983 (as amended under the 2007 Act), staff supervision, practice education and development, and day to day operational management of the multi-disciplinary Community Mental Health Team.

Social work is concerned with enabling individuals, families and groups to function within their social context in ways that optimise the benefits and mitigate the risk to the wellbeing of self and society. In the UK most social work is conducted as a public service demanding accountability to the electorate through its elected members (BASW 2012).

In recent years increasing public demand for accountability, often operated through the media, has led to greater emphasis being placed on the application of theory and evidenced based practice in social work (SCIE 2005). My aim in conducting research was to add to the knowledge base which supports social work practice to achieve better outcomes for those receiving social work interventions.

During my time in practice I observed the introduction of central government policy and guidance on working together to protect adults from abuse 'No Secrets' (2000). As the Senior Social Work Practitioner I was required to put these policies into operation within the local community mental health service. Consequently I quickly undertook the role of investigating officer and subsequently Designated Senior Officer during which I enjoyed the benefit of collaborative working with colleagues from other agencies, especially police and health, across a wide range of adult protection investigations. However, my personal enthusiasm for this area of practice was not widely replicated across the local authority in which I worked. The relatively few number of adult protection alerts raised in relation to people with mental illness in comparison to other categories of the adult population has been remarked upon locally (Cambridge et al, 2006) and nationally (O'Keefe et al, 2007). Indeed the paucity of recognition and response to signs and symptoms of current or past abuse in relation to adults with mental illness by mental health professionals is acknowledged to be an international phenomenon (Read 1998, 2002; Rose, Peabody, Strategias 1991). The reasons why mental health practitioners raised fewer alerts in comparison to their colleagues in other adult service disciplines became the subject of my practice research during completion of MSc studies at the Institute of Psychiatry in 2005 (unpublished). The views of mental health professionals are of particular interest to me in this study as adults with mental disorders (formally diagnosed and not) represent a significant proportion of adults subject to SCRs. These are amongst the reports which comment upon a need to strengthen practitioner understanding of vulnerability and abuse, which will be explored further in this thesis.

In 2004 I took up post as the Multi-Agency Safeguarding Adults Training Consultant, delivering training on behalf of the Safeguarding Adults Executive Board.

My interest in this area of practice has continued to develop whilst reading and researching current and relevant information to support the multi-agency safeguarding adults training programme. In 2004 safeguarding adults practice did not have a foundation in singular statute. In contrast to child protection guidance in Part 8 of the *Working Together* document (DCFS 2010), the framework for vulnerable adults set out in the Department of Health's 'No Secrets' (2000) guidance makes no reference to mechanisms for reviewing cases of particular concern. However, ADASS (2006) assert this as a measure of good practice.

One of the stated aims of an inquiry is to undertake organisational learning and to prevent similar adverse events (DOH & SC 2017). It is, therefore, puzzling that there appears to be no coherent strategy for disseminating the findings of inquiries and no national collation of data emerging from

inquiries relating to vulnerable adults. Flynn (2010) comments on the need to create such a mandate and exhorts this be considered in the consultation of the review of 'No Secrets'.

In the course of my training role, between 2004 – 2014 I have had the opportunity to listen to the experience of practitioners struggling with issues of recognition and response to safeguarding concerns. These concerns related to their own conduct and that of other professionals in the field. Of particular concern were safeguarding responses in relation to adults who fall short of the eligibility criteria enabling access to services. I have also had need to read and disseminate the findings of Serious Case Reviews from within the local authority where I work and where these have been made publicly available. In reading these executive summary reports, I have been struck by some commonalities of theme in relation to the chronicity of the events and circumstances preceding the tragedies. These have included the location of the vulnerable person outside formal services yet with multiple contacts with statutory agencies of numerous identities, and the consistent hindsight bias that is often associated with serious case reviews where the conclusions centre on a lack of co-ordination and collaboration in the sharing of information that might otherwise have led to detection and/or response to signs of abuse. Practitioners hearing about these cases often reflect that on knowing the full picture it was obvious that for this person there was an accident waiting to happen.

These reflections have led me to question whether, in the assessment of risk of abuse, practitioners differentially attend to indicators of vulnerability identified in the person's individual characteristics versus the vulnerabilities associated with their situation/circumstances. These reflections have driven the formulation of this study's questions and methodology which aims to explore how professionals conceptualise vulnerability when assessing Adults at Risk of Abuse (AAR) through direct engagement with the professional groups.

When practitioners are exposed to cases subject to a Serious Case Review (known since 2015 as Safeguarding Adults Reviews) a frequent response heard in the training room was "there but for the grace of God go I". There is much emphasis placed upon inter and intra – organisational learning from SCRs findings and recommendations. Recommendations frequently relate to proposals for changes in policy, and in practice development through training provision for professionals.

1.3. Research Field Context – Two Local Authority Areas

The field context for the conduct of this research is two local authorities in England. These authorities share common policies and other decision making and governance arrangements relating

to the practice of safeguarding vulnerable adults from abuse. This has the advantage of providing the study with contextual stability but may present limitations to the generalisability of the findings.

1.3.1. Introduction to the Local Authority Areas

The largest of the two local authorities in the study serves a population of 1.5 million people. Its districts comprise of a mixture of coastal, rural and urban areas. Overall the age profile of the residents is similar to that of the rest of England. Just under a fifth of the population are of retirement age (65+). The population is ageing and forecasts show that the number of 65+ year olds is forecast to increase by 43.4% between 2010 and 2026, yet the population aged under 65 is only forecast to increase by 3.8%.

The smaller unitary authority is primarily urban in nature serving a population of just over 0.25 million people. The average age of residents is lower than nationally. Compared to England & Wales, the population of this unitary authority has a slightly smaller proportion of people over the age of 65 years. The number of residents aged over 60 has increased by one fifth since 2001. It is estimated that from 2012 to 2021 the number of people aged 65 and above will increase by 22% to 47,000 and the number of people over 85 years will grow by 39% to 6,100 in 2021.

People aged 85 and over make up only 1.6% of its population (4,136 people according to 2010 estimates). People aged 85 years old and older are particularly vulnerable because they are more likely to be frail and have mental health problems such as dementia.

It is considered to be a deprived local authority area. At a ward level the area is mixed; it has both the most affluent and some of the most deprived areas in the country with 23 neighbourhoods being in the 20% of the most deprived areas nationally.

These demographics of the two local authorities provide a glimpse into the populations with whom the public sector professionals come into contact. The age and health profiles are worthy of note in light of our understanding of the significance of age and chronic physical or mental health conditions as an individual characteristic as features in the primary characteristics/indicators for risk of abuse in older adults (O'Keefe et al 2007).

This local government arrangement presents challenges to major public services including primary and secondary health services, social services and the police. However, they have a long established history of co-operation in respect of the development and implementation of Safeguarding Adults Policy and procedures. They continue to share a common set of policies and operate a single Safeguarding Adults Executive Board jointly funded by 6 partner agencies.

1.3.2. Evidence and Engagement in Research and Development

The early development of research in the field of safeguarding adults from abuse has a tradition of collaboration with practice and many early and current studies have been co-authored by researchers and practitioners or subject matter experts. These two authorities have been active participants in both local and national initiatives in research and development in this field of practice. They have been perceived by other local authorities to be leaders in many areas of local government. In the late 80s they were quick to embrace the ideological shift from service provision to service commissioning with the implementation of care management as a model for social care. Furthermore, their early collaboration with applied researchers put them at the cutting edge of practice development, particularly in relation to safeguarding adults practice.

These collaborations between research and practice have helped to provide information to enable managers and practitioners to give thoughtful consideration to the issues as they seek to optimise decision-making for the benefit of the vulnerable victims. They also provide relevant intelligence about the nature of risk in relation to vulnerable adults and the processes and outcomes of adult protection to service better performance.

Whilst the local authorities involved in this study are not unique in their engagement with the development of practice through co-operation with research, it is an important feature of the study context as it indicates the proactive commitment of the partner agencies and employers of the professionals participating in this study. As such, they are employees in organisations and local authorities with a proven track record of engagement and innovation in the development of adult safeguarding practice. This is evident in their structures and strategies for inter-agency working and the broader commitment to joint training and learning. This context is relevant to this study as it helps us understand the working milieu of the professionals participating in the study.

This study will explore what signs of vulnerability are reported to inform their concept of vulnerability and whether these demonstrate any distinction between personal and situational characteristics. Previous studies (Mansell 2009, Cambridge et al 2011) have noted patterns that show links between location, perpetrator characteristics and nature of abuse experienced. For example, people living in care homes were more likely to experience institutional abuse or neglect from multiple members of staff, whereas people living in their own home tended to be at risk of financial, physical or psychological abuse primarily from relatives. Older adults living alone were more likely to experience financial abuse and people with learning disabilities more likely to experience sexual abuse predominantly from other service users, especially when living in care

settings. This helps us understand how vulnerability to exploitation might be a function of the person's circumstances or situation as much as their personal characteristics

1.3.3. Inter-Agency Working – Structure and Strategy

The two local authorities were engaged early in the development and implementation of adult protection policy and procedures, establishing a Multi-Agency Adult Protection Committee, Serious Case Review Panel and local policy and procedures which enabled swift implementation of the guidance in 'No Secrets' (2000).

During recent years, changes giving rise to the current governance and structure of their multi-agency partnership arrangements took place in the context of significant legal and policy changes leading to a period of re-structuring in all public sector services. For example, in the health economy there has been the establishment of commissioning and provision of services in the NHS.

Within the timeframe of this study (April 2011 – December 2017) local health services have been re-organising themselves in the form of shadow Clinical Commissioning Groups in readiness to becoming statutory bodies with full commissioning accountability from April 2013.

The resourcing of safeguarding adults work in the health economy, as evident in the specialist nurse roles for adult safeguarding and commitment to partnership working, has been subject to change (Draper et al 2009).

Historically, partnership arrangements in adult safeguarding were largely a strategic function. However, changes in arrangements for frontline safeguarding adults partnership working have been influenced by recommendations and initiatives for Children's Safeguarding service delivery.

Lord Laming's review of child protection services and procedures (DCSF 2009) called for an overhaul of children's social work. It identified key weaknesses in the way that a range of agencies and individuals, who are separately in contact with a child at risk, share information with one another. This echoes Serious Case Reviews about the safeguarding adults which have highlighted issues in communication between agencies.

In June 2010, the Secretary of State for Education asked Professor Eileen Munro to conduct an independent review of child protection in England. In her final report Professor Munro concluded that child protection has become too focused on compliance and procedures and has lost its focus on the needs and experience of individual children. The Government published a formal response in July 2011 in which it accepted Recommendation 13:

“Local authorities and their partners should start an ongoing process to review and redesign the ways in which child and family social work is delivered, drawing on evidence of effectiveness of helping methods where appropriate and supporting practice that can implement evidence based ways of working with children and families” (Munro 2011 & p.13)

In response to this Devon established the first multi-agency safeguarding hub, brain child of the Police Area Commander at that time, Nigel Boulton (Cooper 2011). In a case study research report it is suggested that:-

“The MASH model offers a more consistent, timely and unified multi-agency response to individual situations, rather than children’s social care services making unilateral decisions in response to referrals. The model’s potential for better sharing of information between agencies means decisions can be both quicker and better in that they are based on a more complete understanding of an individual case. It was envisaged as a multi-agency solution that would remove the barrier of information from different agencies being inaccessible to one another.”
(Golden, Ashton & Durbin 2011, p.1)

Following this research by the Association of Chief Police Officers, the constabulary serving these two local authority areas identified that an integrated referral and assessment service was needed.

In January 2012 a new Central Referral Unit (CRU) was setup in these local authorities, with professionals from Children & Adult Social Services, Police and the NHS (commissioned by the Clinical Commissioning Groups but provided by the Community Health Services Provision). Probation Services have formed a more recent addition to this multi-agency frontline service but Mental Health Services are still notable by their absence.

Whilst a number of other authorities have developed MASH arrangements it is understood that Central Referral Units in this local authority may not be typical of other local authority arrangements. The unit provides an initial response to all new referrals and fresh concerns about the safety of adults whose cases had previously been closed.

The current arrangements, especially for the police, mark a departure from those described by White & Lawry (2009) with specialist posts now being subsumed within ‘combined safeguarding units’ and an expectation for officers to be omni-competent in safeguarding matters from the cradle to the grave.

Throughout all this the local authority has retained a responsibility for leadership in co-ordinating and implementing local arrangements for multi-agency safeguarding adults work acting under the

general guidance of the Secretary of State as required under section 7 Local Authority Social Services Act 1970. In England this guidance was issued under the title of 'No Secrets' (2000). However, the landscape of adult safeguarding responsibilities has shifted from permissive to mandatory. The leadership role for the Local Authority is now established in statute since the implementation of the Care Act 2014 where Section 42 ascribes a duty to Local Authorities to make enquiries or cause others to do so for persons with care and support needs being abused or at risk of abuse who are unable to protect themselves from such abuse or exploitation. Even before this, Directors of Adult Social Services, recognising their leadership role, published a framework of standards illustrated by examples of good practice to support and guide the evolution of safeguarding adults practice. This document stressed the importance of accountability in supporting partnership work to build joint working capability – Standard 1.3 (ADASS 2005).

These arrangements were in anticipation of legislative change for multi-agency safeguarding adults work. In July 2007, Ivan Lewis, then Minister for Care Services, announced that No Secrets was to be reviewed.

However, with an intervening change of administration it wasn't until May 2011 (coinciding with the commencement of this study) when the Government made clear its intention to legislate to provide for a statutory footing for Safeguarding Adults Boards (SAB) (Department of Health 2011). It made this statement with knowledge of the Law Commission report on the law on Adult Social Care (Law Commission 2011) and Clause 35 of the Care and Support Bill (Department of Health 2012) which proposed to provide for a statutory footing for the establishment of Safeguarding Adults Boards (SAB) in each Local Authority. This might have provided some new resources and levers to assist collaborative activity, in particular, the creation of Health and Wellbeing Boards from April 2013 (Health and Social Care Act 2012) and the integration of Public Health with Local Government (Section 116 of the Local Government and Public Involvement in Health Act 2007).

This focus on Local Authority leadership in the legislation provides important context on the changing roles and responsibilities within safeguarding adults practice which inform the working context of the professionals who are the subject of this study.

1.3.4. Multi-Agency Learning & Development for Professionals

Strong partnership working is dependent not only upon all agencies having common definitions and working to an agreed set of policies and procedures but also to understanding one another's roles and responsibilities in relation to these. Policy is only as useful as the workforce ability to put it into practice. This requires that the workforces of all partner agencies are competent. Education and

training are key mechanisms by which employers seek to promote understanding and implementation of their policies.

Whilst recognising that each agency must take responsibility for its own workforce development there is also recognition that Safeguarding Partnership Boards have a central role to play in enabling agencies to plan and commission multi-agency training that promotes mutual understanding (ADASS 2005). The National Framework of Standards ADASS (2005) suggested 14 standards in relation to safeguarding adults training including the following:-

5.1 The 'Safeguarding Adults' partnership oversees a multi-agency workforce development/training sub-group.

5.2 The partnership has a workforce development/training strategy and ensures that it is appropriately resourced.

5.3 The partnership has established standards and agreed competencies for the delivery of all 'Safeguarding Adults' training which is delivered locally. (ADASS 2005)

The Adult Protection Committee for these two local authorities sought to provision this through the appointment of a full-time adult protection training consultant whose job it would be to design and deliver safeguarding training to a multi-agency delegation. The core training structure was based on the common tasks and roles as reflected in the agreed policy, procedures and protocols shared between the local agencies. In summary the aim was to design a training programme in which the content was common to all partner agencies and, therefore, relevant in the course of their duties.

These training arrangements demonstrate the strong commitment in these two authorities to promoting shared understanding and collaborative working practices in recognising and responding to AAR across its staff groups. Whilst training courses offer the opportunity to promote shared understanding of terms, definitions and criteria detailed in law and policy they may not be the only factor informing professionals' concept of vulnerability and governing their responses. This study seeks to explore what influences professional conceptualisation of vulnerability to abuse in adults. The availability of multi-agency training in these authorities is relevant contextual information although it by no means assumes causal influence on the concept of vulnerability. In generalising the study findings this context must be considered, although the direction and strength of any influence may not be possible to state.

Nationally there may be variance in nature and content of local intra and inter-agency training provision but a common mechanism for identifying learning across all authorities across England &

Wales is that of the Serious Case Review. The factors that influence the commencement, course and outcome of inquiries in services for children and adults in relation to social care, health care and mental health services have been considered in detail by Stanley and Manthorpe (2004). In these two local authorities a Serious Case Review Panel was set up in 2006 with an independent chair appointed to its panel. This was 4 years in advance of guidance from ADASS (2010 p.2) which suggested that the purpose of a serious case review was “.....not to reinvestigate nor to apportion blame.....” but to:-

“3.1 establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults.

3.4 improve practice by acting on learning (developing best practice)”. ADASS (2010, p.2)

However, as Brown (2009) points out, each SCR will set its own terms of reference as it seeks to mediate between individual need, corporate responsibility and organisational learning. This latitude for individual variation may mitigate against the utility of such reports for the universal learning of the wider safeguarding community.

If the process of Serious Case Review is to improve the opportunities for organisational learning it must create an approach which minimises organisational defensiveness and maximises transparency within and across agencies (Cambridge 2004). Despite findings of strong support for a national collation of SCRs (Manthorpe & Martineau 2009) the outcomes and learning from such reviews still remains at a local level. The provision of training is a common recommendation in these reports as it often represents an action that is available from a limited pick list of organisational responses. The multi-agency training programme contents in these two local authorities included reference to local SCRs and national ones where this information is publicly available, although not specifically aimed at the understanding of vulnerability. It is likely that participants in this study will have attended training where learning from SCRs has been part of that learning experience.

1.4. Thesis Structure – An Overview of the Chapters

This chapter has briefly outlined the background to the study. The timeframe for research activity is set against the development of law and policy in which a change of terminology can be observed. It has described the professional values and experiences that have framed the study question and the influence of these on the research. It has also described the field context for the study, two local authority areas, and the engagement of partner agencies in the development of safeguarding adults’

policy and practice which provide the working arrangements and support to the professionals who have been the participants. Finally, it sets out the structure of the thesis.

Chapter 2 reviews the literature in adult protection starting with the dominant themes, and narrowing to focus on research relevant to staff attitudes and appraisal in assessing adults at risk of abuse. It identifies the gaps in research providing an account of how the research question was formulated. The key theoretical influences on my thinking are set out to support the phenomenological interpretative approach of later analysis and discussion.

Chapter 3 charts the development of the research question, design and rationale, including methods, data collection and analysis which is situated within an interpretative approach and parallels existing methods in the field. Issues relating to credibility and trustworthiness are explored and ethical considerations regarding the sample population and the field context of data gathering are elucidated.

Chapters 4 - 6 constitute the amalgamated findings from data analysis organised thematically. Chapter 4 explores the themes emerging from a growing body of serious case review literature and relates this to the language of vulnerability mapped throughout law and policy. The emergent critique of practitioner understanding of abuse and vulnerability is then unpacked in Chapters 5 and 6 which elucidate the cues and clues used/described by practitioners in constructing their concept of vulnerability. The core constructs are categorised to represent an emergent, interactive model of factors which constitute vulnerability used by practitioners in considering safeguarding responses.

Chapter 7 details the approach of professionals in combining signs of vulnerability identified in both the person and their situation. It draws attention to the differences between the professional groups in how they attend to signs located in either the victim or the perpetrator.

Chapter 8 explores the primary influences on practitioner recognition and response to signs of vulnerability as it seeks to explain the apparent disconnect between the findings in Chapters 4 -7.

Chapter 9 forms a discussion of the research findings. Lipsky's theory of street level bureaucracy provides an interpretative framework in which practitioner compliance with criterion based decision making and the organisational context of practice decision making is explored. A co-constructed, but untested, model of vulnerability is suggested to support practice decision making which supports a more inclusive model of vulnerability, concurring with a social constructionist perspective. The chapter concludes with the researcher's reflections on the study, including its strengths and limitations and opportunities for practice and further research.

Chapter 2

Literature Review

2. 1. Introduction

The abuse and neglect of adults in the UK is not a new phenomenon but the response to the challenges of this often hidden or ignored problem has been slower than that observed in other countries such as the USA where by the late 1980s almost every State had legislation related to Elder Abuse (Penhale & Kingston 1995, McAlpine 2008). Consequently, public services' response to adults at risk of abuse has received less attention in comparison to children. Children by their very nature and position in society are considered to be vulnerable (RCN 2015). They are perceived as less able to protect themselves from harm for reasons of age and immaturity, thus attracting support for the ethos of State intervention. There is an established framework of law and public policy which reinforces this public position (Children Act 1989 & 2004, Working Together to Safeguard Children 2006, 2013).

However, over the past 25 years there has been a growing awareness of the nature and extent of abuse of vulnerable adults aided by media coverage, such as the investigative journalism of television programmes including Panorama and MacIntyre Undercover (Panorama 2007, 2011, 2012 and MacIntyre Undercover 1999) and newspaper reports of inquiries into tragic deaths such as Steven Hoskins and Fiona Pilkington (Daily Telegraph 2009, The Telegraph 2013). The preponderance of reporting relates to abuse within service settings creating an impression that abuse is largely a phenomenon related to institutional settings, like care homes and long stay hospitals. Less attention is paid to abuse that occurs within domestic settings, with the notable exceptions of Steven and Fiona as previously mentioned. Similarly there has been an increase in the attention given by professionals working in health, social care and criminal justice services to the recognition of abuse and neglect of adults who are vulnerable, especially since the introduction of the Human Rights Act 1998. It would seem that for both public and professionals, the perception of vulnerability in relation to adults has centred on the person's age, illness or disability with those most readily identified as vulnerable being defined as adults with learning disability, mental health difficulties, physical and sensory impairments, and older adults.

This literature review will map the definitions of vulnerability throughout law and policy relating to safeguarding adults from abuse. It will provide an overview of the landscape of current research in adult abuse, identifying studies most relevant to the study question, and the gaps in our understanding which have informed the research questions, and prevalent methodologies in the

field. It will finish with an overview of the primary theoretical concepts which frame the position of this thesis and research questions.

2.2. Methodology of the Literature Review

An initial narrative review of the literature was adopted to gain a general impression of how abuse and vulnerability are constructed, recognised and responded to. It includes legislation and policy in the UK, consultation documents, non-government body reports (e.g. EHRC (2011)), peer reviewed articles, case studies (SCR Executive Summary Reports), websites and anecdotal reports (i.e. Media).

However, some measure of systematic review of peer reviewed articles was required with regard to inclusion criteria to ensure transparency. Peer reviewed articles were selected because they can be relatively easily searched for through on line databases and the peer review process offers a degree of quality control by other interested and involved academics. Details of the search terms used and a full list of information sources, databases and journals accessed are available in Appendix 1.

2.3. The Evolution and Emancipation of Safeguarding Adults and the Emancipation of Public Policy – Background and Context

In the United Kingdom (UK) the subject of Adult Abuse has received very little attention since Baker (1975) and Burston (1977) first remarked on the phenomena of ‘Granny Bashing’, and the majority of research data is drawn from studies in the USA (Finklehor 1990). An overview of recent and current developments by Penhale and Kingston (1995) noted that the recognition of the problem of Adult Abuse has been slow to develop following Stearns’ (1986) inaugural study of elder abuse in the UK. More recently Penhale (2009) has commented that research in this area is still dominated by a focus on distinct areas such as elder abuse and sexual abuse of people with learning disability with much more limited attention being paid to adults with physical or sensory impairments, mental health difficulties, and chronic health conditions.

In the UK there have been a number of reported scandals within the health and social care sector (Butler and Drakeford, 2003; Manthorpe, Penhale, and Stanley, 1999; Martin 1984). During the 1970s a series of scandals involving health and social care providers emerged, mainly in long-stay institutions providing care for older people or people with learning disabilities. At the time these reports provided evidence of physical abuse, psychological abuse, neglect and in particular systemic failures at multiple levels and across all professions within these institutional settings. Inquiries of this kind continue unabated to the present date and from the 1980s onwards there have been numerous inquiries that have taken place across the entire health and social care spectrum, including residential and nursing homes, statutory and voluntary sectors, NHS hospitals (including

wards for older people, people with learning disabilities, and people with mental health challenges), and 'special hospitals' (Burgner et al 1998, CHI 2000, CSCI 2006, CHI 2007, DoH 1999). Throughout the UK these inquiries have found substantial failings in services designed to protect vulnerable adults.

Simultaneously, a body of research literature began to emerge predominantly detailing the various forms of abuse and neglect experienced by people with learning difficulties especially sexual abuse (Brown & Turk 1992, Brown & Thompson 1998, Brown et al 1995). However such literature in relation to people with mental health challenges remains limited by comparison (Brown and Keating 1998; Williams 1995; Williams and Keating 2000), despite the work of pressure groups such as POPAN (now WITNESS) who have sought to advocate for such an examination on behalf of the victims of abuse by professionals in the mental health services.

It was as recently as the mid 1990s that the critical mass of activity from research (McCreadie 1996) campaign groups (Action on Elder Abuse, Ann Craft Society), and professional groups (ADASS) pressed this matter towards a need for public policy. In her review of research outcomes in elder abuse McCreadie (2002) draws some conclusions in respect of the clinical and social governance of elder abuse which she hopes will...

"offer signposts to a certain degree of accuracy about this very complex topic, which in turn will help in setting high standards of professional practice and team working." (McCreadie 2002, p.3)

She comments that:-

"...abuse is a diverse and complex phenomenon, and, to understand it, a considerable task of 'deconstruction' has to occur...pitfalls of language in discussing this potentially emotive issue. The meaning of vulnerability also needs careful examination". (McCreadie 2002, p.4)

Who is most at risk and of what?_McCreadie points to the need to make clear distinction between risk and vulnerability.

The 1990s also heralded a time when legal debates were emerging which aspired to the provision of a legislative framework for the protection of vulnerable adults (Brammer 1996). Implementation of the Human Rights Act 1998 has also proved influential in setting the context for public body involvement with the issues and concerns of adult protection.

In 1993, the Department of Health (DoH) and the Social Services Inspectorate (SSI) (Department of Health 1993) published guidelines for the protection of vulnerable adults for England, Wales, and

Northern Ireland expecting that policies to prevent and protect elders from abuse would be developed and put into operation by multiple agencies. However, it was not until the DoH published and promoted the current official policy guidance 'No Secrets': Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse' (DoH 2000) that multi-agency implementation has become a reality for most local authorities across England & Wales (Sumner 2002). In Scotland the Scottish Executive has not produced anything similar to 'No Secrets'. However, Scottish health and welfare agencies, influenced by the 'No Secrets' have actively engaged with this issue as a matter of public concern and Scotland was ahead of the rest of the UK in enacting and implementing legislation – Adult Support and Protection (Scotland) Act 2007. In England & Wales a Private Members' Bill (under the Ten Minute Rule, SO No 23) 'Support and Protection for Elderly People and Adults at Risk of Abuse Bill 2010 - 12' was submitted by Mr Nigel Dodds on 10th November 2010 but the Bill failed to make any further passage through Parliament before the end of the parliamentary session. 'No Secrets' suggests the creation of a binary approach to determining eligibility for a response using adult protection procedures. It recommends as a starting point the following operational definitions of 'abuse' and 'vulnerable adult'.....

“Abuse is a violation of an individual’s human and civil rights by any other person or persons”.

In giving substance to that statement, however, consideration needs to be given to a number of factors:-

2.6 Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

“Any or all of these types of abuse may be perpetrated as the result of deliberate intent, negligence or ignorance”. (DoH 2000, p.9)

A commonly used definition for elder abuse and one which is preferred by AEA is as follows:-

“a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.” (AEA 1995, p.2)

In contrast to the differentiated description of abuse detailed in ‘No Secrets’, the definition of a ‘vulnerable adult’ receives less detailed attention. In fact the text in ‘No Secrets’ states that:-

“The broad definition of a ‘vulnerable adult’ referred to in the 1997 Consultation Paper Who Decides?, issued by the Lord Chancellor’s Department (Lord Chancellor’s Department 1997), is a person:-

“who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation”.

2.4 For the purposes of this guidance ‘community care services’ will be taken to include all care services provided in any setting or context.” (DoH 2000, p.8)

Yet, despite this guidance, and in the absence of a legal mandate, public body resourcing and responsiveness to adult protection concerns has remained poor in contrast to child protection matters. Highlighting this discrepancy, campaigners such as Gary Fitzgerald, Chief Executive, Action Against Elder Abuse, asserts that many people would be familiar with the case of Victoria Climbié, a child tortured and murdered in the care of a relative, but few would know about Margaret Panting, a 78 year old woman from Sheffield who died after suffering extreme cruelty whilst living with relatives. Following her death, a post-mortem revealed 49 injuries on her body including cuts, probably made by a razor blade, and cigarette burns. She had moved from sheltered accommodation to her son-in-law's home and six weeks later she was dead. The cause of Margaret Panting's death could not be established, and so no one was ever charged.

The UK Government acknowledged its position of ignorance in relation to the nature and extent of adult abuse within the UK and set out the terms of reference for an inquiry into Elder Abuse. The outcomes of this inquiry served to support a strengthening of their statement of resolve to tackle abuse amongst the population of elders (Health Committee Elder Abuse, March 2004).

However, much of this report focuses on the nature of abuse and settings within which it takes place. Little is said about the nature of vulnerability and the focus on elders excludes other adults in the population who may be at risk of abuse and neglect for other reasons related to individual

characteristics or circumstances. In its response to the report (House of Commons, June 2004) the Government concurs with the views expressed by ADASS, that further guidance is required. However, this did not transpire until the implementation of the Care Act 2014 in 2015 which introduced a statutory footing for the Local Authority to make or cause to be made, enquiries regarding adults at risk of abuse or neglect. The term 'Vulnerable Adult' was replaced by the term 'Adult at Risk' but the definition is still hinged to the concept of need for care and support.

There are authors who assert that the concept of a vulnerable adult is an enduring aspect of human history, with numerous historical references in literature, theatre, folklore and anthropological data (Manthorpe, Penhale and Stanley (1999). Despite this there is no commonly agreed construct of the term vulnerable adult. As Brown et al 1999 point out:-

"...there is a central confusion about what constitutes vulnerability and what causes abuse – in many adult protection policies vulnerability to abuse is assumed to be a product of the individual's impairment and not their environment or the perpetrator's behaviour. This goes against the grain of the social model of abuse as well as of disability, which would emphasise structural inequalities such as gender, race and poverty as contributory factors. Hence many would argue that victims of abuse are universally vulnerable because of their experiences of abuse and should be treated in policy and practice as a seamless group". (Brown et al 1999, p.9)

Ten years later ADASS made similar comment on the contentious nature of the 'No Secrets' definition of a vulnerable adult (ADASS, October 2009). They added that another reason for confusion about the definition is that there are multiple definitions of a vulnerable adult employed in public law and policy. These would include the Youth Justice and Criminal Evidence Act 1999, Care Standards Act 2000, Safeguarding Vulnerable Groups Act 2006.

However, all of these relate vulnerability to the characteristics of the individual. To find a definition in law that encompasses characteristics of the perpetrator or environment one has to look to the Crime and Disorder Act 1998 which refers to vulnerable sections of the community and embraces ethnic minority communities and people rendered vulnerable by social exclusion and poverty.

Furthermore, there has been a change in the language and philosophy pertaining to health and social care which influenced the concept of a vulnerable adult. For example, since 'No Secrets' was published, there have been some significant legal and policy changes relating to adult social and health care. 'Fair Access to Care' (DH 2002) stressed 'risk to independence and well-being' as the key criteria for determining eligibility for care services and, therefore, replaces the concept of a

"vulnerable adult" with an assessment of the risk posed by the abuse and neglect to the quality of life of the individual adult concerned. There is now a greater emphasis on supporting adults to access services of their own choosing, rather than service intervention to provide protection. Meanwhile, the duty to provide protection to those who do not have the mental capacity to exercise choice and control themselves has become clearer (e.g. Human Rights Act 1988, Mental Capacity Act 2005, Domestic Violence Crime and Victims Act 2004). Consequently, ADASS (2005) recommended a change in the terminology replacing references to the protection of "vulnerable adults" and to "adult protection" with the new term: '**Safeguarding Adults**'.

Their guidance suggests that:-

"This phrase means all work which enables an adult "who is or may be eligible for community care services" to retain independence, wellbeing and choice and to access their human right to live a life that is free from abuse and neglect. This definition specifically includes those people who are assessed as being able to purchase all or part of their community care services, as well as those who are eligible for community care services but whose need - in relation to safeguarding - is for access to mainstream services such as the police. " (ADASS 2005, p.5)

The extent to which this has clarified thresholds for intervention within defined populations remains unclear. During 2009 the Government undertook a public review of the 'No Secrets' guidance and responses were received from many professional, educational and regulatory bodies. In the response ADASS urged for national definitions stating that....

*"We need clear national definitions to give consistency. The term 'vulnerable adult' is currently subject to different interpretations by different agencies according to guidance issued to them to support their core business. There is also a public expectation about who and what the term 'vulnerable' means, all of which has the potential to lead to or exacerbate confusion and misunderstanding. **The definition should enable everyone, not just practitioners, to understand who a 'vulnerable adult' is**". (Bold my emphasis) (ADASS 2009, p.2)*

Criticism of the term 'vulnerable adult' in safeguarding practice has not been limited to researchers and professional bodies. Campaign groups have also challenged its use claiming that it is counterproductive to the safeguarding agenda because:-

"as a construct it places the focus on the individual as the 'vulnerable person' and not on the circumstances that give rise to that vulnerability. The consequence of this situation is that Government policy is unable (or does not) discern between people of varying abilities and has

chosen minimalist intervention in response to the loud voice of ability rather than the silent voice of inability". (Fitzgerald 2009, p.86)

Scotland made some attempts to address this problem in the Adult Support & Protection (Scotland) Act 2007 by using the term *'adults at risk'* thereby defining the circumstances that give rise to that risk:-

" Adults who are unable to safeguard their own wellbeing, property, rights or other interests, are at risk of harm" and relating this to their individual characteristics...." because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected".

This triangulation of views indicates consensus about the 'confusing and ambiguous' nature of term 'vulnerability'.

There was considerable delay in the response of Government to the consultation process but in May 2011 a ministerial statement set out the Government policy direction for the future. This statement outlined the principles that the Government believed would govern future safeguarding adult policy and practice and stated its intention to place Safeguarding Adults Boards on a statutory footing to strengthen the commitment of all agencies to the work of safeguarding adults from abuse and exploitation. It did nothing to address the definitional confusion that prevails, continuing to refer to 'vulnerable adults'. In a report made by AEA on the statement given to Community Care magazine by a civil servant following a statement made by the Minister Paul Burstow (2012) at an AEA conference saying that new legislation would include the term adult at risk of harm:-

"The minister's response to a delegate's question indicated that legislation will not refer to "significant harm'..... Of course how these terms are defined in the first ever adult safeguarding legislation in England will be critically important, and that is why we have been talking to people working in safeguarding to get their views on these issues".

'No Secrets' remained the primary policy directive until the introduction of the Care Act (2014) and the confusion over definitions remained. Despite the new terminology introduced in the Care Act the term 'vulnerable adult' remains in common parlance. It is a term that has established familiarity amongst health, social care and criminal justice personnel as it appears frequently in both public policy and legislation. The variance in the construction of the term vulnerability and vulnerable in English law is examined below.

2.4. Construction of the Vulnerable Adult in Law

The confusing picture over the definition or construction of the term 'vulnerable adult' is mirrored throughout public law and policy. Professionals in adult safeguarding are faced with a plethora of legislation which informs and supports state intervention for the protection of adults from abuse. These laws often offer no specific definition of a vulnerable adult but their contents contribute to the debate over the framing or construct of a vulnerable adult authorising intervention by the State.

In mapping some of this legislation the mixed and confusing picture within which professionals have to operate will be illustrated. The struggle that health and social care practitioners have in using these definitions has been reported on by Brown (2011) in her examination of complex decision making and the Mental Capacity Act 2005. Brown highlighted how the decision and time specific boundaries of delegated decision making authority of the act fails to address some of the complexities associated with the context of decision making. This presents challenges to practitioners seeking lawful sanction to intervene for the protective needs of some vulnerable adults.

In adult safeguarding practice the jurisdiction of the Mental Capacity Act 2005 is of particular pertinence as it sets out a framework for delegated decision making on behalf of the mentally incapacitated which formalised and developed what had hitherto been the province of common law. Additionally it introduced a new offence in Section 44, Mental Capacity Act 2005 which provides a framework for redress for those who might be considered vulnerable as being unable to protect themselves from exploitation by virtue of mental incapacity. The offence is complete in relation to persons deemed to lack mental capacity. -

Section 1 of the Act sets out the determination of a lack of capacity as follows:

"People who lack capacity:-

(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain".

The focus here is on characteristics that are inherent to the individual, hence vulnerability is constructed in terms of an inability to protect oneself from exploitation by reason of mental incapacity which is determined on the basis of individual characteristics.

Other pieces of legislation, whilst now repealed by the implementation of the Care Act 2014, are likely to have influenced thinking and practice in determining who is considered vulnerable and, thereby, deserving of welfare responses/services. These laws have framed the role and function of social work and are likely to be in the consciousness of professionals working in social care. This legislation includes:-

- The National Health Service & Community Care Act 1990, Section 47, Duty to carry out an assessment of need for community care services;
- Disabled Persons (Services, Consultation, and Representation) Act 1986, Section 4, Duty to consider the needs of disabled persons;
- Chronically Sick & Disabled Persons Act 1970, Section 2, Duty to consider the needs of disabled persons

All of these refer back to the definition under Section 29, National Assistance Act 1948 in identifying persons in relation to whom it has powers to make welfare provision which focus on inherent characteristics:-

National Assistance Act 1948 Section 29(1)

Welfare Services 29. (1) A Local Authority shall have power to make welfare arrangements for promoting the welfare of persons to whom arrangements this section applies, that is to say persons who are blind, deaf or dumb, and other persons who are substantially or permanently handicapped by illness, injury, or congenital deformity or such other disabilities as may be prescribed by the Minister.

It later goes on to describe circumstances that authorise the removal of a person in which the criteria attend to both individual and situational characteristics:-

Removal to a suitable premises of persons in need of care and attention 47. (1) The following provisions of this section shall have effect for the purposes of securing the necessary care and attention for persons who:-

(a) are suffering from grave chronic disease or, being need of care, aged, infirm or physically incapacitated, are living in insanitary conditions, and

(b) are unable to devote to themselves, and are not receiving from other persons, proper care and attention.

By far the most frequently cited definition of vulnerability and a vulnerable adult is that indicated in the Who Decides Consultation paper and adopted in the official policy guidance on protecting vulnerable adults from abuse – ‘No Secrets’. The definition here and in the Domestic Violence and Crime Victims Act 2004 both locate vulnerability in the individual characteristics of illness or infirmity. In ‘No Secrets’ (2000) the broad definition of a ‘vulnerable adult’ referred to in the 1997 Consultation Paper Who Decides? is a person:-

“who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation”.

Domestic Violence, Crime and Victims Act 2005 Section 5(6):-

“vulnerable adult” means a person aged 16 or over whose ability to protect himself from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, through old age or otherwise”.

In contrast the expanded definition offered in the Care Standards Act 2000 and the Safeguarding Vulnerable Groups Act 2006 focuses on the location of the adult, suggesting that vulnerability is to be located in the person’s circumstances as well as their personal characteristics. These mark a departure from those cited previously as both demonstrate a shift in focus, locating vulnerability in the circumstance rather than the person. This is illustrated in the extracts below:-

Care Standards Act 2000, Part V11, Section 80(60):-

(6) “Vulnerable adult” means:-

(a) an adult to whom accommodation and nursing or personal care are provided in a care home;

(b) an adult to whom personal care is provided in their own home under arrangements made by a domiciliary care agency; or

(c) an adult to whom prescribed services are provided by an independent hospital, independent clinic, independent medical agency or National Health Service body”.

Safeguarding Vulnerable Groups Act 2006, Section 59(1) definition of a vulnerable adult focuses on the receipt of care services or settings in which care or control are exercised over the adult. These include:-

(a) residential accommodation;

(b) sheltered housing;

(c) receipt of domiciliary care;

(d) receipt of health care;

(e) detention in lawful custody;

(f) requires assistance in the conduct of his own affairs”.

During the Government’s consultation on a review of ‘No Secrets’ in 2009 views were expressed about the stigmatising and counter-productive effect of the term ‘vulnerable adult’ because as a construct it focuses vulnerability on the person and not the circumstances that gave rise to the vulnerability (AEA 2009, Fitzgerald 2009). Around the same time the Government showed understanding of this in the guidance it issued on forced marriages (HM Government (2009)):-

“It is recognised that the term vulnerable adult is unacceptable to some people with disabilities as it is frequently other people, the environment and social circumstances that make people with disabilities vulnerable and not their disability per se. Therefore, the term “adult with support needs” is used throughout this document to refer to those who fall within the commonly accepted definition of “vulnerable adult”.

However, this new term still hinged on vulnerability due to needs arising out of individual characteristics.

This impetus to remove the term vulnerable adult first translated into law following the introduction of the Protection of Freedoms Act 2012 which amended the Safeguarding Vulnerable Groups Act 2006 (September 2012). The amendment of the definition of regulated activity removed its association with the term vulnerable adult and instead identified activities which, if an adult requires them, lead to the adult being vulnerable at that particular time. This shifted the focus away from personal characteristics and the settings in which regulated activity is received and placed it on the nature of the activity undertaken. Consequently vulnerability in the light of this change is associated with the following types of activity – provision of health care; provision of personal care (including prompting and supervision as well as direct physical care); provision of social work; assistance with cash, bills or shopping; assistance in the conduct of a person’s affairs; conveying to a place in order to receive health, social or personal care.

It is curious, given the leadership role assigned to Local Authorities in arrangements to protect vulnerable adults at risk of abuse, that the legislative framework of reference has demonstrated this obvious division in constructing vulnerability as either inherent to the individual or assigned to the individual's circumstances. In order to see a more combined approach one has to look to the courtroom and associated legislation.

The Youth Justice and Criminal Evidence Act 1999 authorises the protection of vulnerable witnesses when giving evidence by virtue of a number of 'special measures'. The qualifying criteria use a combination of inherent and situational vulnerability. The first criterion draws upon inherent vulnerability to define a vulnerable witness according to incapacity in as much as they:-

“(i) suffers from mental disorder within the meaning of the Mental Health Act 1983 or 1983 c. 20;

(ii) otherwise has a significant impairment of intelligence and social functioning(iii) that the witness has a physical disability or is suffering from a physical disorder”.

The second criterion uses inherent and situational vulnerability in combination to determine a witness whose evidence may be compromised by being in fear or distress. Circumstances which the court must take into account include: the sociocultural origin of the witness, economic circumstances, religious beliefs, the nature of the offence, and any behaviour displayed towards the witness by the accused, his/her family and/or other witnesses in the proceedings.

And finally, situational vulnerability alone is used to make special measures available for complainants who are witnesses in the proceedings relating to sexual offences and some violent offences.

Returning to the observation made by Brown (2011) about the difficulties faced by practitioners in making use of the Mental Capacity Act in justifying interventions in complex decisions involving safeguarding concerns, the mapping of the law above evidences the confusing and complex landscape of law through which professionals in safeguarding practice have to navigate in search of a lawful justification for intervention. These laws frame vulnerability as a binary concept allied either to inherent characteristics of the individual or situational characteristics of circumstance.

In order to observe a blended approach to evaluating vulnerability (combining inherent and situational characteristics of vulnerability) in adults at risk of abuse one has to turn to the arena of the High Court.

In the High Court there have been a number of judgements since the year 2000 which have confirmed and extended its inherent jurisdiction to make declarations of relief to sanction interventions by others on behalf of the 'vulnerable'. The court has not constrained itself to judgement in relation to mentally incapacitated adults. Dunn et al (2008) drew attention to the ways that courts have attended to both inherent and situational characteristics of vulnerability in justifying court intervention as part of a protective framework. However, they were critical in some of the cases as it would indicate that a person assessed as mentally capable of making a decision might not have this respected if a court considers them to be vulnerable.

The benefit of inherent jurisdiction in comparison to the Mental Capacity Act as a framework to endorse State intervention in the lives of adults at risk is that it is not tied to a specific decision or a specific time. This broadens the scope of intervention for persons deemed to be vulnerable enabling pre-emptive intervention within a protective framework to prevent circumstances where an adult might not be able to exercise free choice.

Notable amongst the High Court judges is Judge J Munby. In the case *Re SA (vulnerable adult with capacity: marriage)* [2006] 1 FLR 867 Judge Munby was careful to avoid a definition of a vulnerable adult and in outlining some characteristics that could be considered, he emphasised that this was '*descriptive, not definitive: indicative rather than prescriptive*'. However, later he stated who he would treat as a vulnerable adult in the context of inherent jurisdiction as being:-

"someone who, whether or not mentally incapacitated, and whether or not suffering from any mental illness, or mental disorder, is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation, or who is deaf, blind, or dumb, or who is substantially handicapped by illness, injury or congenital deformity".

Re SA (vulnerable adult with capacity: marriage) [2006] 1 FLR 867, Para 82.

There are strong parallels between this and the definition of a vulnerable adult set out by the Lord Chancellor's Department (1997) in the consultation document 'Who Decides, Making decisions on behalf of mentally incapacitated adults'. These definitions situated vulnerability as being inherent to the individual.

However, later in this case Judge Munby, in describing the circumstances that might give rise to a need for protective interventions by the court, makes reference to the '*circumstances in which the adult might be constrained, coerced or otherwise denied the ability to make a free choice*', thereby attending to situational vulnerability. In justifying court sanctioned intervention Munby suggested that the adult's inherent vulnerability puts them at greater risk of situational vulnerability,

suggesting an interactive account of vulnerability. This position is echoed in 'No Secrets' (2000) para 6.21 which asserts that action to protect should not be limited by the persons' mental capacity. The guidance exhorts that:-

"In order to make sound decisions, the vulnerable adult's emotional, physical, intellectual and mental capacity in relation to self-determination and consent and any intimidation, misuse of authority, or undue influence will have to be assessed". (DoH 2000, p.31)

This resonates with Munby's suggestion that persons with inherent vulnerability by reason of illnesses or infirmities may be at greater risk of exploitation by virtue of the circumstance or situations that these particular needs expose them to. This is a view point affirmed by Brown et al (1999) who reported that concerns for adults in need of health and social care services being more vulnerable to exploitation have been consistently validated by research studies over the past 10 years. Others (Dunn et al 2008) have argued the dangers of assuming that inherent vulnerability automatically heightens the risk of situational vulnerability, and assert that many adults who evidence inherent vulnerability are very able to protect themselves from exploitation. They, like others, warn of the danger of conflating risk and vulnerability, as they are objective and subjective states of being. Additionally they warn of the risks to ethical decision making in law from the current etic and emic accounts of vulnerability and argue for the inclusion of the adult's perspective of their subjective experience of vulnerability as part of the decision matrix.

In conclusion, law and policy frame the understanding and actions of professionals in safeguarding adults practice. The definitional confusion highlighted by early researchers and commentators is reflected in the way vulnerability is constructed in law and policy. This is the landscape that professionals have to navigate in identifying adults at risk of abuse and justifying their responses. In searching for understanding of vulnerability to abuse the law is not clearly definitive.

2.5. Relevant Research

The study of Adult Abuse has received very little research interest since Baker (1975) first remarked on the phenomena of 'Granny Bashing', and the majority of early research data is drawn from studies in the USA. An overview of developments by Penhale and Kingston (1995) noted that the recognition of the problem of Adult Abuse has been slow to develop following Stearn's (1986) inaugural study of elder abuse in the UK. It was not until 2006 the first incidence and prevalence study was conducted in the UK by O'Keefe et al (2007), although small scale local studies have been conducted (Brown & Stein 1998, 2000; Cambridge et al 2011) pre and post policy implementation.

As Northway et al (2005) have commented this sparse attention in the academic community reflects the fact that much of adult protection research has its origins in practice dilemmas and it is increasingly common that articles are co-authored by practitioners in the field and academics. The studies have tended to be of local, small scale, and narrowly focused populations that tend not to extrapolate across populations and across international boundaries. Additionally, the terminology used in the field has been poorly defined and constantly changing. The term vulnerable adult itself only became popular in the 1990s. The field of practice has been re-named each decade from 'Adult Abuse' to 'Adult Protection' and more latterly 'Adult Safeguarding'. The vast majority of adult protection research has been conducted since the late 1980s associated with an impetus for the development of policy and practice initiatives.

However, there has been an increase in the amount of research and other material published on the subject since the beginning of the 90s (Phillipson & Biggs 1992, Pritchard 1992, Decalmer & Glendenning 1993, Bennet & Kingston 1993, Eastman 1994, Kingston & Penhale 1995).

International comparisons have been hampered by a number of difficulties including no shared definition of abuse.

2.5.1. Incidence and Prevalence Studies of Adult Abuse

Early studies on the incidence and prevalence of adult abuse cite varying forms as the most prevalent making it difficult to establish a consistent database on the nature and extent of Adult Abuse (Lau & Kosberg 1979). Some report elder abuse as consisting largely of abuse between partners in later life (Pillemer & Finklehor 1988), others psychological abuse (Block & Sinott 1979) and still others found neglect to be the most common form (Valentine & Cash 1986). The first UK study (O'Keefe et al, 2007) identified physical abuse, neglect and financial abuse to be amongst the top three reported forms of abuse in the elder population.

Notwithstanding the seminal prevalence study in Boston by Pillemer & Finklehor (1988) and studies since in the UK (Ogg & Bennet 1992, O'Keefe et al 2007) these figures are believed to be an underestimate as other studies (Tomita 1982, Fulmer & O'Malley 1987) suggest that older victims tend not to report abuse. O'Keefe's UK study was limited to elders living in the community and therefore did not sample those living in institutional settings. This limits the scope of our understanding. More recent reviews of the research (McDonald et al 2012) have suggested this requires further attention as a significant issue, in light of the World Health Organisation's report (2002), that mistreatment of older adults had been identified in nearly every country where safeguarding procedures exist (Krug, Dahlberg, Mercy, Zwi & Lozano 2002).

Campaign agencies such as Age UK have drawn attention to a rise in elderly abuse highlighting Health and Social Care Information Centre figures which showed that the number of cases referred for investigation by Councils in England rose from 108,000 in 2011/2012, to 112,000 in 2012/2013. Of these, 38% of the alleged abuse took place in the older person's home, while 45% took place in a care home [<http://www.bbc.co.uk/news/uk-24399139> Accessed 16-04-17].

Brown & Stein (1998) draw attention to the relationship between research developments and the growing awareness of abuse in the adult population. In the area of elder abuse a growing body of knowledge suggests abuse most often takes the form of familial violence (Pillemer & Finkelhor 1988), and in the field of learning disabilities attention has been focussed on sexual abuse. Whereas in the field of mental health, research in relation to adult abuse has focussed on the shortcomings of mental health service provision including abuse within the professional relationship (Bouhoutsos et al 1983, Bouhoutsos 1984, Schoener et al 1990, Symanska & Palmer 1993), in-patient victimisation (Nibert et al 1989), and the general tendency of mental health professionals to overlook or deny patients' abuse histories, both current and historical (Rose, Peabody & Strategias 1991, Reed et al 1998 & 2002).

Brown & Stein (1998 & 2000) comment that the level of reporting for adult abuse by mental health services was considerably lower than expected and that this finding was consistent across a number of Local Authorities leading them to conclude that there were major problems with the implementation of Adult Protection Policy in mental health services. They offer some suggestions for this including: attitudes of staff towards the concept of adult protection vary between those who see it as a force for good, a necessary safeguard in the new mixed market of care; and those who see it like the sword of Damocles hanging over the head of individual carers and commercial care providers. Some practitioners adopt a fluid approach to the critical issue of thresholds, concerned to avoid the stigmatising effects of formal procedures and wary of reporting cases which might later be dropped for lack of evidence or not considered serious enough. Brown & Stein (1998, 2000) suggest here, that practitioners adjust the threshold at which they will initiate an adult protection alert in order to keep their options 'open' for action/intervention. The ongoing struggle with fuzzy definitions and poorly defined thresholds has occupied continued debate. Collins (2010) in commenting on the development of thresholds documents in Wales, cites the initiative as arising from differential approaches to thresholds for adult protection referrals between health and social practitioners owing to the grey areas in practice. He echoes the views of Cooper et al (2009) who advocate that:-

“Considering elder abuse as a spectrum of behaviour rather than an “all or nothing” phenomenon could help professionals to feel more able to ask about it and therefore offer appropriate help. (Cooper et al 2009, p.3)

He asserts that the differential approaches to safeguarding concerns across the agencies are particularly concerning and potentially fail to identify crimes. This exhortation for clarity is echoed in a number of Serious Case Reviews which will be explored later. For example, in the Serious Case Review Report into the Death of Steven Hoskin (Flynn, 2007) states that:-

“If clear “thresholds” are set out, such as, for example: any more than three presentations to A&E/Minor Injury Unit (MIU) Services by a vulnerable adult within a period of three months; or any vulnerable adult who presents to A&E/MIU Services having been assaulted/ having taken an excess of drugs and/or alcohol, then the vulnerable adult concerned should always be referred to Adult Protection Services and the Department of Adult Social Care”. (Flynn 2007, p.26)

The above studies consistently draw attention to problems with comparison across Local Authorities due to unclear definitions and differential threshold decision making by practitioners.

2.5.2. Policy Implementation in Safeguarding Adults

The problem of definition has also been reported in research on policy implementation. As policy in the UK began to develop, research interest turned its attention to policy implementation and joint working. Early studies in the UK have examined the outcomes of policy implementation (Rushton et al 2000, McCreadie 2002, Brown & Stein 1998, 2000). The quality of the data/information was patchy and partial, reflecting the newness of the work and the inconsistency of policy implementation across the UK, especially in relation to the recording and collation of information. Consequently, the data needs to be treated with caution and not read as an indicator of Adult Abuse incidence/prevalence but more a reflection of the agencies’ competence in dealing with Adult Protection. Of course, these studies, like many other studies of reported abuse, only tell us what we know about reported abuse and there is widespread acknowledgement that there is a huge reservoir of unreported and undetected abuse about which very little is known.

Differences across disciplines are noted. Using Matland’s (1995) ambiguity-conflict model of policy implementation McCreadie et al (2008) characterised ‘No Secrets’ as a high ambiguity policy, as demonstrated by the discordant views expressed by practitioners about what constitutes a ‘vulnerable adult’. Differences were evident in whether or not the term should exclude individuals who were not recipients of services paid for by the statutory sector. They also existed in relation to

what constituted abuse and whose judgement on this should prevail. These differences were reported to affect whether abuse was reported and how procedures were implemented.

Dogged by definitional confusion, the differences in views were evident and distinct in locating the locus of vulnerability in either the person or their situation/circumstance. The potential for such differing interpretations of the concept of a vulnerable adult were signalled by Brown et al (1999) who pointed out the central confusion about what constitutes vulnerability evident in many adult protection policies.

McCreadie et al (2008) also characterised the adult protection policy as low conflict as studies of early implementation demonstrated high levels of cross-agency commitment. In the UK Northern Ireland has the only fully integrated health and social services structure and Douglas and Halliday (2000) used focus groups to explore the views of a number of professional disciplines to review the implementation of adult protection and procedures and reported that despite a view that multi-professional ownership was essential, in reality this was variable and social work felt the burden of leadership at this embryonic stage of practice development. In the UK, publication of 'No Secrets' issued under Section 7 of the Local Authority Social Services Act (1970) signalled Government's commitment to protect vulnerable adults from abuse. A survey by Mathew et al (2002) and document analysis undertaken by Sumner (2004) found widespread compliance in the development and implementation of policies and arrangements for governance, including high levels of partner engagement and multi-agency management at a strategic rather than operational level reflecting the Northern Ireland experience. Later studies (Penhale et al 2007) on partnership working have highlighted a lack of clarity over roles and responsibilities as a barrier to effective joint working.

These studies also draw attention to confusion over what constitutes vulnerability, lack of clarity over role definitions, and an absence of shared understanding of what constitutes abuse and a vulnerable adult.

2.5.3. Joint Working and Professional Roles in Safeguarding Vulnerable Adults

Challenges in joint working in adult protection have been reported on in the UK and common themes centre on differences in perspectives and commitment to action across the disciplines. Building on existing research Pinkney et al (2008) explored the views of social workers following the introduction of 'No Secrets' whilst others perceive them to have the lead role this was not explicitly defined in the guidance. In this study social workers commented positively upon the value of sharing information, decision making and responsibility through inter-agency working, but simultaneously stated that progress had been slow. Barriers to effective joint working once again

included commitment which was perceived by some to relate to the lack of legal mandate. The introduction of the Care Act (2014) creates a duty to co-operate, although the jurisdiction of this and the mechanisms for enforcement are currently unclear. Further work is required to determine an effect on joint working from the introduction of this mandate.

A series of articles in the *Journal of Elder Abuse* have chronicled a number of perspectives in the United States including adult protective services (Mixon 1995), case manager (Sonntag 1995) legal (Heisler & Quinn 1995), medical (Wetle & Fulmer 1995), mental health (Marin et al 1995), ombudsman (Skelley-Walley 1995) and religious (Johnson 1995) views using commentary on three common case studies of adult abuse. These provide a narrative report of the differing perspectives and ethical dilemmas that have come to bear on these perspectives. However, the articles offer little by way of analysis of the different value or outcomes for the adult at risk from these differing views.

Similar narrative reports of role have been published in the UK (Ramsay 2009, Garner 2004, Hartley-Jones 2011, Gorcynska & Thompson 2007) and others have charted the development of their specialisations within their particular agency (Draper, Roots & Carter 2009, White & Lawry, 2009).

Evaluative studies of roles in Adult Protection are fewer in number. Davies et al (2006) sought to understand police perception of their role in adult protection. Although the sample size was small the data gathered was rich in description, offering insights into the challenges about generic and specialist roles, training needs, knowledge gaps in and differences in legal context in comparison to child protection work. A case study by Cambridge & Parkes (2005) provided insights into the risks and benefits of specialisation versus the development of generic competence in adult protection work.

Other commentators either exhort the need for agency involvement e.g. Parry (2013), citing examples of good practice amongst some housing providers whose role in safeguarding is seen to be less clear and not incentivised. Poor engagement with the agenda by health professionals has received much comment (Morgan 2009; Rose, Peabody & Strategias 1991; Reed et al 1998 & 2002). Morgan (2009) cites reasons for this, including ignorance, failure and fear of recognising abuse by nursing staff, poor nursing care and a lack of strong leadership. In her commentary on the report findings she draws attention to the perception that nursing practice has moved too far towards a biomedical model of care with a focus on task rather than whole person care which was traditionally the essence of nursing practice. She signals the need for continuous improvement through the incorporation of safeguarding into the governance of health care provision. This supports the views

expressed by Brown and Stein (1998) who stressed that procedures do not translate to effective protection without staff having a clear understanding of their roles and responsibilities which requires investment in training. One example of such a strategy has been reported on by Aylett (2009) who stressed that in order to engage all relevant parties, the content of the training delivery must relate to all agencies despite differing roles and responsibilities. A key vehicle for multi-agency organisational learning is the conduct and reporting of Serious Case Reviews (SCRs) because as Cambridge & Parkes (2004) have asserted, if the inquiries are robust in their design they can generate reliable and transferrable findings. Indeed Aylett (2008) strongly recommends the findings of SCRs are included in multi-agency training to disseminate findings, arguing that the return on investment into these inquiries is eroded when lessons are not learned, meaning that service failures are waiting to be repeated. She comments on the puzzling absence of national collation, systemic review or strategy for dissemination in contrast to child protection inquiries.

The research and discourse on roles, responsibilities and joint working in adult protection once again highlights differences of view, understanding and application of safeguarding practice and practitioner decision making.

2.5.4. Serious Case Reviews – The Analysis Thus Far

There is a growing literature on adult Serious Case Reviews which are becoming the subject of a developing interest and theoretical literature in adults safeguarding practice. For example, Clay et al (2014) have recently attempted to summarise and categorise the recommendations of 74 SCRs representing a decade of reviews. Earlier studies focused on the structure and function of SCRs. Stanley and Manthorpe (2004) considered in detail the factors that influence the commencement, course and outcome of inquiries in services for children and adults in relation to social care, health care and mental health services.

Brown (2009) has charted the process and function of Serious Case Review from her experience as an independent chair in multiple Local Authorities. She highlights the inevitable tension between facilitating accountability whilst minimising the risk of defensiveness to enable both organisational learning and emotional catharsis, stating that:-

“The primary purpose of SCR is to focus on those few cases that test adult protection work and the system beyond its capabilities, causing very serious concerns in the relevant professional networks and in the minds of vulnerable people and their relatives. As a process it needs to manage the tension between finding fault and finding a way forward.....” (Brown 2009, p.50)

In her analysis of the eight reported reviews Brown identified some shared features including the chronic and cumulative nature of risk, and the lack of consensus in determining individual versus corporate culpability in the causation of harm. She referred to her earlier comments (Brown 2003) on the need for categories of abuse which focus as much on relationship and context as well as the type of abuse. In so doing one can postulate that more nuanced definitions might support practitioners to recognise and respond to indicators of abuse and vulnerability when they understand how vulnerability arises from universal circumstances rather than individual features of illness or disability. This might support the application of a social model of vulnerability rather than an individual model that the current individual pathological definitions under 'No Secrets' permit. The purpose and process of SCR's in adult safeguarding focusses attention upon the few cases that have tested the system beyond its capabilities and undermined the confidence of both professionals and the public in its fitness for purpose. It is puzzling that there appears to be no coherent strategy for disseminating the findings of inquiries and no national collation of data emerging from inquiries relating to vulnerable adults. Flynn (2010) comments on the need to create such a mandate and exhorts this be considered in the consultation of the review of 'No Secrets' which the Government commenced in 2009. However, it took until March 2017 for the Department of Health to commission work on this which is currently being undertaken by SCIE and RiPFA (2017).

Manthorpe & Martineau (2011) undertook an analysis of a sample of reports examining their utility for learning. They identified inconsistencies in format and reporting as a weakness in this respect. The authors studied twenty two Serious Case Review reports scrutinising them for the rationale for the review, detail of victims and alleged abusers, form of abuse, threshold for the Serious Case Review, timescale, process and methodology, follow-up, etc. They conclude that:-

"From examining a small sample of SCR reports, the evidence from this study is that although the purpose of such reviews is well understood, the reports themselves often lack transparency about their purpose and activities. It may be that a greater degree of standardisation of approach would serve both to raise the quality and usefulness of these reports and the degree to which they are amenable to central collation". (Manthorpe & Martineau 2011, p.239)

More recent studies have examined particular themes from SCRs. Manthorpe & Martineau (2013) examined SCR reports relating specifically to people with learning disability, to draw out material relevant to social work policy and practice.

“Three themes are presented: staff relationships; family and carers; and biography and chronology to draw out material relevant to social work policy and practice. At a time when the English Government has announced plans for SCRs for adults to move to a statutory basis, this paper draws attention to their potential as learning materials, but also the risks of seeing them as presenting a full picture of practice. The case for local flexibility is argued.”
(Manthorpe & Martineau 2013, p.1)

Parry (2013, 2014) highlights the lessons for housing agencies and comments on the apparent absence of action in disseminating such learning in this sector. Braye et al (2015 a & b) explored SCR’s relating to persons who self-neglect seeking to identify indicators for good practice to promote learning for practitioners who may be similarly faced with such complex and challenging case circumstance.

In contrast, thematic analyses of Serious Case Reviews in children’s services are well established and rooted in law and policy. Serious Case Reviews are local enquiries into a child’s death or serious injury where abuse or neglect are known or suspected and additionally, in cases of serious injury, there are concerns about inter-agency working. These reviews are influential and acknowledged to be important sources of learning. Independent biennial national analysis of Serious Case Reviews are commissioned by the Government as required in the Government’s guidance Working Together (HM Government, 2010:255), seeking to draw out key findings from reviews and identify lessons for national policy and practice.

This overly bureaucratic response to learning from inquiries has recently been recognised within Children’s Protective Services, and led to the suggestion of new ways of learning. Classical organisation theories (Weber 1947) deal with the formal organisation and concepts to increase management efficiency. One of the features of Weber’s bureaucratic theory of organisations is predictability and stability meaning that the organisation should operate according to a system of procedures consisting of formal rules and regulations. Many of the categories of recommendations in adult safeguarding SCRs exemplify this bureaucratic principle.

Neoclassical theorists recognised the importance of individual or group behaviour and emphasised human relations. Based on the Hawthorne experiments, the neoclassical approach emphasised social or human relationships among the operators, researchers and supervisors (Roethlisberger and Dickson 1943). It was argued that these considerations were more consequential in determining productivity than mere changes in working conditions. The classical approach stressed the formal organisation, it was mechanistic and ignored major aspects of human nature. In contrast, the

neoclassical approach introduced an informal organisation structure and emphasised the following principles:-

- The individual is not a mechanical tool but a distinct social being, with aspirations beyond mere fulfilment of the task and should be recognised as interacting with task factors.
- The work group is social and informal organisations operate within a formal organisation.
- Participative management or decision making permits workers to participate in the decision making process.

These have led to the development of modern theories which tend to be based on the concept that the organisation is a system which has to adapt to changes in its environment. Some of the notable characteristics of the modern approaches to the organisation are: a systems viewpoint, a dynamic process of interaction, multi-levelled and multi-dimensional, multi-motivated, probabilistic, multi-disciplinary, descriptive, multi-variable and adaptive.

The systems approach is an example of a modern organisational theory. It views organisation as a system composed of interconnected - and thus mutually dependent - sub-systems. These sub-systems can have their own sub-sub-systems. Thus, the organisation consists of basic components which are linked to one another (Bakke 1959). There are five basic, interdependent parts of the organising system, namely:-

- the individual;
- the formal and informal organisation;
- patterns of behaviour emerging from role demands of the organisation;
- role comprehension of the individual, and
- the physical environment in which individuals work.

The different components of an organisation are required to operate in an organised and correlated manner. The interaction between them is contingent upon the linking processes, which consist of communication, balance and decision making.

In 2010 Dr Eileen Munro was commissioned by the Government to undertake a review of child protection services. This review included an examination of the conduct of children's Serious Case Reviews. In her final report (2011) Munro states that her proposals for reform:-

“...involves moving from a system that has become over-bureaucratized and focused on compliance to one that values and develops professional expertise and is focused on the safety and welfare of children and young people”. (Munro 2011, p.6)

Munro used the ‘systems’ approach to understanding how the current conditions of children’s services had occurred. Munro’s use of systems theory to understand the difficulties in child protection practice was extended to recommend that Serious Case Reviews should also be conducted using a systems methodology. This approach has been developed with the Social Care Institute for Excellence (2010) working with Professor Munro called the ‘learning together’ systems approach, now commonly known as ‘the SCIE model’.

The SCIE model seeks to produce explanations about why professionals had acted in the way they did. The approach identifies conditions supporting good safeguarding practice, as well as those influencing professional practice in negative ways. SCIE assert that having a multi-agency ‘review team’ working together from the beginning created a common endeavor, greater challenge and confidence to find new ways of working and effective solutions. In contrast to the former approach of Independent Management Reviews (IMR) conducted by managers remote from the direct casework this approach actively involves frontline workers and team managers throughout the process as a vital aspect of the model.

This new approach to learning from Serious Case Reviews is endorsed by Sidebottom et al (2010) whose research into learning the lessons nationally from SCRs highlighted the value of a more participative approach. They argue that learning can be embedded as part of the process of conducting an SCR as well as an outcome of the process. They recommend involving frontline practitioners at an early stage in the process so that they might understand the purpose of the review with an emphasis on critical reflection at both an individual and organisational level, and training for IMR authors in facilitating learning as part of the process. They also comment that the quality of reporting from this national dataset of overview reports could be strengthened by incorporating it within a framework for national analysis by a single research team enabling not only descriptive data to be available but also time trend analysis as well as comparative and thematic analyses.

Woods (2003) recommends that this methodology should be adopted for undertaking future Serious Case Reviews. Having worked previously together with SCIE to produce guidance on developing a multi-agency systems approach for case reviews (SCIE Guide 24 2009) she highlights that “A key assumption in a systems approach is that human behaviour is fundamentally understandable: even actions or decisions that later turned out to be mistaken or to lead to unwanted outcomes, at the time seemed sensible. It becomes important, therefore, to try and avoid hindsight in reviewing professional practice. Instead, a key task is to reconstruct how people were making sense of an evolving situation”. (SCIE 2009, p.9)

In reading SCR reports it became evident that common themes frequently emerged, such as a lack of co-ordination and collaboration in the sharing of information that might otherwise have led to detection and/or response to signs of abuse. These struggles with regard to threshold decision making are echoed in some of the Serious Case Review reports, where the need to strengthen practitioner’s recognition and response to abuse and vulnerability has been commented upon.

2.5.5. Professional Judgement and Decision Making in Adult Safeguarding

Serious Case Reviews place the judgements and decisions of professionals involved in the case under considerable scrutiny. Our understanding of what influences decision making in adult safeguarding is one in which we are conceptually strong (I will attend to this in my discussion of theoretical concepts informing the research study - section 2.6.3) yet empirically weak.

In their overview report Cuzzi et al (1993) highlight some of the vast literature on decision making theory and research. They note that this largely relates to disciplines outside of social work but espouse that there is conceptual relevance to decision making in social work. They cite a few studies specifically examining decision making in a social work context and topics encompass client approaches to decision making for adults at risk or who have some cognitive decline (Kapp 1988, Nicholson and Matross 1989) and critical reasoning in clinical social work (Gambrill 1990).

A more recent systematic narrative overview specific to decision making in elder abuse was reported on by Killick and Taylor (2009). They note that the complexity of health and social care decision making in situations of uncertainty is gaining research recognition. They identified three broad categories of research activity on what influences decision making in elder abuse as follows: case characteristics, professional factors and agency factors. The impact of case characteristics on practitioner recognition and response to abuse of cognitively impaired persons was noted by Baladerian (1997) who signalled the need for the development of specialist training in disability and skills development for Adult Protective Services workers. One study of particular interest was

Fulmer et al (2003) as it sought to identify the case characteristics attended to by assessing professionals using a grounded theory approach. Limitations of this study were its focus on identification of neglect as a specific form of neglect and the singular context of the sample – emergency hospital setting. Professional struggles with definitions of abuse are discussed by Lithwick et al (1999) where contextual factors also influenced practitioner thinking and highlights the challenge of fitting a multi-dimensional event under a single rubric of elder abuse. If such struggles exist for practitioners in relation to defining abuse then it might similarly be true in relation to determining their vulnerability to such abuse. This study seeks to explore the typology of factors used by human services professionals in their construction of vulnerability for adults at risk of abuse.

Clearly, the attitudes and knowledge of staff have a significant role in determining their approach to/identification of clients' abuse histories and, in particular, the experience of adult abuse. Previous studies (Hargreaves and Hughes 1996) reported variation in the workers approach to abuse in terms of identification, assessment and intervention. Some barriers to identification include fear of a heavy-handed approach, and over reaction causing more harm (Rowlings 1999). Other authors have warned that some practitioners may ignore or modify policy based on local agenda and the use of their own autonomy and discretion (Wells 1997). Preston-Shoot & Wigley's (2002) study was the first to specifically examine social workers responses to multi-agency procedures on Older Age abuse as was thereby limited to workers relating to that adult client category. However, they used a range of research methods in the study to capture both qualitative and quantitative data, including staff questionnaire, interviews and analysis case notes. Despite this the rigour of the study was undermined by the small sample size. The results did, nonetheless, demonstrate some interesting trends including the following:-

- a) most practitioners felt that there was probably serious underreporting;
- b) practitioners expressed much confusion about the extent to which they could use discretion in the application of procedures.

Preston-Shoot & Wigley suggest that the results indicate a need for clarity within policy in respect of what is mandatory and what is permissive. Presumably, in the meantime, practitioners will continue to exercise autonomy and the current variations in report levels will change or remain the same, depending on the knowledge and attitudes of staff.

Taylor & Dodd (2003) were similarly disconcerted by the apparent variation of reporting between workers from different adult service user groups and, in particular, the remarkably small proportion of reports in relation to people with mental health problems. Their research was limited to the staff

within one Local Authority but other researchers (Brown and Keating 1998) have also commented upon the apparent unwillingness of mental health services to address issues of adult abuse within their service population. This would suggest that this phenomenon is not particular to that single Local Authority. In their critical analysis of the policy context of adult protection practice in mental health services Galpin & Parker (2007) identify key issues in the under reporting of safeguarding concerns to include structural (marginalisation of patients), ideological (dominance of medical model linking abuse to individual pathology and affording invisibility to the perpetrators), organisational (managerial policies which promote welfare responses).

2.5.6. The Context of Practitioner Judgements and Decision Making

Studies on agency factors are few in number but those in existence identify resources and policy amongst the conscious or unconscious influences on decision making in adult protection services (Clark-Daniels and Daniels 1995).

Killick & Taylor (2009) comment that studies on professional factors largely related to health and social care practitioners with only one study on police decision making identified in their sample. The studies they identified demonstrated variation in the ways professional groups addressed abuse and in particular that training and knowledge influence the level of abuse identification. Two studies in particular are of interest as they demonstrate parallels to the proposed methodology of this study. The first is Bergeron (1999) who used focus groups and interviews of Adult Protective Services staff to develop a typology of the factors influencing their decision making. The other is Wilson (2002) as the sampling was purposive or even convenience driven and the variance in respondent reasoning and decisions is used to argue for clearer legal frameworks addressing issues of vulnerability, protection and self-determination.

Similar typological approaches have been adopted in more recent UK studies. Gilhooly et al (2013) paid particular attention to detection of cues for financial abuse but in professional groups who do not work directly in safeguarding, as well as social care professionals (although this was reported separately Davies et al (2011)). Using the conceptual model of professional bystander intervention they explored the cues used in detection of financial abuse. Their thematic analysis of indepth interview transcripts revealed a four type cue categorisation. Killick & Taylor (2011) adopted a factorial survey design to explore the effect of case, practitioner and agency factors on recognition and response to abuse in social care professionals. The factors are prescribed in the construction of the vignettes and whilst measures of effect can be explored, this methodology fails to capture a rich description of factors utilised by the practitioner in abuse identification that are not covered in these

prescriptive lists. Their study found that contextual case factors (age, gender, health condition) did not significantly influence recognition or referring of abuse. Instead they found that recognition of abuse was most influenced by type of abuse, frequency and victim wishes. Davies et al (2011) describe a project design that involves three phases. The first two phases involve in-depth interviews to elicit decision cues and then a factorial survey to test hypotheses about factors that account for the greatest variance in judgement. In hindsight, a similar methodology could have been adopted in relation to cues of vulnerability but the scope of this study was influenced by subject availability and a desire to focus predominantly on gaining a rich description of practitioner cues and triangulating these through a number of activities to support greater validity and reliability.

In the literature search only one study could be identified that specifically explored the concept of vulnerability amongst adult social care workers. This was a PhD thesis submitted by Forbes-Parley (2007) who explored the views of care staff working with people with learning disabilities on the concepts of abuse and vulnerability having identified a lack of commonality in interpretation of the terms. Forbes-Parley presents her findings using case studies derived from semi-structured interview transcripts. Themes were elicited in relation to staffs' understanding of vulnerability, noting the difficulty with definition and the predilection of many to locate vulnerability in relation to individual characteristics, such as communication difficulties. Despite the difficulty in defining vulnerability to abuse it was interesting that staff reported that others found it easy to recognise and use to their advantage.

2.5.7. Studies on Vulnerability in Adult Safeguarding Practice

The use of the term vulnerability is pivotal to the decisions about risk and protection in health, social care and criminal justice. However, the use of the term and its interpretation in adult safeguarding practice has received little attention.

There is a paucity of studies in the field of health and social care on vulnerability as a concept. Peterson and Wilkinson (2008) brought together a selection of papers on risk and vulnerability but the emphasis of these related to the application of these concepts in health care rather than social care. This paucity of studies was remarked upon by Little et al (2000) with the notable exception of Appleton (1994) who explored health visitors' perceptions of vulnerability in relation to child protection and observed a lack of consensus and absence of clear definition. Dictionary definitions tend to focus on the condition of the individual or entity whereas, in the field of health care, vulnerability is seen as a dynamic concept which contributes to and arises from a combination of factors including personal, familial, societal and political factors (Shepard and Mahon, 2002). This

view is supported by Appleton (1994) who attributes the causation of vulnerability to a combination of medical, psychological, social and cultural factors. These accounts from health care suggest that a more meaningful construction of the concept of vulnerability is one which is considered holistically and contextually. Others have argued that vulnerability arises from a person's situation. Spiers (2000) sought to understand this relationship between the individual and the circumstance in terms of etic and emic approaches, the former being the susceptibility to harm which may be externally evaluated and quantified in some way, whereas the latter relates to the state for being threatened requiring a more qualitative evaluation judged by the internal appreciation of the person and their situation. This approach seeks a more person-centred evaluation supporting the distinction between two persons with similar characteristics differentially feeling vulnerable.

A number of authors have commented critically on the ambiguity of the term and its application in safeguarding practice (Brown, H et al (1999), McCreadie et al (2008), Collins (2010)). Attempts have been made in both the US and the UK to unravel the conceptualisation of the term in policy and practice. Purdy (2004) notes that the concept is both complex and elusive. In her concept analysis of the terms current usage and application to nursing practice she identifies some of the characteristics and attributes. These frequently included susceptibility of an individual or population to adverse health outcomes, an increased chance of harm, a state of self or biological or social disadvantage. Purdy concludes that the essence of vulnerability is 'openness' and cautions that the concept of vulnerability need not be construed negatively.

A similar challenge has been observed by Johnson (2012) in relation to the term abuse. Having used the prescriptions from policy to construct case studies it soon emerged that practitioners themselves did not necessarily construct 'abuse' and 'adult protection' concerns as coterminous categories. Instead examples illustrated a more partial, less linear relationship between these categories in practice than in the policy constructions, again serving to confirm previous studies that have reported the struggles of professionals with the terminology of adult safeguarding policy. Johnson's report sets out a post hoc commentary rather than a report of research findings as the original data set did not set out to review the relationship between the two practice constructions. The commentary arose out of observations how within the data set, originally targeted at exploring inter-agency collaboration, the occasions were rare where it indicated whether the professional had classified concerns as 'abuse' or not irrespective of whether or not they had classified them as adult protection concerns. The evidence contradicts the 'policy' presumption of a linear relationship in that adult protection would follow from 'abuse' identification. In the examination of cases identified by practitioners as requiring an adult protection response Johnson was struck by the absence of the

terminology 'abuse' in relation to the concerns evident through case documentation or the contents of case related practitioner interviews. The suggestion is that whether a concern was formally labelled abuse was not a key factor in progressing intervention decisions. The concept of vulnerability is bound to that of abuse in adult protection policy so this commentary is of interest to this study in seeking to explore how the construct of vulnerability influences decision making. Johnson concludes that whilst policy prescribes that the concept/term abuse is a *determinant* of safeguarding responses, in practice it was not consistently functioning as a determinant. Instead it is used as a *descriptor*, and the decision that the concerns warranted a safeguarding response were independent of 'abuse' identification. It was not a particularly effective descriptor either, as some professionals were reluctant to use the term to describe the concerns they had identified as necessitating adult protection services. It is possible that a similar phenomenon could be operating in relation to the concept and term 'vulnerability'. Johnson recommends further research as 'Adult Protection' is a constructed discourse and the interpretative actions of practitioners charged with responsibility for State intervention ought to be open to evaluation. This study seeks to gain more understanding of practitioner interpretations of the discourse.

There have been some attempts to elucidate factors which inform the concept of vulnerability and construct models of understanding (Gilhooly et al 2013). Gilhooly's study was limited in terms of population (older adults) and form of exploitation (financial). Furthermore, it is aimed at clinicians and to support the development of their model of social vulnerability they draw on an earlier clinical model proposed by Greenspan et al (2001) in relation to younger adults with developmental disorders. Their model has a positive slant and talks in terms of personal competence as an antithesis to vulnerability. It is an interactive model suggesting that personal and environmental factors combine to either promote or protect against vulnerable outcomes. Central to the model are the concepts of credulity and gullibility. Credulity pertains to a state of mind or belief (i.e. cognition) whereas gullibility involves some tangible outcome. Pinsker et al (2010) explain that in Greenspan's model;-

"... personal competence factors ... cover four broad domains: everyday intelligence, communication, physical competence, and motivation/personality. The domain of everyday intelligence encompasses practical intelligence (i.e. understanding of physical, mechanical, or technical objects and processes in everyday settings) and social intelligence (i.e. understanding of people, relationships, and social processes). Credulity is conceptualised as a deficit in social intelligence that can ultimately lead to a gullible act. In potentially exploitive situations, Greenspan et al. (2001) regard social (cf. practical) intelligence as having overriding

importance in detecting and avoiding exploitive intentions in other people". (Pinsker et al 2010, p.742)

They use this model as a starting point to develop a proposed framework for conceptualising social vulnerability in older adults, adding some factors and reconceptualising others.

One study (Fulmer et al, 2005) has attempted to explore the significance of different constructs in a risk and vulnerability model adapted by Frost and Willette 1994 based on Rose & Killien 1983. In an attempt to identify which factors were of greatest significance, elders with a confirmed diagnosis of neglect and their care givers recruited through four emergency departments in a US State, were interviewed separately. These were compared against adults who had not been so diagnosed. Again, the model is an interactive one suggesting that features of vulnerability combine in some sort of additive way. In the vulnerability construct they identified elder cognitive status, functional status, depression, social support, childhood trauma and personality as significant. In the risk construct care giver functional status, childhood trauma and personality were seen to be significant. A rudimentary typology is emerging but as the study is limited to one form of abuse (neglect) it can't be assumed that the same factors are in operation across all abuse manifestations.

The location of vulnerability in the characteristics of the individual has led some to proffer alternative models of explanation. Wishart (2003) argues that an explanation of vulnerability that focuses on characteristics of the individual risks victim blaming, can encourage self-blame, and contribute to a negative image of people with disability. This view was echoed by some service users in the review of 'No Secrets' (2009) who perceived the term "vulnerable adult" as patronising. Wishart further argues that the individual model fails to take account of the external or contextual factors that have been documented to have an influence on vulnerability to abuse. Drawing upon the social model of disability he promotes the concept of a social model of vulnerability so that the shift of emphasis in the causation of vulnerability is moved away from the person and cited in their circumstances. It asks the questions about the individual in a different way – *'What impairment(s) do they have?'* and *"What are the social responses to these impairments that allow this person to be vulnerable to sexual abuse?'*

Others (Rogers 1997) who have reviewed the literature support the view that vulnerability is best understood as a continuum, a dynamic concept which incorporates both individual and environmental components in the construct of the concept.

Whilst much has been written about models of explanation and the good and bad within these, few studies have been conducted that seek to elicit the views of staff on the concept application. Two of

particular note and interest in relation to this proposed study are Appleton (1994) and Parley (2010). Both studies explore staff concept of vulnerability through interviews. Appleton's study related to Health Visitors and focused on child protection, whilst Parley studied care staff working with adults with learning disability and so that study population is more aligned to this study. However, both report on the difficulty staff had with definition and the ambiguity of the term/concept and both report staff constructing vulnerability as a dynamic concept on a continuum, sometimes conflating vulnerability with risk, and involving a complex mix of factors. Parley (2010) notes that whilst practitioners struggled to define vulnerability they simultaneously asserted that it was visible to others who might seek to exploit. However, in the thematic analysis of the interview transcripts Parley (2010) discerned some characteristics that staff associated with vulnerability to abuse in adults with learning disabilities. These included an inability to understand, inability to communicate, inability to protect oneself, neediness and reliance on others, lack of skill and the status of being cared for. Parley (2010) reports that a number of informants viewed vulnerability and at risk as part of a continuum with vulnerability being at the lesser end of the scale and 'at risk' representing what they perceived as the worst forms of abuse. In this respect they were able to construct that a person may feel vulnerable but be at no risk or, alternatively, not feel vulnerable but become at risk when their plans for safety fail.

There are a few studies which look at how practitioners recognise and respond to signs of abuse, but only one pertaining to perceptions of vulnerability. This was not based on direct observation. Early researchers and commentators have suggested that the definitions of a vulnerable adult used in policy are imprecise. More recently themes emerging from Serious Case Reviews of adult abuse suggest a need to strengthen practitioner recognition and response to abuse and vulnerability.

My study is interested in what cues practitioners employ when assessing vulnerability and how they utilise these in making a judgement about the person's vulnerability, when assessing the risk of abuse/exploitation to that adult.

Research in adult protection is predominantly located in qualitative measures often engaging the views of practitioners through interviews, focus groups and case study reports. Judgements of practitioners are evaluated using questionnaires, survey, vignettes, case study, focus groups and interviews. Few, if any, involve direct observation and in situ practitioner commentary on their reasoning and decision making of recently observed practice. The proposed study will introduce this new qualitative measure and seek to triangulate it with data from research activities more traditional in this field.

In their study of police response to Anti-Social Behaviour (ASB) Innes & Innes (2013) identified three types of vulnerability – personal, situational and incidental. They identified that in order to improve police performance and victim outcomes in relation to ASB required an interactive assessment of all three elements in order to prioritise police responses to the persons most likely to experience detriment to their well-being from these events. Their concept of vulnerability recognises that some people and communities are more liable to being negatively impacted, often because they lack social, economic and psychological resilience. They found that when different combinations of vulnerability are profiled, we find differences in their prevalence and social distribution. For example, repeat and vulnerable victims are disproportionately drawn from poor socio-economic circumstances, whereas repeat, but not vulnerable, victims are not. The report suggests that the three types of vulnerability are not mutually exclusive and indeed overlap which they state helps us to develop a better understanding of why certain incidents, occurring in particular settings, against certain victims, exert profound negative impact on health and wellbeing of the victims. Innes advocates attention to all three types of vulnerability to support differentiated decision making and targeted police action.

Blended theoretical approaches are also popular with some writers in relation to theoretical approaches to understanding phenomena of such complexity as elder self-neglect (Heo 2004). With this in mind I will proceed to outline the primary theoretical architecture of this study.

2.6. Theoretical Frameworks Relevant to the Study

The theoretical concepts that I have drawn upon related to the concept of vulnerability are:-

- Risk assessment models of understanding.
- Judgement and decision making as these pertain to the task of risk assessment and management for which the construction and evaluation of vulnerability forms a part.
- Organisational context – the possible influences on practitioner judgement and decision making relating to the context in which their work is undertaken, roles, responsibilities, policy context and organisational dynamics of policy implementation.
- Social constructionism and the social model of disability, abuse and vulnerability.

The following section details some of the major theoretical concepts and authors which have influenced or supported my thinking about this area of exploration.

2.6.1. Theories about Approaches to Risk Assessment and Management

Approaches to risk assessment and risk management are central to this study. The dilemma of balancing and reconciling the right to protection and the right to take risk is a central feature of decision making in safeguarding practice. Whilst law and policy assist in identifying individual rights (privacy, dignity, independence and choice) and public obligations they are often silent on how to prioritise these. Local Authorities deploy eligibility criteria which set out hierarchies of need with those at the greatest risk seemingly having the greatest claim to services (Parton 1996). Professionals have to exercise judgement and in so doing may be guided by their own personal values and beliefs whilst simultaneously reflecting the statutory obligations and objectives of their employing agencies. Lawson (1996) has argued that principles and values play a crucial role in risk decision making processes. Principles, including equal opportunity, user focus, encouraging independence, self-determination and confidentiality that have to be operated alongside statutory obligations. As such, risk assessments need to be comprehensive and equitable to ensure that any intervention or intrusion by a public body is proportionate to the risk.

Social work in particular has reason to concern itself with evidence based practice which demands neutrality and objectivity in evaluation as it is increasingly called to be accountable publicly. The media has taken increasing interest in failures in adult social care and safeguarding adults practice (Winterbourne View, BBC (2012); Mid Staffordshire NHS Trust, BBC (2013); Steven Hoskins, BBC (2007)) and there is a growing body of Serious Case Reviews, many more of which have come into the public domain since the Care Act (2014), introduced an obligation upon Safeguarding Adults Boards to publish the findings and recommendations of SCRs. When things go wrong, courts and official inquiries are increasingly expected to examine decision making processes in retrospect (Carson 1996). Tanner (1998) suggests that fear of being held responsible for an adverse outcome acts as a significant disincentive to risk taking.

Kemshall (2002) argues that public policy now focuses on the forensic rather than the predictive use of risk, allocating blame when investigating adverse events. At such times risk management is seen as little more than social work protectionism. Parton (1998) claims that making defensible decisions has become more important than making the right decisions.

Risk is a complex concept (Ryan 1996; Stevenson 1999; Warner 1992) and the literature on it encompasses fields such economics and commercial insurance, business studies, engineering, public health and medicine.

The language and concepts of risk assessment are central to understanding how practitioners evaluate and respond to information that suggests that an adult is at risk of abuse or exploitation. However, as Parsloe (1999) has commented there is no agreed definition of risk and in health and social care practice the discourse on risk evidences several meanings... “about whether risk means only the possibility of harmful outcomes, whether it involves a balancing of possible good and possible harm and whether it includes the idea of positive events”. Brearley’s (1982) definition has been influential in social work. I will start with Brearley’s work as it highlights the problem of language and definition in the evolving concept of risk, before elucidating some of the most recent ‘thinking’ in this field.

2.6.1.a. The Problem of Definition

Brearley (1982) notes that dictionary definitions of risk unhelpfully define hazard as risk. The difficulties of definition highlight the problems for understanding risk and vulnerability as distinct concepts and terms. Brearley (1982) identifies that vulnerability is a risk related concept introduced by the BASW Working Group (BASW 1977) and assigns its similarity in usage to the terms hazard and danger in terms of being a determinant of probabilities. However, he highlights that in common usage there is a slight distinction as vulnerability refers to someone who is susceptible to loss: hence loss is a possibility, whereas ‘being in danger’ refers to the likelihood of danger; hence loss is a probability. Brearley (1982) acknowledges that this distinction is, in fact, quite precarious as it seems to rest on a matter of degree, the degree of likelihood which is a continuum whose range might include descriptors such as impossible, remote, likely, very likely, probable, certain.

The actuarial model draws upon the experience of other fields where there has been a development of sophisticated measures of risk, for example in the insurance industry. In this case hazard is defined as ‘that condition which introduces or increases the probability of loss from a peril’. The parallels between the definition of hazard and vulnerability are apparent. Is it any wonder then that when assessing the risk of abuse the person’s vulnerability is perceived as a hazard? Then we can begin to see that using these two words interchangeably practitioners locate the hazard (vulnerability) variably.

Brearley (1982) remarks that attitudes and beliefs about risk are significant in the way we think about it. This may also be true of the effect of our attitudes and beliefs about vulnerability. The social inequalities model would suggest that those that are disadvantaged, mistreated and discriminated against in wider society will be particularly at risk. Whilst this model has been largely used in discussion of race and gender it has something to offer in relation to understanding the effect of our responses to all difference which creates inequality. Add to this prejudice and

stigmatisation which depersonalises and it is even easier to see how the disenfranchised might be further overlooked in recognising and responding to their vulnerability. Kahneman and Tversky (1973) tried to identify the strategies employed by professionals to make risky decision making more manageable and concluded that this was affected by the use of pre-tried psychological routines, or heuristics. They comment that these short cuts in thought can bring about biases or errors in judgement. Whilst they identified a number of biases those considered most relevant to social work are the representativeness, availability and the confirmation bias which I will discuss further later in this chapter.

Issues of accountability and responsibility in relation to risk are discussed by Brearley (1982) in terms of moral obligation and the influence of values in judging safety, legal liability and organisational accountability. He acknowledges the link between risk and responsibility so often framed in the social policy context in which social work operates. The operation of decision making in these contexts is often bereft of explicit guidance and consequently permissive of individual discretion. The influence of values has a critical role to play in determining acceptable risk and normative responses.

2.6.1.b. The Actuarial Model of Risk Assessment

Brearley (1982) identifies three definitions which have their separate existence whilst remaining closely related. These are identified as follows:-

- *'Risk' refers to the relative variation in possible loss outcomes.*
- *'Probability' refers to the relative likelihood of outcomes.*
- *'Uncertainty' refers to the subjective responses of the person who is exposed to risk.*

From the field of technological and scientific risk the primary concern is to establish the likelihood of that loss and the factors that bring it about or influence that likelihood. He selects a further two definitions to bring to the discussion of a model that is relevant for social work. These are:-

- *'Hazard' refers to any existing factor – an action, event, lack, deficiency or entity – which introduces the possibility or increases the probability of an undesirable outcome.*
- *'Danger' refers to a feared outcome of the hazard which is either expected to be a loss outcome or which is associated with loss in the expectation of the observer.*

The concept of vulnerable groups as persons who are in possession of less power is resonant with the discourse on disability politics and the operation of oppression by the dominant groups. Brearley (1982) draws a distinction between vulnerable groups and endangered individuals, vulnerability and danger in order to signal the possibility of identifying groups or individuals who are susceptible to danger (danger is possible) and groups or individuals who are in imminent/serious danger (danger is probable). In other words, there is a difference between those who are vulnerable because a number of possible outcomes might happen to them and those who are vulnerable because they are exposed to a particular hazard. As mentioned previously, the recent changes in law and policy have sought to move away from defining persons as vulnerable as it locates the vulnerability entirely within individual characteristics, which disability rights campaigners have argued is patronising and discriminatory.

Brearley (1982) goes on from this distinction to progress a further tentative distinction between what he terms 'predictive' and 'precipitative' or 'situational' hazards. The former refer to factors which make a danger a possibility and the latter refers to factors which have a more immediate effect. By way of illustration, my wife has a physical impairment giving rise to a need for some care and support. However, her vulnerability to danger is dependent upon the nature of the hazard. So, in comparison to myself as an able bodied person in the presence of threat of physical assault by another (hazard) she is at greater risk of danger due to an inability to escape. Whereas, in the presence of a high pressure sales person (hazard) she is no more or less at risk than I by reason of that physical impairment. This demonstrates the interactive nature of vulnerability and hazard and if we consider vulnerability as an additional hazard we begin to see how the combination of hazards increases the danger but to assess the risk requires detailed knowledge of both the person and circumstance. In adult safeguarding practice a 'predictive hazard' might be 'residency within a 24 hour care setting' the 'precipitative or situational hazard' might be verbally aggressive or hostile care giver, the 'risk' (possibility or probability) of 'danger' (emotional distress from discourteous treatment) prevails for all occupants of that setting, however, the actual danger may be differentially experienced by individuals dependent upon other vulnerabilities such as communication impairment (unable to voice concern) or compliance (unwilling to raise complaint).

Recognising the vulnerability of risk assessment to subjectivity some approaches (particularly evident in the world of workplace safety) have sought to calibrate the separate axis of likelihood/probability and consequence/danger by developing descriptors to which a numerical value is assigned and applying the formula of multiplying the numerical values assigned to the descriptors on each axis that most approximate to the observer's event. The outcome value of this multiplication is then transferred onto a matrix which assigns the risk as low, medium or high built

on a shared language for the component parts of likelihood and outcome/danger. These are known as RAMs or Risk Assessment Matrices and are peppered throughout the literature on Health and Safety in the Workplace (<http://www.hse.gov.uk/risk/faq.htm> accessed 27-05-17). In some areas of practice there are well developed statistical probabilities scales to support decision making, for example, the DASH RIC - Domestic Abuse Stalking & Harassment Risk Indicator Checklist. These have been derived from common features present when someone is killed at the hands of an intimate partner. In safeguarding adults practice the development of such evidence based assessment tools is lacking, although there is a growing body of literature since the work of Martin (1984) on abuse scandals in NHS settings, from abuse inquiries in institutional settings such that we are beginning to build a profile/typography of the features of abusive care settings (Marsland, Oakes & White 2007).

Whilst Brearley (1982) relates all this to the role of the social worker, the issues are not limited to social work and might encompass many agents of public services including health professionals and police officers. These work roles are what Michael Lipsky (1980) came to term “street level bureaucrats”. I will return to an exploration of Lipsky’s theory in considering the literature on decision making.

2.6.1.c. Risk Versus Uncertainty

Brearley’s (1982) model of risk assessment in social work prevailed as the dominant paradigm until the late 1990s when other definitions were offered and some empirical work began which has challenged the negative framing of risk and broadened our thinking about this concept. The notion of uncertainty and the role of social work in working with uncertainty has been advanced (Parsloe 1999) and Jaeger et al (2000) offered an alternative definition of risk as ‘a situation or event in which something of human value (including humans themselves) has been put at stake and where the outcome is uncertain’. These authors promote the idea that humans occupy environments, both naturally occurring and of their own design, that contain desirable and undesirable risks.

Parton (1998) challenged the concept of risk based on an assumption that the world of human behaviour can be subjected to prediction and control and instead advances the concept of uncertainty. Parton (1998) uses the word ‘risk’ to mean the calculable and ‘uncertainty’ to mean that which cannot be calculated. He argues that notions of ambiguity, uncertainty and complexity lie at the heart of social work. Similarly, Lupton (1999) draws a distinction between risk ‘conditions in which the probability estimates of an event are known or knowable’, and uncertainty, ‘when probabilities were inestimable’ (1999: 7).

Parton (1998) promotes the principle of developing trust and respect for difference in the practitioner/client relationship, with a view to producing more creative and innovative responses to risk. Whilst Parton (1998) focused on Children's Services, the conflicting principles he identified between partnership with families and protection and prevention of significant harm echo the inherent dilemmas in adults safeguarding relating to empowerment. The objectives of the person and that of the professional or their agency may not be compatible as risk is differentially perceived as something that is either life enhancing or undesirable. Protection from undesirable outcomes may conflict with the adult's desire for and pursuit of personal autonomy. Tindall (1997) has commented on how risk management tends to focus on harm minimisation and is rarely conceived as a process to promote self-determination and liberation from service dependency.

Lupton notes that 'risk and uncertainty tend to be treated as conceptually the same thing' (1999: 9). Parsloe (1999) remarks that Social Workers are constantly working with uncertainty, particularly where risk is linked with significant harm as the notion of significant harm is revised according to prevailing social norms.

Many writers (Gurney 2000; Parsloe 1999; Stevenson 1999) have noted the lack of a coherent social model of disability. Consequently the extent to which blame for risk taking is seen as an individual or collective responsibility depends on how far risk is seen to be a consequence of social conditions. This construct of risk would permit for risks associated with the environment as noted to be the case with some older adults (Wilson 1994). Vulnerability is a concept bounded to risk and thus these ways of construing risk are of relevance to understanding professional conceptualisation of vulnerability.

2.6.1.d. Structured Clinical Judgement

The established use of actuarial models in predicting risk in criminal justice services was subject to critique by Gottredsen & Gottredsen (1993) who discussed the limitations of the approach in terms of accuracy due to an over reliance on the static factors and less consideration of the more fluid individual or environmental factors.

Clark et al (1993) sought to introduce a new methodology that would overcome these difficulties by combining these factors with knowledge and observation of behavioural traits, personality characteristics and situational factors.

Following the Ritchie Report a blended approach gained increasing impetus in mental health services (Royal College of Psychiatry 1996). Static risk factors (age, sex, offence history, health record etc.) do not change and perhaps, for this reason, are seen as more reliable indicators of future risk.

Dynamic factors, on the other hand, include drug use, employment status, traumatic events, income etc, and are both variable and often out of the control of the individual. They are also deemed less promising indicators of future risk. It is suggested that static factors on their own are unlikely to gauge future risk but when combined with dynamic factors are more likely to effectively predict risk.

Ryan (in Kemshall 2002) affirms this view. In relation to services for people with mental health problems, Ryan suggests that whilst pre-admission RA's will have been completed the real assessment begins when the resident moves in and is a continuous and fluctuating process. Other examples of this approach can be found in seeking to understand suicide amongst young women in custody (Lyon & Coleman 1996). In their attempts to understand the pathway to suicide they set out a model which looked at the interacting effects of individual vulnerability, person induced stress, situational triggers and protecting agents.

Tony Maden (In Kemshall and Wilkinson 2011) elucidates this blended approach in what he terms structured clinical judgement. He cites the example in mental health services of the HCR - 20 (Hart, Cox & Hare 1995). The actuarial approach is criticised for its inflexibility whereas the clinical assessment approach lacks accountability and transparency. The HCR - 20 combines the two in the form of 10 historical items (PAST), five clinical items (PRESENT) and five risk items which refer to the FUTURE. The aim is to support practitioner judgement rather than replace it. In forensic mental health services it has become the 'go to' tool (Khiroya, Weaver and Maden 2009). The approach changes the focus in risk assessment towards maximising prevention, dealing with uncertainty and harm reduction not removal. In recognition of the subjective nature of risk activity recommendations are that risk decision making should be a shared activity both within (e.g. reflective supervision) and across agencies (e.g. Multi Agency Public Protection Arrangements).

Whilst these approaches to risk take account of both individual and situational factors, some have argued that we still lack a social model of risk which takes account of cultural, economic and material factors (Stalker 2003).

2.6.1.e. Risk Taking and Positive Approaches

As the conceptual landscape of risk in social work continues to change a more positive approach, Risk Taking, has been espoused. It seeks to challenge the negative and defensive practices in risk management and is based on 'the belief that risk and the right to take risks is a normal part of everyday living' (Gurney, 2000: 303). Risk taking approaches promote a view of the service user as an active citizen with rights and responsibilities. The approach purports to value the individual's own expertise, rather than seeing the professionals as the only experts (Gurney, 2000).

Empowerment is at the heart of the risk taking approach and Tindall (1997) describes risk taking as a means of empowering the individual and assisting personal development, a view endorsed by other writers as generally accepted as reasonable and indeed a right (Brearley 1982, Kemshall et al, 1997, Waterson 1999).

Titterton (1999, 2005) has begun to promote the concept of benefits in risk, highlighting the tendency to overlook competence, coping and capacity in the individual or circumstance. Titterton (2010) has argued for the development of a more explicit model which explores the relationship between risk, vulnerability and resilience in support of the worker's attempt to get the balance right between the individual's right to protection from abuse and the right to self-determination. The positive risk taking approach seeks to enable clients to engage in some risk taking activity without undue interference by the State but it can be challenging for staff, particularly in the context of risk averse policies and concerns for both professional and organisational reputational integrity. In joint training of social work and health professionals in risk assessment and management Titterton advocates a focus on what he calls PAIR (purposeful, acceptable, informed and reasonable). He argues for a promotion of risk literacy amongst professionals using an understanding of the theoretical and practice matters that influence decisions and to align this with greater service user involvement. Titterton suggests that this approach is more empowering for the individual, and for professionals in contrast to the regulation driven responses that derive from late inquiries into adverse events.

Titterton (2005) asserts that by focusing on resilience and capacity building, positive risk taking frameworks help practitioners to adopt more person-centred risk assessment and management practice, therefore promoting dignity, respect and autonomy for the service user. He similarly acknowledges the fact that there are few helpful definitions and himself offers a definition as follows...

"a course of purposeful action based on informed decisions concerning the possibility of positive and negative outcomes of type and levels of risk appropriate to certain situations".
(Titterton 2005, p. 25)

This approach is resonant with the value base of social work and the principles of partnership and proportionality detailed in the Care & Support Statutory Guidance (2017). In relation to the principle of partnership, the absence of the views of service users from the risk literature has been noted by Langan (1999) despite the views expressed by Stanley & Manthorpe (1997) who urged that service users should be much closer involved in risk assessment and risk management. Even stronger views are expressed by Parsloe (1999) who asserts that social workers should seek the person's informed

consent as risk assessment constitutes an invasion of their right to privacy. This would support the empowerment principle in safeguarding adults from abuse but serves to highlight yet again the delicate balance to be struck between the rights of the individual and the rights and responsibilities of others. Littlechild and Blakeney (1996) report concerns amongst relatives and professionals that service users are less likely to identify risks to themselves but it may also be true that service users come under pressure to conform due to the anxieties of others.

The application of the principle of proportionality requires professionals to recognise that life is inherently risky and that people have a right to take risks. In respect of working with older adults, Stevenson (1999) discusses the challenges of identifying acceptable and unacceptable risk, in deciding when to intervene, and argues for a focus on unacceptable risk as the determinant for State intervention. However, Stevenson (1999) also reminds us of the age old tension between autonomy and protection, warning that social workers can over-value choice and autonomy as a justification to do nothing. This may reflect the value attributed to older people in society but might also be influenced by limiters on service access encouraged by the organisations in which professionals operate. As Tanner (1998) has pointed out problems can occur when service users perceive a risk but professionals do not, or the perceived risk does not meet eligibility criteria for a service. Tanner concurs with Titterton (2005) on the need to engage people in what risks are acceptable to them but not just in terms of the risks they wish to take. Tanner suggests that true empowerment means also enabling people to identify what is a risk to them (even if others consider it not to be so). In respect of vulnerability a similar approach would support the personalisation agenda giving credence to their experience and beliefs. Once again this directs the professional toward an exercise of judgement utilising all the information available to them about the person's views on their abusive experiences rather than a reliance on prescriptive practices and eligibility criteria. As Ryan (1997) has pointed out, views of risk vary according to how much choice and control people think they have in relation to it.

The notion that people can be architects in solutions to their own problems is attractive in safeguarding practice, especially during times of restricted resources. The growing interest in the concept of resilience supports the protective agenda by identifying what resources are available within the person's own social capital. Fraser et al (1999) suggest resilience can take the form of individual characteristics, family factors or extra-familial circumstances. Resilience, it is suggested, can be enhanced by building on existing strengths and reducing risk factors (Jackson 2000). It is still early days, and the relationship between risk, resilience and vulnerability needs to be better explicated to develop more effective models of working with people so that positive risk taking is

central to the agendas in social welfare about self-management, personalisation and self-directed support (Hunter and Ritchie 2007).

2.6.1.f. Organisational Contexts of Risk Decisions, Professional Difference and the Influence of Resources

However, individual practice cannot be divorced from the context in which it is conducted. In the field of child protection practice recent critiques (Calder 2011) have been proffered regarding political drivers leading to organisationally dangerous practice. Calder argues that Central Government have created an environment where Local Government organisations are required to deliver increasingly diverse duties in the context of under-funding creating a breeding ground for individual and organisational dangerous practice. He forcefully cites ill-conceived and incoherent policies which have driven organisations to focus professional time away from direct work with clients and on to unhelpful micromanagement and target issues. Calder believes that this creates an environment where professional dangerousness arises from being caught in a system where practitioners are psychologically and emotionally battered by clients, colleagues and the system sometimes leading to defensive or even destructive responses for the service users. He describes organisational dangerousness as being where the organisation fails to address professional dangerousness, often leaving the individual to be held to account for failures that bear some individual contribution but are equally organisational in terms of causation. Calder echoes the views expressed by Eileen Munro (2009):-

“The task force makes a strong case for the high level of intelligence and emotional wisdom needed to do the job well... However, social workers are not autonomous individuals. They are employed in complex organisations that shape their practice for good or ill. We need radical reform of the inspection and management systems, eradicating the fantasy that social work can be reduced to a set of bureaucratic tasks and acknowledging that it requires skills in engaging with people and making fallible professional judgements about how best to help them.... Only then can we expect skilled workers to stay and build up the profession’s expertise”. (Munro 2009, p.4)

Professionals working in safeguarding adults inhabit a multi-disciplinary and multi-agency terrain. Whilst working to common policies and guidance it cannot be presumed that they do so with consistency or even with reference to these at all. The potential for different organisational approaches, or different approaches between practitioners and managers, has implications for multi-agency working and developing a shared understanding of risk and approaches to the management thereof.

One cannot presume that just because guidance and policies exist in agencies that they are always used or drawn on in everyday practice and decision making. Researchers (Alaszewski & Manthorpe 1998, Alaszewski et al 1999) demonstrated that guidance is used flexibly by different practitioners, depending on professional autonomy and perceptions of their own professional role and responsibilities. Differences between managers and practitioners were observed in relation to the role and value of guidance. Amongst practitioners the use of guidance depended on its perceived relevance and usefulness in the wider context of each practitioner's own professional judgement. Professional judgment drew upon factors such as client circumstances and preferences and practitioners' own experiences. In contrast, managers tended towards adherence to agency policies and guidance. Such differences of opinion can lead to conflict about the nature, intensity and timing of risks permitted in the client group.

Differences of opinion were also noted between the same professionals working with different groups of clients (Alaszewski et al 1999). Interviews with nurses revealed that most were very aware of risk and its associations with danger and professional accountability, and only a few took a more positive approach to risk, recognising its empowering potential for service users. Differences also existed across nursing disciplines. As Barry (2007) reports Alaszewski et al identified three models of risk amongst nurses:-

- Risk as a 'hazard' and the nurse as a 'hazard manager' - largely associated with nurses working in mental health.
- Risk as potentially 'empowering' and the nurse as a 'risk facilitator' - a view more likely to be held by nurses working in learning disabilities.
- Risk as a 'dilemma' and the nurse as a 'dilemma negotiator' - this perspective was associated with nurses working with older people.

The authors suggest that these three approaches to risk and risk management reflect the wider professional ethos and social contexts within which nurses are trained and practice.

Calder (2011) commented on the context in which social work operates defining it as increasingly regulated and decreasingly resourced. It is not surprising that some authors have explored and found connections between risk and resource allocation.

In their review of the literature surrounding the personal Social Services and Probation Service Kemshall et al (1997) and Waterson (1999) suggest that risk assessment has developed an increasingly important role for practitioners as a means to allocate limited resources with 'risk' replacing 'need' in the gatekeeping task.

Risk as a resource allocator was clearly demonstrated by Ford & Postle (2002) who explored how risk assessments and decisions were influenced by resource availability. Albeit a limited scale study, it highlighted tension for social workers in their role as service user advocates in the face of limited resources to meet their needs. In such environments risk operates as an enhancer to eligibility. The impact of limited resources as effective barriers to risk management strategies was demonstrated in the work of Healy & Yarrow (1998). Their study explored the views of 71 health and social care practitioners who highlighted four key areas they felt should be prioritised in order to prevent accidents and enable older people to live more safely in their own homes. However, the nurses interviewed felt they frequently could not develop these risk management strategies. They were very aware of inadequate resources impeding their work. Professional barriers existed too as nurses felt the focus of their work was responding to accidents (reactive rather than preventing them (pro-active)). Healy & Yarrow's study illustrates the frustration felt by practitioners, as they try to adopt pro-active risk strategies within a context of material barriers.

The studies cited pertain to health and social care workers but the issue of resource limitations creates tensions for all professionals in human services in trying to meet the public's needs/preferences whilst also fulfilling their professional obligation of a 'duty of care' and public protection.

Risk assessment is acknowledged to be an imprecise science. Social workers and others in the helping professions are often working with uncertainty and partial information. Consequently, understanding and accepting the limitations of our knowledge is a critical skill. Additionally, understanding the influences upon how the job role is conducted and, in particular, how judgements are formed and decision made is essential information too.

This turns my attention to the second significant body of knowledge which supports my understanding of this issue in practice at the centre of this research design, which are theories on judgement and decision making, including the work of Lipsky, on how the work conditions and work practices of individuals working in public services interact to influence the client outcomes.

2.6.2. Street Level Bureaucracy Theory

As previously elucidated, the practice of safeguarding adults from abuse has witnessed an unparalleled development of policy in the UK over the past 16 years. Professionals working in this field have been required to navigate a plethora of legislation, criminal and civil, to support their interventions. In this ostensibly rule-governed landscape the struggles of practitioners implementing policy in practice has been commented on in relation to the difficulties with

definitions. In this respect Michael Lipsky's (1980) work – Street Level Bureaucracy – and that of subsequent researchers in this field, might offer some analytical benefit in understanding what influences professionals' determination of vulnerability in responding to adults at risk of abuse.

In his foundational work on Street Level Bureaucrat Theory (SLBT) Lipsky (1980) argues that frontline workers were not merely implementers of policy but creators of policy in their actions as they seek to navigate the context and constraints of their work environments. Lipsky identified the characteristics of the work situation that underpin the organisational and policy making power of these street level bureaucrats and placed the dilemmas of frontline worker discretion, judgment, and power at the very centre of our understanding of bureaucracy and the administrative state.

Lipsky (1980) applied the term Street Level Bureaucrat (SLB) to frontline workers in the public service sector. In the foundational works of SLBT this term encompassed many frontline workers, but it is evident that the roles of police officers and social workers were central to the development of this paradigm. SLBT examines these frontline workers within their organisational context where their relationship to supervisors/managers, peers, clients and citizens is perceived to shape their judgements. Lipsky prefaced his book by stating that:-

"I locate the problems of street level bureaucrats in the structure of their work". (1980, p. xv)

During the 30 years that have ensued since Lipsky first published his book the landscape of public sector work contexts have changed, especially in relation to the provision of welfare services. Despite this, the enduring relevance of SLBT to the present day work contexts of social workers has been commented upon by Ellis (2011) who has also highlighted its relevance for further research into adult social care, especially the question of the nature and scope of frontline worker discretion in the advent of personalisation. In their overview of Lipsky's theory and review of subsequent research in the ensuing 30 years, Manyard-Moody & Portillo (2010) point out that irrespective of changes in work context Lipsky's theoretical model remains a starting place for understanding street-level work by public servants.

SLB's are frontline workers and share many characteristics of others at the bottom of the organisations' hierarchies, often being the least valued and rewarded and the most expendable or replaceable. Working in the context of limited resources they often have to decide how to devote and distribute their time, exercising discretion over whom to simply process and whom to employ more time consuming social work skill with. Similar workplace demands of unrelenting pressure and public demand operate within policing services. For both disciplines there is some autonomy to operate situational rather than categorical compliance with work rules and procedures. Police

officers' discretion ultimately decides which citizen infringements of the law are overlooked and which are pursued.

In the field of safeguarding adults practice professionals are guided by definitions of vulnerability detailed in law and policy. As I elucidated earlier, the development of these definitions in law demonstrates a shift in focus to embrace signs of vulnerability which are located both within the personal characteristics of the individual but also the circumstances or context within which they find themselves which heighten the risk of abuse. However, professionals operate in work environments governed by eligibility criteria and subject to resource limitations (in particular time and human resource). The exercise of discretion by frontline workers may have the effect of constraining their concept of vulnerability to that which is endorsed as worthy of their agencies' response and resource. Differences amongst the professional groups with regard to the characteristics attended to in their construct of vulnerability might reflect the dominant paradigms and primary drivers of their employing organisations. Public bodies are often driven by what they must do (lawful obligations – duties) rather than what they can do (lawful permissions – powers).

SLB's work requires them to engage in direct contact with the public, the duration of which may be fleeting or sustained but these personal encounters expose the emotional lives of both client and worker giving rise to a mixture of emotions. This contrasts with the idea of a detached actor implementing public policy. As Lipsky himself writes:-

“In short, the reality of the work of street level bureaucrats could hardly be farther from the bureaucratic ideal of impersonal detachment in decision making. On the contrary, in street level bureaucracies the objects of critical decisions — people — actually change as a result of the decisions”. (Lipsky 1980, p.9)

These people who come into contact with SLBs are not volunteers to become clients (or in the parlance of the police – suspects or offenders). They become identified as such by what Lipsky describes as 'people processing':-

“People come to street level bureaucracies as unique individuals with different life experiences, personalities, and current circumstances. In their encounter with bureaucracies, they are transformed into clients, identifiably located in a very small number of categories, treated as if, and treating themselves as if, they fit standardised definitions of units consigned to specific bureaucratic slots”. (Lipsky 1980, p. 59)

SLBs have inherent discretion over policy implementation which seems paradoxical given that the work world of SLBs is governed by extensive, and some would argue excessive rules and procedures.

SLBT argues that this discretion operates because clients don't fit into neat rule based categories, SLBs are influenced by and respond to the variance in human behaviour. Managing workload demands incentivising SLBs to exercise discretion as a tool for self-preservation in the workplace, personal values and professional experiences will add to the set of beliefs that the SLBs operate which influences discretionary judgement.

SLBs have autonomy in decision making as their work contexts constrain the level of supervisory oversight, and supervisors are often dependent upon them for information which introduces the opportunity for selection in response.

In SLB Lipsky has asserted that the operation of this discretionary decision making is what makes SLBs the 'ultimate policy makers' as opposed to the last piece in the chain of policy implementation. Lipsky argued that policy is only truly defined when it is delivered to its intended population and that, in contrast to previous scholars, he saw deviations from policy not as failures but as creative responses to impossible mandates.

Lipsky's model has been challenged in recent years by those who believe that the impact of managerialism has been to produce more compliant social workers, thus undermining the use of discretion in social work (Jones 1999, Lymbery 1998, 2000). Howe (1991) was critical of the application of Lipsky's model during the changes in social work during the 1990s, arguing that there had been a shift away from practitioners' discretion towards a practice which was defined and constrained by statutes. He argued that practitioners:-

"Except in matters of style, all the substantive elements of their work are determined by others, either directly in the form of managerial command or indirectly through the distribution of resources, departmental policies and procedures, and ultimately the framework of statutes and legislation..." (Howe 1991, p. 204)

However, others have argued that discretion is not all or nothing and that professional may have degrees of freedom (Dworkin 1978). In circumstances where competing rules exist degrees of discretion may be exercised on a day to day basis. This was observed in child protection practice by Howarth & Calder (1998) where professionals expressed concern about the absence of clear guidance.

These central tenets of SLBT may have current resonance with safeguarding adults practitioners who struggle daily to put into practice the laws and policies which have already been commented upon as lacking detail and precision in terms of guidance and definitions (Brown et al 1999).

This exercise of discretion has remained central to more contemporary researchers who have highlighted the dangers of the discretionary judgement in the exercise of power in relation to the powerless (Handler & Hasenfeld 2007) and those who support the original views of SLBT, that such discretion can be used to produce benefit for citizens and salvage impractical policy (Maynard-Moody & Musheno 2003). Recent research in the field of adult safeguarding by Ash (2013) utilised Lipsky's work as an analytical tool to explore questions about social recognition and response to abuse. Following her involvement in a Serious Case Review, Ash observed that such inquiries rarely explore the impact of environments, and the influence of managerialism on professional practice. Ash (2013) sought to identify the constraints and realities social workers faced when implementing policy to protect older people from abuse. Ash (2013) concurs with the view of Lipsky (1980) who suggested that to understand why policy was not always implemented as policy makers intended, 'we need to know how the rules are experienced by workers in the organisation and to what other pressures they are subject' (Lipsky 1980, p. xi). An oft-cited Lipskian quote summed up the process:-

"...the decisions of street level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out". (Lipsky 1980, p. xii)

Lipsky suggested street level bureaucrats made policy in two ways - through individual acts of discretion and by the aggregation of those individual acts that became, de facto, policy operated at the street level. This discretion was shaped variously by how much freedom in decision making the agency permitted and, conversely, by the need to make decisions when agency policy was ambiguous or non-existent. This phenomenon has been observed recently by Ellis (2011) who, in a review of social work assessment practice, found that decision making was influenced by different micro environments, one of which was managerialism. And so, with this in mind, I will attend to the literature on judgement and decision making as it pertains to the conceptual backcloth of this study.

2.6.3. Literature on Judgement and Decision Making – Theoretical Models

The literature on judgement and decision making is rich and diverse but not specific to the field of adult safeguarding. However, there are some conceptual frameworks that provide face value validity for professionals working in this field supporting the understanding of the nature and analysis of judgement. Hardman (2009) introduces social judgment theory (SJT) which tries to identify what kind of information people are using when making certain judgements and how they weight these different types of information. Applied in relation to judgements in professional settings the challenge is to identify the numerous factors or cues that are relevant to diagnosing a cause or predicting an outcome. Through statistical analysis of particular judgements the model

concerns itself with identifying rules for how particular cues should be weighted or combined to support predictive future judgements. These have become known as linear or actuarial models. In contrast to these, unaided human judgements are often described as clinical predictions. Studies spanning over 40 years (Meehl 1954, Grove et al 2000) suggest that actuarial models outperform clinical judgements. These models suggest that people are essential to identifying the relevant cues but become less reliable in applying the right cues for a number of reasons which include inconsistency, attention bias, incorrect evaluation or weighting of information. Despite this, the model of human judgement in decision making remains in popular usage. Whilst SJT uses statistical analysis to identify patterns of cues used in making judgement it doesn't help us understand how the person's mind arrives at these judgements.

The theory of probabilistic mental models was forwarded by Gigerenzer (1991, 1996). This theory suggests that when faced with being unable to distinguish between two alternatives the individual searches for a cue that enables them to choose one alternative over another and once they have found this cue then they stop searching. This is sometimes known as one reason decision making or 'fast and frugal heuristics' because less processing of information is required.

Other researchers such as Kahneman & Tversky (1972, 1973, 1983) have described types of heuristics, including representativeness and availability heuristics, and explored how these affect judgement. They describe representativeness as:-

"an assessment of the degree of correspondence between a sample and a population, an instance and a category, an act and an actor, or more generally, between an outcome and a model". (Tversky & Kahneman 1983, p. 295)

"A person following this heuristic evaluates the probability of an uncertain event, or a sample, by the degree to which it is (i) similar in essential properties to its parent population: and (ii) reflects the salient features of the process by which it is generated". (Kahneman & Tversky 1972, p. 431)

Availability heuristic relates to the theory of associative memory suggesting that the judgement of likelihood is based on the strength of memory associations such that the easier it is to bring instances to mind the more likely the event is to be estimated in terms of frequency.

However, Tversky & Kahneman (1974) also caution about the vulnerability to distortion and bias in making judgements, particularly under circumstances of uncertainty having identified distortions to judgement relating to numerical estimations which they proposed related to the use of a heuristic called anchoring and adjustment in which people make an estimate using a starting value and then

adjusting it to arrive at a final judgement. In the evaluation of risk and vulnerability practitioners are asked to evaluate the degree of vulnerability to rate or to rank people as more or less vulnerable so the understanding of how this distortion occurs may be relevant in this study.

The other distortion that is relevant in thinking about this research question is that of hindsight bias. Human beings are natural pattern seekers and will seek to make sense of their worlds by finding explanations for events by interpreting the present according to the known outcomes in the past. The potential deficit of this can be the unfair assignment of blame or causation for an outcome that was largely unpredictable. Baruch Fischhoff (1975) termed this tendency as 'creeping determinism' (Fischhoff 1975, p. 288). The concept of hindsight bias is that an uncertain outcome *seems* more likely *after* the event has occurred. Fischhoff suggested that this was due to the memory being immediately updated in light of the outcome information. Whereas others (Carli 1999, Hastie 1984, Pezzo 2003) prefer the explanation of memory reconstruction suggesting that hindsight bias occurs as a consequence of retrospectively reconstructing one's judgement in the pursuit of sense making. They have advanced this phenomena observing that the more unexpected the outcome the higher the engagement in sense making activity. Pezzo's model of hindsight bias asserts that the greater the ease with which sense making can be achieved the more likely hindsight is to operate as initial surprise from an outcome that is not congruent with expectations is reduced and presumably alongside that any cognitive dissonance is similarly reduced. The operation of hindsight bias in the construction of Serious Case Review reports may be a feature in the findings and recommendations of these reports.

Decision making in the context of safeguarding adults from abuse is complex and interdependent with real world variables. An area of research that might assist in understanding is a field known as Naturalistic Decision Making (NDM) which attempts to understand how people make decisions in real world contexts rather than laboratory controlled experiments. This approximates with the approach of this study in as much as it seeks to elicit knowledge from those with expertise in their field. NDM has generated a number of theories but two have prima facia relevance in the context of decision making by social work, health and criminal justice personnel, both of which propose a role for knowledge in decision making.

The first is *image theory* which offers a theory of both individual and organisational decision making suggesting that people select a series of options between which they make final choices, or even that choice is primarily driven by the rejection of options that are inconsistent with values of the individual/organisation (Beach 1990). This theory has an intuitive appeal in a field of practice and a population of practitioners whose practice is perceived to be governed by values/principles.

The second is the theory of *recognition-primed decision making* (aka intuitive decision making) arising from studies of decision makers in high pressure and high stake situations, such as firefighters and battlefield commanders (Zsombok & Klein 1997). This theory proposes that people in these decision making contexts draw upon previous experience to frame present decision making, matching the current circumstances to previous experience and using this to generate a single choice response and only deviating from this where they identify a significant discrepancy.

Safeguarding adults practice is conducted in a multi-agency, inter-professional work context. Consequently, some but not all decisions will be conducted within teams or inter-professional groups. Whilst this might be expected to be more effective than individual decision making many studies have identified structures and process which undermine the benefits assumed with diversity, including conformity or obedience to authority, polarisation towards majority views prior to group discussion, and a tendency to focus on shared knowledge rather than tease out differences in knowledge and understanding. Janis's (1982 [1972]) work on group think suggests that a combination of factors, such as a high group cohesion or desire for group cohesion coupled with provocative situational conflict tends to influence group members to strive for unity in decision making rather than explore the conflicting alternative options for action.

One of the critical skills in safeguarding adults from abuse is that of risk assessment. Commentators on child protection practice have highlighted that:-

"Since risk assessment is, by definition, making judgements under conditions of uncertainty, there is an unavoidable chance of error. It is impossible to identify infallibly those children [or other clients] who are in serious danger of abuse [or other harm]. Professionals can only make fallible judgements of probability of [the undesirable event occurring]". (Munro 2008, p. 40)

Taylor (2010) cites Rightland et al 2003, in his commentary that researchers often focus on clusters of characteristics of risk or categories to make this manageable conceptually. These clusters delineate a typology of risk factors including:-

- Historical or developmental factors.
- Dispositional or personal factors.
- Symptom (presenting issues) factors.
- Contextual or situational factors.

As mentioned previously, the actuarial approach to decision making about risk is considered to be more accurate than clinical prediction as a number of potential biases are introduced by the human decision maker affecting the consistency of their approach. These influences include stress, tiredness or emotion. All of these will prevail in the context of decision making in adult safeguarding. It is for these reasons that a blended approach to risk assessment has been promoted so that actuarial approaches can strengthen clinical approaches by minimising individual bias whilst recognising their limitations due to a reductionist approach to appraising the phenomena. Added to this is that human beings have free will to choose and their decision outcomes are not always rational or predictable which complicate the professional task of predicting individual human behaviour.

It also needs to be recognised that in the field of health and social care one of the challenges of using statistically based prediction tools is that such tools are less helpful in predicting events that occur rarely (Gigerenzer 2002) and this can lead to some fault lines in reasoning and interpretations, as has been evident in some inquiries into child abuse (Munro 2008). As Rightland (2003) points out:-

"violence is a rare event, and rare events are inherently difficult to predict". Rightland (2003, p. 33 - 4)

Government policies recognise the dilemma for practitioners in balancing the needs, rights and choices of the individual in the practice of safeguarding:-

"There is a delicate balance between empowerment and safeguarding, choice and risk. It is important for practitioners to consider when the need for protection would override the decision to promote choice and empowerment". (DH 2007, p. 30, para 2.50)

In these situations the practitioner's task is to distinguish between situations requiring a safeguarding response or not. Policies imply that there are thresholds to be applied which encourage a criterion based judgement. This judgement is what lies at the centre of this research question and the extent to which this operates in the evaluation of vulnerability to expand or constrain their constructs. In adults safeguarding the development of tools that support the prediction of risk through the combination of actuarial and clinical appraisal is still in its infancy. Such criterion based judgement is perceived to be a requirement in relation to threshold criteria for statutory intervention to protect the individual.

In the evaluation of risk the concept of 'vulnerability' has been constructed as a predisposing factor or background hazard (Kelly 1996) therefore developing an understanding of how practitioners

construct and apply their concept of vulnerability is critical if we are to find ways to support this judgement in the decision making process.

Carson & Bain (2008) note two approaches to or levels to understanding risk:- (1) Factors associated with the individual and (2) The context or situation within which they live and interact, and their social circumstances. They cite the work of Applebaum et al (2001) who commented, from their research into risk posed by people with mental disorder, that although the situational or contextual factors are amongst some of the most powerfully predictive, they are the least researched. Vulnerability as a bounded concept in risk assessment may demonstrate a similar bias in the attention given to it by practitioners. This study will seek to elucidate this and consider the implications for recognition and response using formal safeguarding procedures.

Carson outlines a five level model to understanding risk assessment as follows:-

- Risky or dangerous people.
- Dangerous contexts or social settings.
- Dangerous decisions/decision makers.
- Dangerous management presiding over unsafe work systems.
- Dangerous systems which provide the context in which the decision has to be taken.

Carson comments that the first is often given greatest attention, the second is sometimes given consideration whereas as the other three are given little attention.

The decision making theories detailed above are all of interpretative value to this research study in various ways. For example, Social Judgement Theory (SJT) is concerned with how people make judgements. In an attempt to explain how attitudes are expressed, judged, and modified It describes the process of discrimination and categorization of stimuli which support judgements. This study similarly seeks to identify cues that professionals report as relevant to their 'judgement' of vulnerability. There may be insights to be gained in how these signs are combined. However, unlike SJT it does not use statistical analysis to identify any rules employed to weight or combine the cues but could provide data to develop such an analysis. Professionals making decisions about who requires a safeguarding response are often required to do so under time pressure to ensure that the immediate safety needs of the person are identified and secured in a timely manner. Understanding how the professional arrives at that judgement is central to this study. Taking into account the imprecise definition of vulnerability and the working context in which professionals have to form a

view and make a decision, the operation of heuristics offers a framework to understand the influences of professional conceptualisation of vulnerability and their application of this is in deciding to progress a safeguarding enquiry/response or not. It elucidates some of the approaches to decision-making in circumstances of uncertainty which the imprecise definitions of vulnerability in safeguarding adults policy may create in practice. Whilst Gigerenzer has argued that heuristics can be used to make judgments that are accurate alternatives to more complicated procedures, others have focused on their effect in creating bias. Fischhoff's 'creeping determinism hypothesis' offers insight into the operation of hindsight bias which is relevant to the reported findings/recommendations of serious case review reports. The naturalistic decision-making models provide an interpretative framework to explore factors which influence professional recognition and response to vulnerability in adults at risk of abuse. The concept of vulnerability is closely allied to that of risk. Conceptual models of risk often cluster characteristics to aid understanding. It is possible to observe a similar phenomenon in relation to vulnerability. These models have supported my thinking about the conceptual model of vulnerability proposed from the findings of this study.

2.6.4. Social Constructionism and the Social Model of Vulnerability

2.6.4.a. Social Construction Theory

'Social Constructionism' is a major sociological perspective. Central to this perspective is the idea that our view of reality is constructed by individuals and communities, and so forms the 'perceived truths' of our world which will then be subject to change over time and different groups (Berger & Luckmann 1966). This ideology suggests that identity is not a fixed, static or pre-determined condition but one that is fluid and constantly being revised and shaped by the people and experiences we encounter. In contrast the 'Essentialist' perspective centres on a belief that people have a fixed essence. It tends to take a more generalised view of individual identity based on their affiliation to certain groups and assumes universal features associated with those groupings. Common groups include age, gender, sexual orientation, social class, religious affiliation and occupation. The extent to which the concept of a 'vulnerable adult' is a matter of static factors or shaped by the experiences of adults who are abused and exploited and the professionals who work with them is central to this study so this theoretical perspective is pertinent in understanding the perspectives and understanding of participants in this study.

Burr (2003) explains that our understanding of the world, the categories and concepts we use are historically and culturally shaped. All ways of understanding are historically and culturally relative, dependent upon the social arrangements prevailing at any given time. As commented previously in

this review of the literature, the concept of a 'vulnerable adult' is seen to be an enduring aspect of human history and yet, at the same time, the current definitions of the term lack common agreement (Manthorpe, Penhale & Stanley 1999).

Social constructionism argues that what becomes knowledge is a function of what people construct between themselves, the shared meanings developed through daily interactions which make the place of language so powerful in the way we construct this shared understanding/knowledge. Reality is not considered to be an objective phenomenon but one that is socially constructed and consequently changing relative to the participants in the construction. The evolving construct of risk was noted in the section on the risk literature. Vulnerability is a risk related concept and might also be changed and shaped by those involved in the discourse of abuse and vulnerability. What is truth or knowledge is a matter of our current accepted ways of understanding the world and, therefore, not a product of direct observation, but rather a product of social processes and interactions of people.

Our knowledge or beliefs and our actions work together as the way that we construct something invites certain actions so, for example, at one point in our history being gay was perceived as deviant and a threat to the moral cohesion of society so the action that invited was imprisonment. Others constructed it as a sickness, something to be 'treated' and 'cured'. In adult safeguarding it could be argued that how professionals construct their concept of 'vulnerability' will inform their responses to it. This is a field of public practice where the professional's authority (power) to act is endorsed through policy and law and to whom they can respond is underpinned by what shared meanings they have of what constitutes a 'vulnerable adult' or an 'adult at risk' of abuse or exploitation. The multi-agency nature of the working arrangements invites different perspectives which have the potential to create greater confusion or greater certainty of the meaning of 'vulnerability' in adults at risk of abuse.

Social constructionism rejects the ideology of essentialism which it states limits people to being defined by a collective of characteristics, some of which are pathologised which leads to oppressive practice. It questions realism saying that knowledge is not a direct perception of reality, that there are no such things as objective facts and that knowledge is derived from seeing the world from another's perspective. Definitions, such as those evident in safeguarding policy, prescribe the characteristics of categories. However, the extent to which these are operationalised by professionals in practice might be subject to variation based on their perspective. For example, a sociological perspective of vulnerability is offered by the social inequalities model which suggests that people of particular groups are more vulnerable because they are treated as of less value,

occupy lower social status and, therefore, have less social currency. Williams & Keating (2000) for example, make this argument in relation to abuse within mental health services where the use of power is legitimised in law and sustained in the social institution of mental health care delivery.

Language provides a framework for the meanings ascribed to the concepts we construct, thus the way that we talk to each other about a phenomena supports the construction of our world. Language is not merely a passive vehicle for our thoughts and emotions but rather an active agent in the construction of our realities. Higgs (2001) has remarked on this in relation to clinical reasoning research, observing that language is not merely a mechanism for representing our world but a way of bringing it into being. The importance of language insisted upon in Social Constructionist thought makes it the obvious object of study in seeking to understand how vulnerability is conceptualised by adult safeguarding professionals and the extent to which these have shared meaning. This naturally leads to the selection of qualitative methods to access the words people use. Even since the introduction of formal adult safeguarding policy in the UK the language used to describe this field or practice has changed from 'adult abuse' work to 'adult protection' and currently 'adult safeguarding'.

2.6.4.b. Social Model of Disability and Vulnerability

In its rejection of the essentialist tradition of psychological models of understanding human behaviour through the thoughts, attitudes and motivations of the individual, the social constructionist approach de-pathologises the individual and seeks to focus its understanding on the social practice and interactions between people. In this way, rather than pathologising the person with a difficulty or difference, it seeks to construct the difficulty not within the person but within the interactions of that person with others. Social constructionism forms the foundations of the social model of disability. In the world of adult safeguarding the term 'vulnerable adult' has been criticised for pathologising the individual by assigning vulnerability to individual characteristics of difference and failing to take account of how vulnerability emerges as a function of circumstance or situation. How professionals talk about vulnerability and, therefore, what informs their construct of vulnerability is the subject of this study. In the analysis of the language used by professionals it remains to be seen to what extent vulnerability is a function of objective reality and located in individual characteristics and how the concept of vulnerability is shaped and formed, to what extent it is a socially constructed term.

The social model of disability (Oliver 1983) is a social constructionist approach which sprang from the politics of disability. This sought to challenge discriminatory effects of the essentialist approach

by re-constructing disability as a consequence of the effects of the world the person inhabits as opposed to the individual characteristics of physical impairment. The social model of vulnerability takes its impetus from these constructionist approaches as Wishart (2003) has elucidated. The extent to which this model is operational in practitioner construction of vulnerability will be examined in the course of this study.

Heaslip & Ryden (2013) view the concept of vulnerability as a mechanism to identify 'vulnerable groups/populations' susceptible to adverse health outcomes. They highlight that one of the key drives of this perspective is to see vulnerability as a problem to be addressed by public policy. This notion in health care policy is also visible in social care policy (adult protection) where the need for protection was closely linked to the state of being a vulnerable adult (DoH 2000). In the review of 'No Secrets' (DoH 2009) this precept came under strong criticism as a term that was paternalistic and potentially stigmatising. Prior to the review Penhale & Parker (2007) had asserted that the term 'vulnerable adult' attached a blaming victim status to the adult rather than aligning blame to the individual, agency or social context responsible for the abuse.

In contrast to this the perception of vulnerability as an existential experience detaches vulnerability from individual characteristics and deposits it in the lived experience of the person. Vulnerability is then seen as part of the human condition which individuals will experience differentially, depending on their exposure to harm or threat to their integrity. Spier's (2000) emic model typifies this as it defines vulnerability in terms of the individual's perception of their self, their exposure to harm and their resilience and/or resource to respond to the challenges to their integrity. In this sense vulnerability can be seen as a much more fluid and shifting experience.

Critics of the social model (Bury 1997) have argued that it offers a falsely unitary account of disability by arguing for an exclusive focus on a disabling society. It fails to take account of the full range of disability or impairment so that, for example people with communication and language problems (maybe due to stroke) or intellectual difficulties (mental disability or disorder) are poorly served by the theory. The nature of the impairment may be highly significant and cannot be treated as an initiating factor to wider social exclusion. It is perhaps more representative to explore the interactive effects of individual impairment and disabling environments. In a similar way vulnerability to abuse may be seen as a matter of a combination of condition and position that exposes a person to a higher level of exposure to abuse. Another critique (Twigg 2006) relates to its failure to engage with the lived experience of persons with disability and risk, avoiding the reality of impairment, particularly physical impairment, although the emic model reported by Spiers contradicts this. This has parallels with current critiques of our ways of understanding risk which fail

to take account of the individual's experience of threat to them. Twigg also draws attention to the neglect of culture in the social model which parallels Stalker's (2003) comments on a social model of risk.

2.7. Concluding Comments

The aim of this chapter was to set the practice concept of vulnerability within the legal and policy context which frames safeguarding adults practice. By mapping the definitions of vulnerability throughout the relevant law and policy I have sought to demonstrate the confusing territory that professionals in safeguarding adults have to navigate. The lack of clarity and common agreement about the concept of vulnerability is evident in how these definitions change location of the characteristics of vulnerability from person to circumstance, and in some cases both.

Research into safeguarding adults from abuse is a relatively new field of academic interest so the next part of this chapter serves to illustrate the state of play in current research in this field. It provides an overview of recent research in adult abuse, identifying studies most relevant to the study question, the gaps in our understanding which have informed the research questions and prevalent methodologies in the field. Early research studies largely focused on the nature and extent of abuse, with an emphasis on abuse within the population of older adults and people with learning disabilities. There have been few studies examining how practitioners recognise and respond to signs of abuse and others have been published during the course of this study. Only a couple of studies have explored practitioner views of vulnerability. These have related to allied areas of practice, such as health visitors in relation to child protection or have focused on non-registered staff working exclusively in learning disability services.

This study sought to address that gap by exploring how professionals (registered staff) in human services conceptualise vulnerability in adults at risk of abuse. It does so by seeking views across a range of disciplines in human services (health, social care and criminal justice services) and professionals working in safeguarding across all adult client groups. In adult safeguarding practice the Serious Case Review mechanism serves as a naturally occurring case study. The findings and recommendations from the examination of these extraordinary cases infer deficits in practice and this study seeks to examine what evidence there is of this in relation to professional understanding of vulnerability.

The chapter finishes by detailing some of the key theoretical frameworks which have supported my initial thinking and subsequent interpretation. Whilst grounded theory approaches promote a development of theory from the data it would be dishonest to deny the influence of these theories

in the formulation of my thinking as much as it would be for me to deny my position as an inside researcher and disregard the influence of practice and experience in the course of this study.

Chapter 3

Methodology

3.1. Introduction

This is a qualitative study which adopts an interpretivist phenomenological approach. In subscribing to the interpretivist position as an acceptable way of gaining knowledge I concur with the view of Maya Angelou:-

“There’s a world of difference between truth and facts. Facts can obscure the truth”. (Maya Angelou Quotes. https://www.brainyquote.com/quotes/maya_angelou_125778)

This chapter will consider all aspects of the methodology, including the research design and rationale, sampling, data collection and analysis. Starting with the role of reflexivity in identifying the research problem and forming the research question, the chapter goes on to explore the research strategy and rationale. It describes the methods used and details how data was gathered, handled and analysed. The chapter concludes with consideration to the issue of rigour and the ethical implications of the design and data collection.

3.2. Reflexivity - The Role of Researcher in Identifying the Research Problem

The aims of this research are to understand the meaning of the concept of vulnerability for professionals working in adult safeguarding practice within the context of that practice. It has been influenced by my experience as both a Social Work Practitioner and Practice Educator in the field of adults safeguarding.

Anecdotal observations of the criticism levelled at practitioner knowledge and understanding reported in multiple serious case reviews fuelled my interest in this field. As a practitioner and practice educator I read a number of the early serious case review executive summary reports and was struck by the recurrence of theme in many of the recommendations and findings. Amongst these was a recommendation to strengthen practitioners’ understanding of abuse and vulnerability. In adults safeguarding training sessions I discussed these case findings with practitioners who often responded with the comments that suggested, with the benefit of hindsight, these individuals in their particular circumstances were an accident waiting to happen. The adults themselves were often seen as persons who would not meet the threshold for services or a safeguarding response based on initial information or that they refused public service involvement, but that taken together with their particular circumstances there were signs retrospectively that the adults(s) were

vulnerable to abuse. These conversations influenced my thinking in the early development of the research study as I started to consider whether practitioners might be over attending to signs of vulnerability located within the person (innate vulnerability) and under attending to signs located in the person's circumstances (situational vulnerability).

Research questions need to be clear and understandable. This requires that the conceptual and operational definitions of the subject of inquiry, or variables, are unambiguous and understood. Herein lay the first dilemma of this research. Comment has already been made on the ambiguity and problems of co-operation by some early research into the implementation of Adult Protection Policy. McCreddie et al (2008) claim that detailed interviews with staff charged with developing multi-agency procedures confirmed the ambiguity of the policy and the uncertainty experienced by staff as a consequence. Confusion arose not only from differing interpretations of the concept of a vulnerable adult but also regarding what constitutes abuse.

This suggests that the operational concept of 'who is a vulnerable adult' and what constitutes vulnerability is vague. Consequently, the research must first start with outlining the indicators currently used to determine vulnerability amongst the adult population. This can be informed by examining how vulnerability is outlined in relevant documentation (law and policy) but as the discourse above suggests, this might not yield much in the way of clarity. Therefore, I would propose to solicit this view from practitioners currently engaged in the work i.e. how do they conceptualise vulnerability in adults at risk of abuse (AAR)? What indicators/descriptors do they use?

SCRs are noted to be vulnerable to hindsight bias – which supports the expressions of practitioners that on reflection knowing what we do now about the person AND the circumstances, put together this was an accident waiting to happen. Consequently, as I moved from a positivist to an interpretative approach the questions detailed below were refined by removing the focus on situational vulnerability to enable a less biased evaluation of the conceptualisation of vulnerability used by practitioners in their assessments of AAR.

As detailed above, multi-agency cross discipline adult safeguarding practice is a relatively new and under researched field of practice. There is recognition of the definitional difficulties with the operational terms of abuse and vulnerability in early research and commentary but these are still not addressed in law and policy. The knowledge and understanding of the concepts of risk, vulnerability and abuse are 'presumed' but rarely elucidated or explicitly contemplated and articulated. The variable definitions across law and policy testify to the social construction of

vulnerability as a concept. The challenge is to identify and describe what informs the conceptualisation of vulnerability to abuse across the professional groups and how this might inform our understanding of recommendations from Serious Case Reviews as the primary instrument for learning.

The selection of this approach for this research study was reflective of the journey of development that I undertook in formulating the research questions and considering the research design. On reflection my initial conceptual bias towards positivism was identified as being rooted in my MSc study experiences. These had equipped me to critique the positivist approach and quantitative methodologies as dominant models in psychiatry. However, it had not liberated me from them as a legitimised way of developing knowledge. The probing questions of my supervisors helped me to change my direction. Arriving at a phenomenological interpretivist approach was like coming home to myself and the value base of social work practice making the onward journey through methods and data collection a more cognitively resonant one. Furthermore, the empowering nature of this approach of representing reality through the eyes of the participants had particular resonance as it contrasted with the apparent lack of voice for practitioners in the production of Serious Case Review reports and their resultant commentary on areas for practice improvement. The methodologies of SCRs have relied predominantly on document analysis.

In contrast to the distant researcher typical of quantitative research methods the qualitative researcher is much more engaged with the research subjects. This necessarily gives rise to the need to consider the impact of power, position and trust in the relationship between the researcher and the researched. Nunkoosing (2005) draws attention to the need for the researcher to have an awareness of the impact of that relationship reminding us that *all relationships involve a balance of power and consent to participation may not obviate anxiety for participants who may be concerned with expectations of them and how they might be regarded by the researcher.*

It might reasonably be expected, but not presumed, that a degree of familiarity and previous good relationship with the researcher might aid this unease in participants and promote engagement. As the lone researcher in this study I have a long established history in these Local Authority areas, both as a social care practitioner in and out of normal working hours, and more latterly as the multi-agency safeguarding adults training consultant, countenancing contact with a multiplicity of health practitioners and specialist police officers. A potential benefit of this established personal history of commitment to learning and development in this area of practice might be securing positive engagement from the necessary professionals.

3.3. The Research Problem and Questions

The research problem arises from the development of the Serious Case Reviews in the context of adults safeguarding practice and its promotion as a mechanism for organisations working together to learn lessons from adverse events (ADASS 2006). During the course of this study, what started as a permissive, has evolved into a statutory requirement as Section 44 Care Act 2014 introduced an imperative not only to **identify** the lessons but to **apply** those lessons. Action plans from these reviews often refer to implementing training.

Legislation now requires Safeguarding Adults Boards (SAB) to conduct these reviews where certain criteria are met as detailed below:-

Care Act 2014 Section 44 Safeguarding Adults Reviews.

(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the Local Authority has been meeting any of those needs) if:-

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if:-

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if:-

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

These cases reviews provide a window into safeguarding practice and the possible fault-lines in effective working to protect adults from abuse and neglect.

The exhortation to disseminate findings and the imperatives to 'learn the lessons' invoke a political pressure on practice at both individual and organisational levels. Experience in Children's safeguarding suggests that this ethos of blame acts as a barrier to learning (Rawlings et al 2014).

However, the formation of the research question for this study pre-dates this publication and in my reading of some of the SCR executive summaries the finding of a need to strengthen practitioners' understanding of abuse and vulnerability was noticeable, if not empirically identified, as a recurrent theme.

The prevailing methodology of Adults SCRs is the use of independent management reports by contributing agencies. It is unclear to what extent they directly report the voice of the practitioners as these reports are not publicly available. A driver in this research was a desire to give an explicit voice to the adults safeguarding professional by exploring their understanding through their own oral and written reports and by direct observation of professionals in practice.

This study was primarily interested in what signs of vulnerability practitioners employ when assessing the risk of abuse/exploitation in adults and what contextual factors or operators have a bearing on the conceptualisation and subsequent responses. The study aims to:-

1. Identify and describe how safeguarding adults practitioners conceptualise vulnerability.
2. Identify and describe what else affects their conceptualisation and subsequent response to signs of vulnerability to abuse.
3. Understand and analyse the recommendations of Serious Case Reviews in the light of 1 and 2 above.

The principal research question was "How do police officers, health and social care practitioners conceptualise vulnerability when assessing adults at risk of abuse and how do these conceptualisations vary across the professional groups"? A secondary question was: "How can the findings and recommendations of Serious Case Reviews be understood in the light of this"?

3.4. The Research Design and Rationale - Phenomenological/Interpretivist Methodologies

This study adopts an epistemological position described as interpretivist (Bryman 2001) by examining the world of safeguarding professionals through the interpretation of that world by them. It seeks to make sense of a situation without imposing pre-existing expectations upon participants. It takes an inductive view of the relationship between theory and research by grounding the analysis in the data, thereby generating theory rooted in the data. This involves creating the understanding or meaning of the participants, which means being able to demonstrate some empathy with the participants, an ability to relate to their subjective feelings, perceptions, and thoughts. This approach, known as Grounded Theory, seeks to picture the world as it exists to those under investigation rather than to fit it to what the researcher imagines it to be. Miller & Jones-Harris (2005) argue that qualitative research, such as ethnography, phenomenological and grounded

theory approaches, are best suited to answer questions relating to questions about beliefs, attitudes or personal experience.

McNiff & Whitehead (2002) argue that the traditional epistemological dominance of positivism denigrates the knowledge of practitioners regarding their form of theory as practical problem-solving rather than proper research. Practitioners are viewed by these abstract theorists as dealing with matters of everyday significance and not validated as legitimate knowers.

The methods of scientific enquiry differ and often reflect the epistemological position of the enquirer. Whilst in social science research the epistemological positions of positivism and relativism, and associated methodological approaches (broadly described as quantitative or qualitative) are not mutually exclusive. For this study I have chosen the qualitative approach. According to Bryman (2001: 264) the qualitative approach has three distinctive elements:-

- *“An inductive view of the relationship between theory and research, whereby the former is generated out of the latter”.*
- *“An epistemological position described as interpretivist... the stress is on the understanding of the social world through an examination of the interpretation of that world by its participants”.*
- *“An ontological position described as constructionist, which implies that social properties are outcomes of the interactions between individuals rather than phenomenon ‘out there’”.*
(Bryman 2011, p. 264)

Habermas (1972, 1974) describes three types of human interest - technical, practical and emancipatory. Practical interests are concerned with meaning, making and interpretation. It is the latter with which I have most sympathy. As a practitioner and practice educator I am interested in what informs professional judgement and decision making, especially in a field of practice that is characterised by uncertainty. The desire for practical outputs is acknowledged and there is potential for, but not a presumption of, the development of tools to support practice decision making based on real world experience. Interpretative research values practitioners as participants and seeks to validate their accounts as well as the views of the researcher/observer. The traditions of phenomenology and ethnomethodology seek to find meaning and provide explanation of the participants' actions, thereby supporting a more democratic approach. Research subjects are frequently involved in the interpretation of the research findings.

McNiff & Whitehead (2002) argue that the traditional epistemological dominance of positivism denigrates the knowledge of practitioners regarding their form of theory as practical problem-solving rather than proper research. The scientific 'positivist' paradigm asserts a hierarchy of evidence and this hierarchy denigrates many qualitative methods used in social research. However, Miller & Jones-Harris (2005) argue that qualitative research, such as ethnography, phenomenological and grounded theory approaches are best suited to answer questions relating to questions about beliefs, attitudes or personal experience.

I have selected the qualitative approach as Dey (2004) suggests that they are generally engaged when there is a need to explore, describe and/or interpret the individual and social experience of a group of people from their unique perspective.

Elliott, Fischer & Rennie (1999) report that:-

“the aim of qualitative research is to understand and to represent the experiences and actions of people as they encounter, engage, and live through situations”. (Elliott et al 1999, p. 216)

And Devine & Heath (2009) conclude that there are actual advantages of qualitative research where the aim is to explore individual experiences, practices, values and attitudes in depth and to establish their meaning for those involved or concerned with such meanings. In qualitative approaches the data often takes the form of verbal reports from participant observation, individual and group interviews and documentary material and the analysis of such data is concerned with the context in which it has occurred in order to derive interpretation from it. Elliott et al (1999) describe the role of the researcher as:-

“attempting to develop understandings of the phenomena based as much on the perspective of those being studied”. (Elliott et al 1999, p. 216)

It is favoured as a way of giving voice to the research subjects, placing a focus on the participants rather than researcher focused.

My observations about the apparent absence of the voice of the practitioner in the publicly available reports, SCR executive summary documents, made features of the ontology of relativism attractive and concordant with my personal and professional values. The features central to this view include:-

1. Reality is represented through the eyes of the participants. Valuing the views of practitioners was an important ethic in this study approach.

2. The role of language is emphasised as the object of study as it is the instrument through which the world is represented and constructed. Accepting that the concept of vulnerability is a socially constructed one, then examining the language used by participants would be essential to understanding its meaning for them.
3. The importance of viewing the meaning of the experience in context is stressed. Understanding the context in which the concept is constructed as possible influences on the way meaning is shaped.
4. The development of theory stresses the emergence of concepts from the data rather than their imposition in terms of an apriori theory. This feature supported the shift in my thinking, moving from a theory testing to a theory generating stance.

The interests of this research are practical, aspiring to inform theory which supports improved safeguarding adults practice. The goals and methods of grounded theory lend themselves to such aims. Grounded Theory (GT) claims that theory developed this way is more based in or grounded in reality than one which is derived from a collection of loosely connected propositions or series of concepts. GT seeks to achieve subjective understanding. The researcher is not so detached from their subjects, and has a more humanistic approach that requires the researcher to have an empathic understanding with the people they are studying.

The developers of grounded theory approach, Glaser & Strauss (1967) describe this as the development of theory from data which has been systematically gathered and analysed throughout the research process. The process is inductive rather than deductive. GT tends to focus the researcher on the micro level of social interaction, experiences and meanings for the participants. This may need to be set in the macro context of what other operators may have a bearing on the participants' perceptions and responses e.g. policy directive, lawful responsibilities and authorities, role expectation, professional identity. As the aims of this research are to understand the meaning of the concept of vulnerability for professionals working in adult safeguarding practice within the context of that practice the GT approach would seem to be the best fit.

3.5. The Research Design and Rationale – a Mixed Qualitative Methods Approach

Whilst the debate over relative efficacy in the war between quantitative and qualitative research continues to rage unabated, fuelled by the partisanship of the paradigm and philosophical positions

of both, there is a suggestion of 'paradigm peace' with the emergence of the popular approach of mixed methods. However, as Brannen (2005) points out, a mixed methods approach does not necessarily imply a mix of quantitative and qualitative methods and may also be constituted in a mix of either qualitative or quantitative approaches.

According to Brannen (2005) the rationales for choice of different methods can be distilled into what she calls the three P's – *paradigms and philosophical assumptions, pragmatics and politics*. Mixed methods approach is often associated with the pragmatic researcher, where, as Brannen comments:-

“The framing of the research question is in part shaped by epistemological assumptions but is also influenced by the need to find theory that ‘fits’ a specific set of cases or contexts”.
(Brannen 2005, p. 8)

This sometimes means that the pragmatist is less purist in terms of methods and paradigm fit, and more concerned with the utility of research findings in relation to practice or policy. The pragmatic rationale might also relate to the availability of resources and the feasibility of the methods. Certain methods might be chosen because they improve the probability of co-operation with potential respondents.

The pragmatic approach had particular resonance for me because I am motivated by a desire for this research to inform practice in a way that is meaningful and politically persuasive. The research activities, for practical reasons, were conducted in the workplaces of the participants. Amongst the advantages of conducting research in natural settings it is suggested that there is improved validity by reducing participant performance, i.e. doing what they think the researcher wants. The aims and approaches of this study concur with those adopted by other current researchers in this field of study. For example, in their study on Serious Case Reviews in Adult Safeguarding, Manthorpe & Martineau (2010) embraced methods such as general survey, semi-structured interviews and document analysis.

A mixed qualitative methods design has been chosen for this research study. The type, order and purpose of each research activity is detailed in table 2 below.

Table 2. Summary of Research Activities and Aims

Research Activity	Purpose/Aim
1. Document analysis – law. Policy, Serious Case Reviews.	Track the language of vulnerability throughout law and policy. Undertake a thematic analysis of Serious Case Reviews with reference to the concept of vulnerability.
2. Semi – structured Focus Group discussion – single discipline.	Identify the indicators actually used to determine vulnerability by practitioners. (What they say about vulnerability).
3. Direct observation of live practitioner decision making on Safeguarding Adults referrals.	Content analysis to observe actual decision making and analyse the content of field notes in relation to reported indicators from focus group. Triangulate with practitioner reporting in focus group (what I see and hear in their discussion and real time decision making).
4. Semi-structured interviews.	Obtain more detailed description of the indicators of vulnerability reported by practitioners during direct observations and their views on the relative import of these as well as identifying other factors influencing their concept of vulnerability (contextualising what they actually do).
5. Document analysis – referral records.	Content analysis to identify description of vulnerability in written records of decision making. Triangulate with practitioner reporting in focus groups (what the records reflect).
6. Focus group – mixed discipline.	Test and validate emerging theory from analysis of data in previous stages (building and testing a model/theory for practice).

I shall now focus my discussion on each of the research methods. Each section will detail the rationale for that choice, and methods of sampling and data analysis.

3.5.1. Case Study/Document Analysis – Serious Case Review (SCR) Thematic Analysis

3.5.1.a. Rationale for Choice of Method

As the methodology of GT suggests part of the task of the researcher is to comprehend the context in which the phenomena being studied resides. This was established to some extent in an examination of the grey literature as part of the literature review which traced the evolving concept of a vulnerable adult as this has been constructed in UK law and policy.

Case studies allow for the intensive study of an individual or a small group of individuals within their unique context. It is not uncommon for the objects of study to have either unusual characteristics or exceptional circumstances. In the field of Safeguarding Adults there is a growing body of naturally occurring case studies emerging through the process of SCRs. Each SCR represents circumstances where the statutory bodies involved believe there is some failing in working together to be explored for the benefit of future learning. Collectively these SCRs represent multiple cases with some replicative characteristics. However, as Manthorpe & Martineau (2010) have commented there is a lack of consistency and rigor in the scope, methodologies and publication of these reviews. Few are published in full, meaning that the information available is limited to executive summaries.

These reports are of interest to me in this study because they offer a window of insight into practice and, in particular, where it is necessary for practice to be improved. One of the stated purposes of SCR's, according to ADASS (2006), is to inform and improve local inter-agency practice. As stated previously, my unsystematic review of their contents drew my attention to some apparently recurrent themes. One of these themes was the findings and recommendations about the need to strengthen practitioner understanding of abuse and vulnerability. This urges a more systematic evaluation to examine the extent to which this was pervasive in the commentary of these texts. The more pervasive it is the more likely that the findings and recommendations may not be local and may have wider significance for the network of safeguarding practice. In order to understand the salience and import of the concept of vulnerability in adults safeguarding practice I undertook a thematic analysis of SCR reports to examine the extent to which it was a phenomena receiving commentary in these reports.

3.5.1.b. Data Collection

In February 2012 I searched the public websites of 54 County Councils, 33 London Borough Councils and 23 Metropolitan Councils in England & Wales to locate any adult safeguarding Serious Case Review (SCR) publications. On all occasions only executive summary reports of Serious Case Review

could be found. In total 39 SCR Executive Summary Reports were found published on these websites at this time. The distribution of these was as follows: 10 out of the 54 County Councils, one out of the 33 London Borough Councils, five out of the 25 Metropolitan Councils. Despite the limitations of the reports initial reading revealed that there were themes to be observed in the findings and recommendations.

In March 2013 a Freedom of Information (FOI) request (Appendix 10) was submitted to the same Councils for full and/or Executive Summaries for all SCRs undertaken in relation to Adult Protection/Adult Safeguarding cases from 2000 - 2012. The request included those Councils who had already published SCR Executive Summaries in case full reports would be made available or additional ones had been conducted but not published. Where Councils responded with a website link these were checked to determine if any additional SCR Executive Summaries had been added since the checks done in February 2012.

By November 2013 all but five of the Councils had responded and a total of 76 additional SCR Executive Summaries were made available providing a total of 115. However, only 114 were counted for analysis as one SCR Executive Summary report was duplicated in the sample as it related to a case that involved two London Boroughs who had both separately published the report.

In total 112 Councils in England & Wales were contacted, 29 reported that no SCR's had been conducted between 2000 - 2012, one stated that an SCR had been conducted but the report was not yet available, and nine Councils declined the FOI request and refused to share any information about their conduct of SCR's in adult safeguarding, often citing a need to fulfil their obligations under the Data Protection Act (DPA) 1998 to secure and protect personal and sensitive data from disclosure. Seven out of the nine refusals originated from London Borough Councils.

Even where further requests were made for redacted versions to overcome the DPA obstruction, these were declined, although one Council did state that even a redacted version would reveal personal and sensitive data breaching their obligations under the DPA.

No authority gave permission for disclosure of the full report, so only Executive Summaries could be obtained. These varied considerably in quality and quantity. The length of reports varied from four short paragraphs of two to three sentences each, providing little or no demographic case details, to comprehensive detail extending over 75 pages. This demonstrates that the publication of SCRs was not universal practice across Local Authorities in England & Wales and helps us to understand that the original purpose of SCRs was to undertake 'local' learning and presumably the imperative to disseminate the learning was also expected to be local. However, the publication on websites has

made these truncated reports available for external view. Whilst this serves the need for public accountability and transparency it creates an impetus for self-examination by other Local Authorities in a political climate of blame and scrutiny.

3.5.1.c. Data Analysis

A qualitative content analysis approach was adopted whereby each SCR Executive Summary report underwent triple layered reading. Firstly I read the redacted summary report and a summary sheet was completed whereby data was collected on case characteristics, conclusions and recommendations for each report. For the criteria for these summary reports please see Appendix 9. The demographic case details were entered onto a database and the data cleaned to support frequency analysis but without losing some of the case specific detail. For example, in the nature of abuse category 'died in hospital' was revised to 'death' but where the cause of death was known this was recorded as 'death – septicaemia'. The conclusions and recommendations were then read a second time to identify frequently occurring conclusions/recommendations or proxies of these. These were then numerated to suggest the strength of occurrence. In some reports the conclusions/recommendations were so specific to the particular case that they would only have achieved a frequency count of one, which has been interpreted as a poor indication of commonality and, therefore, discounted in the frequency counts. In the identification of frequently occurring conclusions/recommendations only those which achieved a frequency count of five or above were counted as first level themes upon which to base the second level of categorisation. Finally, these were read again to identify categories (see Appendices 10 & 11). Some conclusions/recommendations were counted in more than one category.

3.5.2. Focus Groups – Single Discipline

3.5.2.a. Rationale for Choice of Method

In order to explore the language of vulnerability used by practitioners and identify the characteristics used in their concept of vulnerability, semi-structured focus group discussions were the method of choice. Defined as an organised discussion a focus group is designed to obtain the perceptions of participants on a defined area of interest (Kitzinger 1994). The questioning relates to a defined topic and one with which participants are understood to be involved. The output can be greater than the sum of the parts as the process incorporates group interaction and influence as group members respond to each other's ideas and comments, which enables joint construction of meaning (Bryman 2012). This research method has gained popularity with researchers whose purpose is to examine

the ways in which people construe the topic which is the focus of the research and how they do so in conjunction with one another. It offers the opportunity to get beyond the general question and answer approach of individual interviews and allows for a probing of the how and why of participants' views, i.e. the reasons for holding a particular view (Morgan 1997). The advantages of this approach are that participants may reconsider their views in the light of the discussion and this can produce very interesting data. Multiple and contradictory views can be elicited and this can help to explain what lies behind apparently contradictory views. People may find it interesting and empowering to be involved in a focus group (Race, Hotch & Parker 1994). This feature of the research method resonates with the philosophical position of this research which seeks to reinforce the value of practitioner perspective in an area of practice that is dominated by policy dictate.

These were conducted as single discipline, by which I mean that the participants in the group all operated as professionals working with specific adult social care client populations. They were purposively sampled because they occupied job roles that required them to assess adults who may be at risk of abuse and make decisions about the need to conduct safeguarding enquiries and to take protective actions. These decisions involved assessing the adult's vulnerability in order to apply the eligibility criteria for safeguarding duties to be actioned. Focus group participants comprised of registered practitioners from health and social care working in community social care across the following disciplines – Learning Disability, Mental Health and Older Persons and Physical Disabilities Services. Participants shared a common discipline or client group although they had different professional backgrounds and qualifications. Two focus groups involved registered practitioners from health and social care working in community social care across all the aforementioned disciplines plus police officers working in specialist public protection services incorporating both children's and adult safeguarding, domestic abuse, missing persons and violent and sexual offenders.

Guidance suggests that a typical group size should be between six to ten members (Morgan 1998). However, where expressions of interest exceeded this number, these were not declined to mitigate against any persons who failed to attend on the day. This meant that some groups exceeded this number.

Single discipline groups were preferred as this more closely replicates the working milieu in which such judgements about an adult's vulnerability to abuse are formulated. Additionally, being amongst others with whom they share professional identity might support the social comfort of participants. However, due to the practical difficulties of arranging single discipline focus group discussions with Police Officers an opportunity of police availability was exploited during a training initiative which resulted in mixed agency focus group discussion.

In total eight focus group discussions lasting between 45 – 60 minutes were facilitated using a guided questioning schedule. A participant profile for the full study, including the focus groups is available in Appendix 2. This number of groups was not pre-determined and through discussion in supervision a decision to stop at eight was agreed as no new material was being generated and patterns in the content were beginning to become evident.

The role of the moderator or facilitator is an active one which seeks to guide the discussion. However, the emphasis is on facilitation rather than directing or leading. As such the facilitator gives up a certain amount of control to the group which enables the group interaction to develop the issues of most concern or saliency (Morgan 1988). My professional roles in relation to this area of research interest supported the study in several ways – credibility with participants, knowledge of and familiarity with practice context and skills in facilitating individual and group discussion. However, care was required not to lead the participants in their discussions of the perception of vulnerability so as to introduce features that are my insights rather than their own. Reflective journaling and discussion in supervision served as an external mechanism of accountability to observe for and mitigate against this.

3.5.2.b. Sampling and Data Collection

Participants were recruited to inform four different types of data, of which focus groups were one. Participants were not involved in all four research methods but they were recruited from the same populations.

Focus group participants were recruited via the safeguarding lead officers in Police, Adult Social Care Services and Mental Health Partnership Trust. These are persons with whom I had direct acquaintance through my work role as a multi-agency safeguarding adults training consultant. These persons all had a leadership role in safeguarding adults within their own agency and were able to provide me with links to operational managers and endorse staff involvement, promoting the research and staff involvement in it. I responded to their invitations to speak to managers and operational staff groups about the nature of the research to enable them to think about whether or not they wished to engage with any of the research activities individually or as a collective. Access to and selection of the participants can be a difficulty encountered for some research. In this study my local knowledge of and established working relationship with key personnel in all agency groups positively enabled access to research subjects across all agencies.

A research project brief was developed, explaining the purpose and process of the research, plus desired research subject profile (Appendix 5). This was circulated by e-mail to operational managers (provided to me by the adult safeguarding leads) of the relevant staff groups and voluntary participation sought from relevant practitioners. Participants were asked to make contact with me by telephone or e-mail and I provided a further information sheet and consent form to be returned by e-mail or post. Thought was given about how to deal with a greater number of respondents than the group number required. In the preparation of the information leaflet it was stated that focus group composition would be as the result of random selection and should not be viewed as rejection. This was an attempt to mitigate against any feelings of rejection experienced by the volunteer. Where slightly higher numbers expressed an interest this was tolerated in case people were unavailable to attend on the day or wished to drop out for some other reason.

Prior to participation in the focus group each participant received a written explanation of how the research will be conducted, what their role in it will be, how things will be reported, the agreement of confidence and any limitations to such confidentiality (Appendix 6). They were asked to sign a consent form (Appendix 7 & 8) and reminded at the start of any process that they were free to withdraw their consent at any point in the proceedings without question, offence or redress.

Team leaders in the various agencies and disciplines were then contacted to arrange a time to visit and discuss the study aims and participant expectations. A participant information sheet and focus group protocol was circulated to team members prior to this discussion session. A focus group time was negotiated locally with each group at a venue convenient to their workplace. Any staff member not wishing to participate was not required to attend, participation was by voluntary consent. Prior to starting the focus group discussion the study aims were explained again, and written consent to participation and audio recording obtained from each individual participant. The semi-structured focus group discussion was facilitated using a prepared question schedule.

Each focus group lasted between 60 - 90minutes duration, was recorded using a Livescribe Echo Smartpen (<https://www.livescribe.com/en-gb/smartpen/echo/>- accessed 25-11-17) to minimise the potentially obtrusive effects of recording equipment. This pen has the appearance of an ordinary writing pen and uses specially impregnated paper to link the written word to the audio recording enabling the researcher to touch the paper and receive real time playback from any point in the recording. "The **Livescribe** paper-based computing platform consists of a [digital pen](#), [digital paper](#), software applications, and developer tools. Central to the Livescribe platform is the *smartpen*, a

ballpoint pen with an embedded computer and digital audio recorder. When used with [Anoto digital paper](#), it records what it writes for later uploading to a computer, and synchronises those notes with any audio it has recorded. This allows users to replay portions of a recording by tapping on the notes they were taking at the time the recording was made. It is also possible to select which portion of a recording to replay by clicking on the relevant portion of a page on-screen, once it has been synced to the Livescribe Desktop software” – (<https://en.wikipedia.org/wiki/Livescribe> - [accessed 25-11-17](#)).

Table 2 describes participants’ profile in the focus group, separating the specialists by either male or female participants. Focus group participants from social care services were categorised according to the client population with which they predominantly worked (mental health, learning disabilities, or older persons and physical disability), gender, and status as either a generic practitioner for whom safeguarding adults is part but not the whole of their work role) or specialist (for whom safeguarding adults was the whole focus of their job role).

Police officers who participated in focus groups worked with all adult client group populations and were all working exclusively in Public Protection of Vulnerable Persons (Adults and Children). Gender was the only personal characteristic that was recorded and was representative of the typical distributions in services. Social Care has a predominantly female workforce and a similar gender profile is evident in Police Public Protection Units.

Table 3. Focus Group Participant Profile

	Male Adult Generic Worker	Female Adult Generic Worker	Male Specialist Safeguarding worker	Female Specialist Safeguarding worker	Total Discipline
MH	1	2	3	3	9
LD	3	12	1	0	16
OPPD	5	18	0	0	23
Police	0	0	3	7	10
Health	4	0	0	2	6
Total – generic vs Specialist	13	32	7	12	64/64

3.5.2.c. Data Analysis

As stated previously qualitative research strategies have a high regard for the importance of language and its relevance in analysis that concerns itself with meaning and interpretation in human interaction (Bryman 2012).

Originators of the GT approach Barney Glaser & Anselm Strauss (1967) assert that the aim is to generate a theory to explain what is central in the data and that accounts for a pattern of behaviour which is relevant and problematic for those involved. The task is to find a central core category which is both at a high level of abstraction and grounded in or derived from the data that has been collected and analysed. The first task is to find conceptual categories in the data. This is labelling the data in order to separate, compile and organise it (Charmaz 1983) achieved by a process of coding.

To draw conclusions or make observations relating to the whole will require identification of themes in the data – common domains, topics, issues that occur in the different accounts. The audio recordings of the interview and focus group were transcribed by the researcher.

Whilst time consuming, this transcription task proved invaluable. It helped me to familiarise and immerse myself in the data through recurrent listening and re-listening to the recordings. The benefits of this in terms of bringing me closer to the data and helping to kick start the identification of themes and seeing similarities and differences in the accounts within and between groups have been reported by other research students (Barnes, R in Bryman 2012).

Charmaz (2000) argues for a constructivist approach to GT which recognises the effect of bias and biography in the researcher's development of categories, concepts and theoretical analysis. She asserts that this is an iterative process which emerges from the researcher's interaction in the field and their questions about the data. Others have taken this idea further and celebrate the strengths of the insider researcher position.

Yates (2004) advocates that attending to this experiential data as valuable. He justifies this saying that inductively, hunches often come from personal experience with the phenomena and not just from theoretical appreciation of the prevailing literature. Deductively he asserts that success rests not only on the ability to think logically but the researcher who is able to locate their thinking within their own experience is able to think more effectively and propositionally. In consideration this allowed me to exploit my unique positioning as practitioner/educator and researcher, in relation to the practice concepts and the operators of those concepts.

Data analysis was performed through a process of open coding, where themes in the data are identified and given a code for later appraisal (Strauss & Corbin 1990). Data analysis began by reading through all transcripts from focus groups. While no codes were created during the initial read through, potential themes were noted. The transcripts and notes were then read through again, creating initial codes. During the final read through codes were refined and combined to highlight themes that were pervasive throughout the data. Using structure as outlined by Sheppard (2004) to judge a core category, the analysis searched for the main themes. These were judged as pervasive where they were frequently occurring across the data sets. NVivo 10, qualitative analysis software, was used to assist in the coding process. NVivo10 allows for the easy organisation of data and codes, and allowed the researcher to simultaneously consider codes across all data types.

3.5.3. Direct Observations

3.5.3.a. Rationale for Choice of Method

As part of the triangulation of methods in this mixed methods study direct observations of professionals engaged in work place decision making with regard to referrals for an adult

safeguarding response were undertaken. As Dewalt & Dewalt (2002) observe, participant observation supports a more holistic understanding of the phenomena under study. It is a living form of theory in which theory is developed **from** practice rather than developed in the abstract **about** practice. Direct observation within the usual surroundings of the professional evaluation of vulnerability and decision making enabled me to see as well as hear what was salient to professionals in assessing vulnerability. It provided opportunity for insight into the context in which their evaluation of vulnerability took place and to observe what contextual activities informed the formulation of their views. This added another layer to understanding what was most salient to professionals in assessing vulnerability to abuse. Using the natural setting of safeguarding professionals offers some mitigation against the kind of self-censure in reported conversations from focus groups.

The type or role of the observer can be seen on a continuum from complete participant – participant as observer – marginal participant – the observer as participant – complete observer.

My role was that of observer as participant because, due to my role and history in this Local Authority and Out Of Hours (OOH) Social Work Services, the position of marginal participant, i.e. passive but accepted participant, was not achievable. My work roles gave me prior acquaintance with many participants and it could be argued that my high visibility makes it impossible to be purely an observer. This was quickly confirmed during the pilot sessions when practitioners expressed difficulty and discomfort with silent and non-participatory observation by me as someone from whom they were used to seeking advice and guidance on practice. Furthermore, in terms of the methodology and data capture, it became evident that when practitioners were evaluating referrals their thought process was not available for observation. Consequently, I adapted and re-negotiated the protocol for observation, gaining participants' consent to articulate their analysis of vulnerability out loud during the course of referral management. This presented an increased risk of observer effects. To minimise this strategies of 'minimal interaction with the participants' and 'habituation' (prolonged exposure to desensitise the observed to the observer) were employed. As Adler & Adler (1994) note, this "peripheral membership role" enables the researcher to "observe and interact closely enough with members to establish an insider's identity without participating in those activities constituting the core of group membership".

3.5.3.b. Sampling and Data Collection

The working environments of social care, health and police personnel are generally closed to the public. Gaining entry, establishing rapport and familiarising oneself with the setting are necessary to promote observation (Bernard 1994). He recommends the use of personal contacts to ease entry.

In this study the direct observations were conducted at the Central Referral Unit (CRU) which hosts both children's and adults' safeguarding professionals from a number of agencies including children and adult social care, police, community health and probation. The latter two agencies were excluded from the observations as ethical approval had not been sought from their employing bodies. The environment was already familiar to me, having previously worked in the Emergency Duty Social Work Team and recently moved into the CRU as a Senior Operational Manager for Safeguarding Adults for the district teams. I had no management role within the CRU. Many staff in the OOH Service were previously known to me as peers. Many of the staff in the CRU (social care and police) were known to me as participants in the joint agency (Police and Social Work) training courses I had delivered in this Local Authority area.

In a similar way to the focus group participant recruitment strategy, participants were recruited via the safeguarding lead officers in Police and Adult Social Care Services. However, on this occasion I made direct approaches to the operational managers in the CRU (Detective Inspector for the police and CRU and the Social Work Service Manager for CRU and OOH). These are persons with whom I had direct acquaintance through past and present work roles. These two persons both had a leadership role in safeguarding adults within the multi-agency safeguarding hub and were able to provide me with direct access to their staff groups, endorsing and promoting their participation in the direct observations. I responded to their invitations to speak to operational staff, individually and collectively, about the nature of the research and, in particular, the nature of the direct observation, to enable them to consider whether or not they wished to engage.

A research project brief was shared with both managers, explaining the purpose and process of the research. This was then circulated by e-mail by them to operational staff inviting their voluntary participation. The site of the direct observations was a single office base hosting the multi-agency safeguarding hub and OOH Social Work Team so participants in the direct observations were recruited from this pool of staff. Participants were asked to make contact with me by telephone or e-mail and I provided a further information sheet and consent form to be returned by e-mail or post. An additional protocol (Appendix 11) was designed to be shared with potential participants that set out a code of conduct for the researcher as observer. This protocol made explicit that the demands

of operations were to be prioritised over the needs of the research and made explicit reference to the researcher's objective to gather their views rather than judge their practice.

“Participants will be reminded that it is not the role of the researcher to evaluate their practice but to record perceptions of vulnerability”.

The ethical demands of this research in terms of my obligations to the data subjects required consideration of the power dynamic between the observer and the observed, especially in light of my known roles as a practice educator and senior operational manager in this field of practice. I also have obligations to the employers and needed to be mindful of the time demands being made of participants who are public servants. Further consideration of ethical obligations will be explored later in this chapter.

Prior to participation in direct observation sessions each participant received written explanation of how the research will be conducted, what their role in it will be, how things will be reported, the agreement of confidence and any limitations to such confidentiality (Appendix 6). They were asked to sign a consent form (Appendix 7 & 8) and reminded at the start of any process that they were free to withdraw their consent at any point in the proceedings without question, offence or redress. Participants were registered professionals in social care working in specialist roles in adult safeguarding and police officers specialising in public protective services but not exclusively in adult safeguarding.

Table 4 below details the participant profile in the direct observations. Participants included social workers and police officers. Social workers were identified as working either as a specialist or a generic social worker. The three generic workers who participated in the direct observation sample worked for the OOH Service. These workers cover all client groups outside of working hours and, as such, are generic workers rather than specialist in contrast to the other seven social care workers who all had roles specialising in adult safeguarding. The police officers work shifts and would be consistent across the 24 hour period so both specialist and generic social care workers would be working alongside these officers.

Table 4 describes the direct observation participants, noting the participants' speciality and gender.

Table 4. Direct Observation Participant Profile

	Male Adult Generic Worker	Female Adult Generic Worker	Male Specialist Safeguarding worker	Female Specialist Safeguarding worker	Total Discipline
Social Care	0	3	2	5	10
Police	0	0	4	5	9
Total – generic vs Specialist	0	3	6	10	19/19

These observation sessions took place during the professionals' normal working hours and involved me sitting alongside practitioners for the duration of their shift lasting between eight – ten hours. They included some sessions outside of normal working hours (OOH). During these OOH sessions the police participants remained consistent whilst the OOH registered social care workers were drawn from generic rather than specialist social care roles. A participant profile is available at Appendix 14. Due to the open plan nature of the office environment the use of audio recording was neither practical or appropriate so field notes were taken at the time of the observation which related to the content of the referrals evaluated by the professionals, including any articulation of the adults vulnerability, inter and intra professional group discussion of the referrals, direct case discussion with the researcher (professional articulating their analysis of vulnerability out loud to the researcher), observation of ancillary activities, such as telephone contacts and database interrogation. Angrosino & DePerez (2000) describe this as 'selective observation'.

A total of 16 direct observation sessions were conducted over a nine month period extending from April - December 2015 and data saturation was achieved. A total of 107 case referrals/incidences were observed in this period.

3.5.3.c. Data Analysis

The data for analysis comprised of the colour coded field notes recorded in written format during the observation sessions. The data was categorised into four typologies as follows:-

1. Researcher's observations of reported rationale.
2. Observed discussion between professionals - intra and inter-agency.
3. Discussions between researcher and professional.
4. Researcher recording contextual activities, e.g. phone discussion, checking information systems, such as SWIFT and GENYSIS.

As with the focus group transcripts, data analysis was performed through a process of open coding, where themes in the data are identified and given a code for later appraisal (Strauss & Corbin 1990). Data analysis began by reading through all the field notes from direct observation sessions. While no codes were created during the initial read through, potential themes were noted. The transcripts and notes were then read through again, creating initial codes by marking the participants' exact words and using memos to comment on the reasons this might be of interest. The memos enabled me to explore how the ancillary activities related to the reported indicators of vulnerability and thus supported the professional's overall evaluation of vulnerability.

3.5.4. Semi-Structured Interviews

3.5.4.a. Rationale for Choice of Method

Bryman (2012) observes that definitions of participant observation and ethnography at times are difficult to distinguish. However, ethnography is often taken to refer to the written output of the research. This study does not assert to take an ethnographic approach but I would wish to acknowledge that the methods used in this GT approach share commonalities with ethnographic approaches. As Bryman (2012) sets out, ethnography can be taken to mean a research method in which participant observation is used in combination with interviews with the informants under observation as well as document analysis.

In order to understand the context of and influences on professional conceptualisation of vulnerability I needed to probe for further details using the data derived from the real world observations of these practitioners. Doing so would enable me to elicit these in a concrete way related to actual practice examples within the direct experience of the professional rather than some abstract retrospective assessment of the influences on their judgement and decision making. Whilst reactive effects of being observed might have dissipated through the duration of being

observed the interview also offers the professional a chance to balance the books and expand on the observations made of them to give further insight into their thinking and reasoning.

In the original planning of the research process and activity I identified a need to capture not just content but context of the practitioner's recognition and response to vulnerability in AAR. This was to be captured through just in time brief interviews based on cases selected during the observations where there had been a decision to progress to further safeguarding enquiries, therefore, confirming that the individual and their circumstance met the eligibility criteria to progress further enquiries. However, during the pilot sessions it was recognised that this was not practically or ethically achievable in the context of a busy duty response to new and urgent safeguarding referrals. Further re-negotiation was required with participants and individuals who had been involved in the direct observation sessions to participate in further interviews. These interviews adopted a similar semi-structured approach as the focus group discussions (see Appendix 3) and case details from the field notes were collated for each interviewee to prompt discussion regarding their observed practice.

In a way similar to focus groups the qualitative interview can be inductive as it seeks meaning though interpretation and context. In analysis the use of coding enables the identification of themes. However, in order to ensure that discussion remained focused on the areas of interest in this study, a semi-structured interview was adopted. This has the advantage that the interviewer has developed an interview guide whereby questions are clustered in relation to key topics or themes but the respondent has a high degree of freedom in their responses in contrast to the more formulaic survey techniques which provide the respondent with a number of forced choices. This also assists in organising the data for later coding and analysis. Semi-structured interviews have been the instrument of choice by other researchers concerned with the perceptions of staff in relation to safeguarding adults work including beliefs about vulnerability (Taylor & Dodd 2003) but these have yielded broad perceptions of most vulnerable groups rather than factors that delineate vulnerability.

Interviews are useful for constructing the meaning of a phenomenon from a variety of perspectives. My interest is in how individuals interpret or construct something. In this study I was also interested in what influenced this construct. Participants discuss their unique perspectives to enable them to construct their own meanings of the phenomena under investigation. McNiff (2002) argues for the need for dialectical forms of theory in understanding practice – positivist approaches see truth as one unified story. However, human stories are rarely one unified story told by one person who knows, but an accumulation of multiple stories, told by the people themselves, who share different

views, hopes and visions (Berlin 1998). Interviews offer access to these individual and collective stories of practice.

In this study, the semi-structured interviews with practitioners served to elicit more detailed descriptions from the professionals otherwise not available during direct observations. Professionals were reminded of their direct case work from the field work notes as a prompt to help elicit further detail about the features attended to by the professional in determining the individual's vulnerability to exploitation.

3.5.4.b. Sampling and Data Collection

Many researchers using interviews as their instrument of choice recommend the application of purposive sampling in order to establish a good correspondence between the research question and the research sample. Interview participants were identified from the pool of practitioners who had participated in the direct observations in the CRU. The working environment of the CRU is typical of the Multi-Agency Safeguarding Hubs that have been adopted in many Local Authority areas.

Each participant was contacted by e-mail, reminded of their original consent to participation and right to withdraw consent. They were sent a copy of the interview protocol and given an explanation of the change in arrangements for interview as it had not been possible to obtain details of their thinking about referral decision making in real time. Participants who indicated consent to participate in the interviews were then contacted to arrange an interview with them at a time of their convenience and at their place of work.

Prior to participation in interview each participant received written explanation of how the research will be conducted, what their role in it will be, how things will be reported, the agreement of confidence and any limitations to such confidentiality (Appendix 6). They were asked to sign a consent form (Appendix 7 & 8) and reminded at the start of any process that they were free to withdraw their consent at any point in the proceedings without question, offence or redress. Interviews were conducted in rooms where audio recording could be facilitated using the same recording equipment used in the focus groups (Livescribe Echosmartpen). Each semi-structured interview lasted variably between 30 - 60 minutes and was facilitated using a semi-structured questioning schedule similar to that used with the focus groups.

The theoretical sampling approach recommends as many interviews as it takes to reach theoretical saturation or until there are no new themes emerging from interview. The number of interviews possible in this study was prescribed by the population of participants in the direct observation

sessions. Interviews were conducted with five out of 10 social care participants and five out of nine Police Officers. Further interviews were not conducted with the remaining available participants as analysis indicated that no new themes in the data were emerging.

All participants in the interviews were full time specialists in safeguarding adults practice. These participants worked either as social workers or police officers. Nine participants worked full time in the CRU and one participant worked full time in a specialist adult safeguarding role and provided professional cover in CRU. Table 5 describes interview participants. Participants were identified as being male or female, and whether they were a generic social worker or a social worker specialising in safeguarding work.

Table 5. Interview Participant Profile

	Male Adult Generic Worker	Female Adult Generic Worker	Male Specialist Safeguarding worker	Female Specialist Safeguarding worker	Total Discipline
Social Care	0	0	1	4	5
Police	0	0	2	3	5
Total	0	0	3	7	10/10

The audio recordings of the interview were transcribed by the researcher. I refer the reader to the costs and benefits of this reported in relation to the focus group data.

3.5.4.c. Data Analysis

As with the focus group transcripts, data analysis was performed through a process of open coding, where themes in the data are identified and given a code for later appraisal (Strauss & Corbin 1990). Data analysis began by reading through all the interview transcripts. While no codes were created during the initial read through, potential themes were noted. The transcripts and notes were then read through again, creating initial codes by marking the participant’s exact words and using memos to comment on the reasons this might be of interest.

3.5.5. Document Analysis – Written Referral and Decision Making Records

3.5.5.a. Rationale for Choice of Method

The final method used to explore professional conceptualisation of vulnerability was the casework record or written record of decision about the evaluation of the referral information to determine whether or not a statutory duty to make safeguarding enquiries regarding the adult existed and what the agency response would be. The data derived from the focus groups, interviews and direct observations provided access to a rich description of what professionals say they do which could be referenced against what I saw them doing to identify the frequently recurring themes in the data. The written record of decision making is an instrument of recording which should capture the professional's articulation of vulnerability and provide further triangulation of any emergent themes. It would also be free from any influence by the researcher unlike the other methods, but the written record must be recognised as only a partial representation of the professional's conceptualisation at the time the record is made. As a practitioner in the field and having made many such written recordings myself, I am aware of the context in which the records are made. Records cannot be assumed to be either contemporaneous or to have been completed in 'real time'. It is not uncommon for written records to be compiled after some time has elapsed between the active evaluation and decision making. In working environments when professionals may have multiple competing demands and time pressure on task completion it would be tempting to think that their written records represent an insight into the most salient features of their analysis but this cannot be presumed.

However, these documents did represent the final part in the triangle of sources sequencing information from what professionals **say** about vulnerability, what I **saw** them take into consideration when assessing vulnerability to abuse and then finally what did they **write/record** about their understanding of the person's vulnerability in deciding whether further safeguarding enquiries were warranted or not.

Underpinning the rationale for this mixed methods approach was a desire to improve the validity of the research and the findings. Creswell & Miller (2000) describe validity in terms such as trustworthiness, authenticity, and credibility. Creswell (2009) recommends using more than one strategy of which the following were employed in this study:-

1. Triangulation – converging different data sources.
2. Use of thick description to add context to the finding to enhance their realism.

3. Clarifying bias – through reflection on researcher’s own role and how their personal characteristics (history, experience, gender etc.) have influenced the interpretations.

Triangulation refers to the use of more than one investigative approach to a research question. Denzin (1970) describes four types of triangulation but the one employed in this study was *Methodological Triangulation*, which put simply is gathering data by more than one method.

The concept of triangulation has been of influence in the growing popularity of mixed methods research in applied social sciences. The strength of the approach is said to lie in the enhanced reliability of the findings where convergence is achieved across methods or data collection. Examples of these are evident in adult protection research, more latterly in reports of the Brunel study on developing decision training tools to detect and prevent elder financial abuse (Gilhooly et al 2008).

3.5.5.b. Sampling and Data Collection

Direct approaches were made to the performance/data management officers of both adults social care teams and the constabulary already known to me. These officers have access to large databases of casework activity which can be linked to individual professionals, geographic areas within the authority (including the CRU,) and to particular adult disciplines in the case of social services - Learning Disability, Mental Health and Older Persons and Physical Disabilities. These officers were requested to generate lists of 25 randomly selected cases where professional involvement had been started and finished between October 2014 and September 2015. This end date was chosen as the safeguarding referral form up to this date included a section which prompts the professional to write an evaluation of the adult’s ‘vulnerability’. The Social Services’ Data Performance Officers was asked to add additional filters in their searches to ensure that within each discipline the case lists had a spread of cases across geographic teams, and individual social workers. Similarly, to avoid oversampling a particular police officer a request was made to select cases for each of the police officers currently operating out of the CRU. This approach sought to protect against any bias in case selection and improve the representativeness of the written records provided for content analysis.

Using these case lists and the unique identifiers assigned to each client record, contact was made by e-mail with the Safeguarding Co-ordinators for each area and discipline with a request to provide me with access to the full written record of the initial evaluation and decision making – also known as the safeguarding alert and referral form. Copies of these records were stored in a folder on my work area as an employee of Social Services in that authority to avoid any potential data breach by

transmission of these documents outside the Local Authority. Excerpts from these full client records in relation to the professional's evaluation of vulnerability were pasted into a Word document where all identifiable information had been removed. This document then formed the basis of the data for content analysis. In relation to the police, the data management officer undertook this anonymising exercise before sending me a document in which police officers' decision making log on safeguarding vulnerable adult referrals had been compiled using extracts from the police information and record system. Whilst individual officers were identifiable in relation to the decisions made any personally identifiable information relating to victims, suspect and witnesses had been removed.

Requesting information on cases that were complete ensured that the written record of decision making should be populated. The profile of participants included in the written record sampling is available at Appendix 4. A total of 98 written records of decision making in relation to persons referred for a safeguarding evaluation and response were analysed.

3.5.5.c. Data Analysis

I have elucidated the process of coding in relation to the transcript outcomes of the focus groups, interviews and direct observation field notes elsewhere in the chapter so will not repeat that here. The compilations of written records of evaluation and decision making regarding vulnerability in responding to safeguarding adults referrals by both police and social services were added to the transcripts and notes detailed above in the performance of this qualitative content analysis across all four data sources simultaneously in order to highlight the themes that were most pervasive and improve the validity of the findings.

Validity is defined as the strength of our conclusions, the extent to which the researcher can make justifiable inferences, legitimacy (Cresswell 2003). There are different types of validity and some measures of validity might be more appropriate to qualitative methods. One such type is external validity which refers to the ability to generalise the results of a study to other settings.

Guba and Lincoln (1994) in Bryman (2012) propose the following as criteria for assessing qualitative research:-

- Credibility.
- Trustworthiness.

There are 2 primary ways to achieve this – respondent validation and **triangulation**.

Bryman describes research as being credible where it has been carried out according to principles of good practice and has face value acceptance by the persons who were the subject of study, i.e. it makes sense to them and accurately reflects their understanding of the world.

3.6. Ethical Considerations

Considering the consequences of one's actions upon others, individually and collectively, is the responsibility of all social researchers. As a practitioner in the field of social work I am familiar with the need for accountability in public services dealing with human activity and have lived through a period of increasing scrutiny through regulation, serious case review, the operations of the Parliamentary Ombudsman and media attention focused on public services including police, health and social care practice. More recently, we have witnessed an increasing concern to ensure that research is conducted in compliance with any lawful requirements. Especially important has been the Human Rights Act (1999), Article 8. *The right to private and family life*.

The Social Research Association (2003), which produced ethical guidelines, recommends a framework of principles to enable individual researchers to consider the ethical issues pertaining to their specific project within a wider system of shared values. There are a number of key phrases which require further attention and I will elaborate each of these in relation to this study.

Voluntary participation which requires that people not be coerced into participating in research. Closely related to the notion of voluntary participation is the requirement of ***informed consent***. Essentially, this means that prospective research participants must be fully informed about the procedures and risks involved in research and must give their consent to participate.

Ethical standards require that participants are not put in a situation where they might be at ***risk of harm*** (physical or psychological) as a result of their participation.

There are two standards that are applied in order to help protect the privacy of research participants - ***confidentiality*** - they are assured that identifying information will not be made available to anyone who is not directly involved in the study. Many researchers prefer the stricter standard of ***anonymity***. In this study the use of unique identifiers ensured that individuals were not identifiable in the data. Identification was limited to job role and number, e.g. Police Officer 4. The assignment of identifiers to the named participants was stored separately and known only to myself.

3.6.1. Obligations to Subjects, and their Employers

The subjects of this study were professionally qualified public sector workers. It is not anticipated that there would be any predictable issues in respect of individual mental capacity to give consent, and none were encountered. Voluntary consent to participation in this study was sought and participants were reminded of their right to withdraw consent at any point throughout each phase of the research. This study was independently funded and not resourced from any of the participants' employing agencies.

To ensure that the consent given was informed consent, participants were given an information sheet explaining the purpose of the study, how it would be carried out, what their role in it would be, how data would be collected and stored (see section on confidentiality later) and how and to whom the outcomes of the research would be disseminated (Appendix 6).

It is impossible for social research to be completely value free. Most participants had previous acquaintance with me in my professional role as the multi-agency safeguarding adults training consultant. The congruence of this role in enabling practice development potentially lent credibility to assertions of the research aim to elicit practitioner perspectives. The power of being listened to cannot be under-estimated, especially when placed against a backdrop of practice evaluations, such as SCRs, which highlight the failings of practitioners but rarely give voice to their views and a research norm of survey techniques aimed at testing practitioner decision making. The balance of power between researcher and researched has to be considered in the overall research design and the interpretation of the outcomes of research. As a researcher with a proven practice background in safeguarding adults practice and an established role in learning and development for all the professional groups engaged in this work, I aimed to redress the usual in-balance between observer and observed by giving voice to the voiceless. As an informed observer, sharing characteristics of the observed group, my status may promote trust and assurance.

However, as a researcher there is an obligation upon me to ensure that participants in the study come to no harm. In this case, how the findings are reported will be of critical importance. Practitioners may have some anxiety that their views will be reported back to employers or that errors of judgement will be individually identifiable. The issue of confidentiality is of particular importance in this study as the sampling was purposive and limited to two Local Authority areas. It was likely that practitioners and their employing agencies will be invested in protecting their individual, professional group, and agency integrity. This research was independently funded and consequently I was under no funding contract with the employers of the participants. However, it

must be acknowledged that at the commencement of this study my full time role in which I was engaged was funded by the multi-agency SVA Board, which includes employers of the participants such as police, health and social care. I, therefore, have a twofold responsibility to uphold professional integrity in the conduct of this research and my own employment status and reputation. In securing any co-operation approval from the employing agencies to conduct this research by access to their paid staff I outlined the plans for dissemination so that all parties were clear on what they were giving consent to, for the reporting of findings. Confidentiality was assured to all participants with regard to the reporting of any data gathered and any quotes used did not contain personally identifiable features. The aforementioned is notwithstanding my lawful and professional obligations in relation to the reporting of abuse of an adult or child, prevention or detection of a crime, including maladministration or misfeasance. In such circumstances, it was agreed consultation with my supervisor would be sought to agree the next steps. Permission was sought from participants to assign quotes to their professional grouping, e.g. 'one police officer commented that.....'. As stated previously, complete anonymity could not be guaranteed as the study is limited to two Local Authority areas. However, all attempts have been made to anonymise the data reported. Data collected in this study falls in to the category of 'personal' rather than 'personal and sensitive' data and was processed according to the principles of the Data Protection Act (1998). The data was stored on a University hard drive and an encrypted personal laptop computer. It is not required beyond the period for completion for the PhD. Assurance of data destruction has been given as part of ethical approval by the University.

3.7. Concluding Remarks

In this chapter I have set out the influence of reflexivity in the development of the research problem and question and set the scene for this project. The research question is identified and the research strategy is discussed with further detail of the rationale for the choice of particular methods included in the overall mixed methods approach. Mechanisms of data collection and analysis are described. It finishes with an outline of the key ethical considerations undertaken and underpinning the project. In the design of this GT approach to the research project I have drawn upon a framework proposed by Yardley (2000) as a guide to quality and fitness for purpose:-

- Sensitivity to context, social, theoretical and ethical.
- Commitment and rigour, to the subject matter and good practice in research.
- Transparency and coherence, in the arguments articulated.
- Impact and importance, to theory and practice.

Chapter 4

Serious Case Reviews – Universal Truths?

4.1. Introduction

This chapter starts by exploring the status of SCRs as a mechanism for learning lessons and the critiques of this in recent years. I then report some of the themes arising from the analysis of findings and recommendations of SCRs. Amongst these SCRs is an inferred criticism of practitioner understanding of abuse and vulnerability. These suggest that their understanding lacks depth and breadth and thus requires strengthening. This is set alongside commentary by Brown (2003) who promoted the need to develop more nuanced definitions of abuse and vulnerability. The chapter moves on to report empirical work undertaken in the analysis of SCR's, identifying the areas studied and the gaps. It provides a descriptive analysis of some of the demographic characteristics. The imperfections and inconsistencies in data collection across SCRs highlight the precarious nature of the outcomes of this process as vehicles for learning. Despite this, and the critique of others (Manthorpe & Martineau 2011, Warner 2006) their value for learning is consistently promoted by Central Government (DH 2017) and significant professional groups (ADASS 2005).

Serious Case Reviews (SCRs) occupy a status and gravitas in practice which imputes significance to the wider safeguarding audience, and urges a need for learning from these adverse outcomes. The recommendations represent a view of what practice ought to look like to avoid future bad outcomes. They are important to examine as collectively they provide an insight into perceived areas for improvement. In this chapter the findings and recommendations are explored to identify recurrent themes. It is argued that whilst themes relating to the recognition of abuse and vulnerability can be identified, what these texts do not provide is the details of what is missing from their recognition of vulnerability, nor how this relates to professional responses to it and the factors which have a bearing on responses. Consequently, the insights they offer are partial.

This chapter reports on the findings from a thematic analysis of findings and recommendations from 114 Executive Summary reports of SCRs, the largest sample of reports undertaken in the UK at the time of this study. These are a precis of the full reports of these reviews. They provide an insight into practice in safeguarding adults where failures are believed to have occurred. Their value as instruments of learning is promoted. An exhortation to SABs to disseminate learning contained in

the Care Act 2014 Guidance (DH 2017) advances the idea that the learning can be extended beyond the local context of the event and be applicable to the wider safeguarding community.

The impetus for this study derived from a personal observation of apparent repetition of themes from a selection of SCR reports, read in the preparation of safeguarding training materials. The inferred criticism of practice aroused my curiosity about how professionals conceptualised 'vulnerability' in adults at risk of abuse and what informs their responses to this.

The analysis of findings and recommendations of SCRs in this study confirmed that there was a recurrent theme which recommended a need to strengthen practitioners' understanding of abuse and vulnerability. It constituted the origins of the research problem and forms the background to the next two chapters, in which I argue that the findings which infer that failures relate to errors of judgement and practice, thereby requiring remedial action, are not borne out from evaluations of practice in the field.

4.2. What have we Learnt – Serious Case Reviews as Legitimate Mechanisms for Learning Lessons beyond the Local Context?

The status of SCRs in adult safeguarding has undergone transformation during the course of this study. Initially, in contrast to Child Protection Guidance in Part 8 of the Working Together documents (DfES 2010, 2013), the framework for vulnerable adults set out in the Department of Health's 'No Secrets' (2000) guidance, made no reference to mechanisms for reviewing cases of particular concern. However, ADASS (2005) asserted this as a measure of good practice and advocated it as a vehicle for promoting learning through the dissemination of findings from inquiries. In the last couple of years the implementation of the Care Act 2014 changed the status of the SCR, giving it a statutory footing. Section 44 makes the undertaking of the newly named Safeguarding Adult Reviews (SARs) a duty upon Safeguarding Adults Boards (SAB). A SAB must arrange for a review of a case where an adult has died or experienced serious abuse or neglect *and* the death is known or believed to have resulted from abuse or neglect *and* there is reasonable cause for concern about how the SAB or members of it or other persons with relevant functions worked together to safeguard the adult. Co-operation is demanded to serve the aims of identifying the lessons to be learned and applying those to future cases.

During the timeframe for this study the SCR Executive Summary reports sampled relate to a period when the statutory obligations referred to above were not in operation. Consequently, SCRs have

been conducted using different formats and protocols. As Walsh (2002) points out, one of the stated aims of inquiries is to facilitate organisational learning at different levels. Originally intended to operate as internal reviews to inform local policy, procedure and practice, these reviews and subsequent reports have gathered gravitas as documents of collective worth in recent years. Despite the inherent focus on failures, the expectation is that these inquiries will offer insights that can be of use across the whole field of safeguarding adults whilst other lessons will be directed towards specific agencies and areas of practice. This thinking has been reinforced by the Department of Health as recently as 2017 when it commissioned SCIE and RIPfA to improve the quality and use of SARs, which included making the learning from them accessible through a national library.

SCR reports across Local Authorities in England & Wales represent a significant body of literature and as vehicles of learning for organisations. As Cambridge & Parkes (2004) assert, if inquiries are robust in their design, they can generate findings that are reliable and transferable. The relative import given to these documents has been remarked upon by Warner (2006) in relation to children's services and mental health services. She notes the intertextual effect between these reports and subsequent policy and draws attention to the political pressure on practice which arises from the production of these reports and media accounts. In reflecting upon her study of mental health social workers Warner reports:-

"... practitioners did not all have to read the report of a major inquiry into homicide in order for it to directly organise and co-ordinate their practice particularly in terms of managing their fear of being personally involved in an inquiry themselves". (Warner 2015, p. 116)

Her observations testify to the ripple effects on practice from these reviews and reports.

All this seems to urge learning as an imperative. However, there is a growing body of literature which has begun to challenge their effectiveness as instruments of learning. In promoting the development of a systems approach to case review Munro (2011) identified the role of hindsight bias in distorting judgement about the predictability of certain events. As Macdonald & Macdonald (1999) argue, the hindsight fallacy serves to make the sequence of events leading to an adverse outcome appear predictable when, in fact, the context of risk decisions and actions are considered decisions thought to be optimal at the time of taking but at some point become sub-optimal. This being the case, they suggest that a bad outcome in and of itself is not evidence of erroneous

decision making. However, as Munro has suggested the operation of hindsight bias in SCRs has led to a tendency towards human error becoming the explanation for bad outcomes.

4.3 Serious Case Review – Thematic Analysis – Commentary

The findings of this thematic analysis of the conclusions and recommendations of adult safeguarding SCR reports concur with the observations of previous authors in relation to the fragmented nature of the data collected. Manthorpe (2013) cautions us not to see SCRs as presenting the whole picture. However, in the thematic analysis of this study the understanding of vulnerability emerged as a recurrent theme.

The initial reading of SCR summary reports identified recurrent commentary on the need to strengthen practitioners' recognition and response to abuse and vulnerability.

The relationship between identifying a person's vulnerability and their being at risk of abuse is commented on in these reviews. They suggest a lack of clarity exists in relation to what constitutes vulnerability as, despite the presence of some clues, the adult was not identified as being such. For example:-

“Recommendation 7.2.3 Safeguarding Adults Board to raise with partners the continuing need for clear risk criteria and thresholds with respect to safeguarding vulnerable adults corresponding to those for the protection of children.

*The report identifies that Adult A's case once again illustrates the need for clearer guidance of what comprises vulnerability. Despite all the clues and markers – learning difficulties, poor mental health, chronic physical ill health, hard to reach - easy to overlook and missed appointments – none of the agencies in this case saw Adult A as vulnerable or alerted partners. **This failure to recognise vulnerability continues to pose a significant threat to effective safeguarding of vulnerable people**”. North Tyneside (2011)*

Other reports have urged for review of existing definitions of vulnerability, questioning whether the existing definitions, clearly hinged to eligibility criteria, are inclusive enough. This seems to be especially true in cases where the adults at risk don't quite reach the qualifying criteria for a service or, in fact, refuse services that are offered. They identify a need to take into account the individual's context/circumstances as well as individual characteristics of vulnerability which might more readily

identify them as eligible for services. In Rutland & Leicester the SCR Panel embraces the guidance available from 'No Secrets' (2000) but asserts that still more needs to be done.

*"Conclusions - 3.10 Such guidance is valuable, **but those involved need to be able to recognise vulnerability in the first place.** When vulnerability is recognised, support then requires effective collaboration between agencies. This is a developing area nationally for agencies.*

"Recommendations Relating to all Agencies:-

4.11 It was the view of the Serious Case Review Panel that A focus on individual or family vulnerability, regardless of eligibility or presenting need for specific care services, would be more likely to lead to a multi-agency safeguarding response.

4.12 The Panel therefore recommends that:-

The Safeguarding Adults Board should initiate a policy review, to establish whether current definitions of vulnerability are inclusive enough and whether current procedures are sufficiently well developed to enable effective responses to individuals or families subject to significant community pressures". Rutland & Leicestershire (2008)

The above quote illustrates a view that failures in recognition rest in the lack of definitional clarity in the guidance documents available to staff. Recognition of vulnerability is referred to in several reports as the pre-cursor to action or response. For example, Dudley (2010):-

*"Recommendation 5 – Identifying someone as vulnerable. Individual agency reports have highlighted clearly that their **staff did not always recognise BD as a vulnerable person and, therefore, did not take action to address that vulnerability**".*

However, unlike Rutland & Leicestershire, in this report the lack of recognition is attributed to poor staff understanding which can be inferred from the recommendation that staff should be identified for training:-

"..... agencies identify which of their staff need to be able to recognise if a person might be vulnerable and what action they should take to respond to this. Safeguarding Board

*members need to produce agency plans that **ensure all staff who need to have this training are identified....***" (Dudley 2010)

The view that recognition is a matter of staff understanding and performance is re-enforced in other reports. The quote below from a report in Bury (2009) suggests that the need for knowledge and skill in this area of practice amongst staff groups is widespread.

*"Recommendation 5.2.3. **Ensure that knowledge and skills now being developed by call handling staff in the recognition, assessment of and response to vulnerable victims becomes firmly embedded in the practice of all officers and staff.** This should include assistance and support in managing the expectations of vulnerable citizens and helping to facilitate their integration into local communities as well as improving their safety and sense of security".* Bury (2009)

These excerpts from my initial reading of the SCR executive summaries appear to suggest that they regard the recognition of vulnerability in adults at risk of abuse by professionals as problematic. It is not clear how pervasive a problem it is and the causation of this problem is variously located by these SCR summary reports, in policy and professional knowledge/understanding. In order to understand the pervasiveness of the problem a thematic analysis of the findings and recommendations of SCRs was undertaken and is reported in the next section.

4.4. Serious Case Reviews - Thematic Analysis of the Conclusions and Recommendations

Findings from this analysis indicated that the recognition and response to vulnerability by professionals emerged as a significant theme making it worthy of further research attention. It led to further work being undertaken in this study to explore if the findings from the SCR summaries are replicated in practice where such failings have not been identified and scrutinised. The outcomes of those research activities form the basis of subsequent findings chapters.

The problem of recognising and responding to vulnerability was categorised as a theme occurring in 20% of the sampled reports. This was often associated with circumstances where an adult was self-neglecting or had refused services, and was often characterised by inconsistencies across professionals in the identification of vulnerability in the adult at risk. The problem of inconsistency in recognising vulnerability was a characteristic also identified in other themes that were identified

in the reports and was associated with poorly co-ordinated assessments, including risk assessment, poor application of policy and poor implementation of the principle of the Mental Capacity Act. Overall, problems in consistent identification of VULNERABILITY was a theme that occurred across four out of the five categories of conclusions. Other commentators (Brown 2003, Action on Elder Abuse 2004) have criticised the imprecise and poorly defined concepts of abuse and vulnerability in adult safeguarding work.

An atmosphere of anxiety prevails in practice where many practitioners voice a fear of their casework ever being the subject of an SCR. I would argue that these findings relating to failures in safeguarding practice are not necessarily representative of practice and thus, whilst the learning from them may be of universal significance, this is not necessarily because the failures are replicated universally in the practice population.

Inadequate recognition and response to vulnerability, especially in adults who were difficult to engage or refused services, was found to be a recurrent theme across the summary reports. Five themes of varying strength were identified. The themes are presented below:-

1. Poorly co-ordinated assessment across agencies (including risk assessment and determination of mental capacity).
2. Inadequate information sharing and recording practices.
3. Inconsistencies in understanding and application of concepts in SVA policy.
4. Ineffective application of the principles of the Mental Capacity Act.
5. Vulnerability inadequately recognised and responded to especially in circumstances of service refusal and self-neglect.

Further details of the analysis of SCR summary report conclusions can be found in Appendix 13.

Reported problems in the consistency of identifying vulnerability emerged as a theme, particularly in relation to people who refused services or were thought to be self-neglecting. It was also seen as a problem in relation to many of the other main themes, including ineffective understanding and

application of safeguarding policies, the principles of the Mental Capacity Act and co-ordinated cross agency assessment, including risk assessment.

Categories 1, 2 and 5 bear some similarities to the following issues in reports identified by Manthorpe & Martineau (2011) in their analysis of 22 SCR reports – namely, inter-agency communication, no lead agency, threshold issues.

The analysis of the recommendations produced the following themes:-

- Providing for staff training and developing competence.
- Reviewing and improving policy, procedure and guidance.
- Facilitating information sharing and communication within and across agencies.
- Developing effective governance systems.
- Holistic multi-agency assessment, planning, monitoring and review.
- Develop dynamic risk assessment and risk management by assertive outreach to vulnerable adults.
- Engaging with a wide range of agencies and interests in Safeguarding Vulnerable Adults.

The first two categories give an indication of where the principal actions for improvement are perceived to lie. Staff training and competence will need to be related to policy and guidance where the confusing definitions of vulnerability have been criticised. These categories show a strong resemblance/congruity to those identified by Clay et al (2014) in his analysis of 41 SCR reports. This is important because the triangulation of findings between independently conducted analyses improves the credibility of these findings.

The primary purpose of an SCR is to learn lessons. If SCRs are to make an effective contribution to improved safeguarding practice this is most likely to be achieved when the learning can form part of the universal experience for all safeguarding practitioners. The perceived status of SCRs as mechanisms for learning with universal application creates pressure on all professionals and

agencies to learn in order not to repeat the mistakes. As Warner (2015) has commented, workers do not even have to have read a SCR report to feel the effects of it in shaping their work.

In the thematic analyses of the conclusions and recommendations of the reports clusters could be identified and categorised. Perhaps of greater interest and relevance is that the commonalities and the lack of variation of theme between this analysis and that of Clay (2014) indicated that these are not changing remarkably over time. This recurrence of themes from SCRs has been commented on previously (Aylett 2008) as an indicator of our inability to learn from them. Clay makes a further separation of the themes in the recommendations, identifying them as either operational or strategic. The recommendations are typically bureaucratic and, as such, may represent a limited pick list of responses available to organisations in bringing about change. However, they also seem to suggest that professionals are not tuned in to vulnerability. This study seeks to explore if this appears to be the case in practice.

4.5. Serious Case Review – Thematic Analysis – Case Report Demographics

In their analysis of the adult protection referrals in two English Local Authorities, Cambridge et al (2011) found that almost half of the referrals (46%) were for people in residential or supported living compared to just under a third (32%) for people living with a family. Assuming the proportions relating to perpetrator characteristics reported by Cambridge et al are not untypical of wider patterns in Local Authority referrals, the data from the SCR reports generally mirrors this pattern.

Conversely, the UK prevalence study (O’Keefe et al 2007) reported that women were three times more likely to report abuse as victims than men. This contrasts markedly with the gender profile of the victims referenced in the SCR reports examined, in which men and women victims were equally represented. This evidence suggests that particular victim characteristics, such as gender, might be influencing referral to SCR and that male victims might be over-represented in such referrals. It is also conceivable that service responses are poorer for men thus leading to outcomes that make an SCR more likely.

A similar difference between general referral profile and SCR reports profile can be observed in relation to location of abuse. In contrast to the figures from Cambridge et al (2011), stated above, in 101 SCR reports 45 (45%) referenced the location of abuse as ‘own home’ and 38 (37%) as

residential/nursing care home'. This might suggest that circumstances which generate a need for review are more frequently associated with abuse that takes place behind closed doors.

It is also evident that in almost half of the SCR reports examined (54 cases, 60%) the victim was referenced as having some form of mental disorder, and of this cohort (26 cases, 23%) referenced a specific mental illness. This is surprisingly high given the wider evidence on the under-reporting of abuse in mental health services (Brown & Keating 1998, Williams & Keating 2000). Such evidence suggests that mental disorder might also influence referral to SCR and that people with mental health problems might be over represented as subjects of these reviews considering the wider evidence of the under-representation of mental health in mainstream adult protection referrals. It is not possible to say with any certainty what explains this but it is noticeable that people who refuse services are a prominent group amongst the subjects of SCRs. The scarcity of resource in mental health services and the inefficient use of these have been remarked upon by others (Saxena, Thornicroft, Knapp & Whiteford 2007). Add to this the effects of stigma which constrain individual access to the available resource and it is possible to speculate about a correlational relationship between a high proportion of people with mental health needs as subject of SCRs and the availability of resource to recognise and respond to their vulnerability when at risk of abuse.

It is interesting to note what is reported about case characteristics and what is omitted. In respect of professional recognition of vulnerability it may offer some insights into any signs of vulnerability located in either the innate qualities of the adults at risk, the context in which they are abused (or find themselves vulnerable) and the character or condition of those who have abused which are associated with cases of failure. In other words, are there signs of vulnerability that these cases indicate which are overlooked or under attended to, such that they represent recurrent patterns or signs of vulnerability which are not recognised or responded to by professionals?

Whilst the lack of consistency in reports makes analysis to support learning and practice development challenging (Braye et al 2011, Manthorpe & Martineau 2013) they nonetheless shed some light on our understanding in safeguarding practice. I wanted to examine if the SCR summaries reported particular characteristics of vulnerability which they claim or imply were being overlooked or under-attended to by practitioners – routinely or otherwise.

Or, as with the findings of Braye et al (2015) in their thematic analysis of SCRs of persons thought to have self-neglected, can no typical presentation be discerned to provide clues as to what signs of vulnerability might not be understood by professionals. The presence or absence of any discernable

patterns could then be compared to the reported and observed understanding of professionals currently engaged in safeguarding adults practice.

4.5.1. Serious Case Review Report Process and Construction

This study, like others (Manthorpe & Martineau 2009), found that the quality and quantity of SCR reports showed great variability. This is important to note as the lack of rigour and consistency in a) the methodologies of the reviews and b) the formats for reporting, undermines the comparability of the texts. I would argue that this presents challenges to the representativeness and universal application of findings derived from them for practice by the wider safeguarding community.

The quality and quantity of information contained within the various SCR executive summary reports collated evidenced the lack of consistency indicative of the lack of standardisation commented on previously by Manthorpe & Martineau (2009). Some authors have considered aspects relevant to report whilst others have not and there is no agreed format that would support consistency in report content to support greater reliability of findings from analysis. As Manthorpe & Martineau (2011, 2012) have observed, little is known about the rationale behind decisions whether or not to commission an SCR. They similarly caution against seeing the reports as a full representation of practice but recognise their potential as learning materials (Manthorpe & Martineau 2013).

The production of SCR report summaries was slow to start following the introduction of 'No Secrets' in 2000 with only six reports in the sample compiled within the first five years post policy implementation. In 2006 ADASS produced some additional guidance on the conduct of SCRs. Since then reports seem to have peaked at 19 and 22 per year, respectively in the years 2010 and 2011.

The profile of agency involvement in the SCR process predominantly included Local Authority Adult Social Care Services, Police, Community Health Services, Hospital Trusts and Housing Agencies. Not surprisingly the Local Authority Adult Social Care Services, given their lead agency responsibilities in the development and implementation of adult protection policy and procedures, were involved in the greatest proportion (60%) of the SCRs.

As with Manthorpe & Martineau (2009) this examination of the SCR executive summary reports identifies an inconsistency and a lack of rigour in reporting the methodologies of the reviews but it would appear that methods were predominantly paper-based culminating in a collation and analysis

of Independent Management Review Reports (IMRs) to support the production of the overall report. IMRs form part of the traditional approach to the SCR process and involve the agency in producing a chronology and analysis of their involvement through a review of case files and other documents held by the agency in relation to its contact with the adult and direct discussion with staff involved.

The length of these summaries varied from four short paragraphs of two to three sentences, each providing little or no demographic case details, to comprehensive detail extending over 75 pages. One of the primary outputs of a report is the recommendations for action. These also showed considerable variation with the numbers of recommendations ranging from one to 55. However, 40% of the reports produced between one - 10 recommendations and 30% of the reports produced between 11 - 20 recommendations.

4.5.2. Report Demographics/Case Characteristics – Victim, Perpetrator and Location

In examining these case characteristics I sought to explore if there were any indicators to assist in understanding whether particular signs of vulnerability were represented in the SCR case summaries as being poorly understood by professionals and possibly overlooked or disregarded. There were no discernible patterns to identify if signs of vulnerability associated with either victim, perpetrator or the setting of the abuse were recurrently overlooked or disregarded. However, it is interesting to note that persons with a form of mental disorder represented over 50% of the victims in reported cases. Previous studies (Read et al 1998, 2002) have remarked on the apparent failures of mental health services to recognise and respond to abuse of adults with mental disorder. Unsurprisingly the persons alleged responsible fell predominantly into four major groups - family, friends, neighbours and paid carers. This raises a question about whether professionals are identifying signs of vulnerability in the conduct of the perpetrators and what might impede their assessments of a victim's vulnerability in this respect, such as the 'rule of optimism' which has been identified in children's services to influence the professional construct of a child's vulnerability to abuse (Dingwall et al 1983).

4.5.2.a. Who were the Persons Subject to the Abuse (Victims)

The characteristics of the abused adult were reported in 89 of the SCR reports. In these cases this person was identified as having a mental illness in 16 (18%). This figure rose to 26 (29%) where older people with mental health problems or dementia are included in the frequency count, and in

28 (32%) cases the abused adult was identified as having an intellectual developmental impairment. In total persons with some form of mental disorder represented 60% of the reported cases in these case summaries. As already mentioned, the dominant definition of vulnerability in relation to safeguarding adults from abuse has drawn a strong link between individual characteristics of illness and disability and subsequent need for community care services. In the SCR summary reports it was not always clear whether these adults with mental disorder were in receipt of community care services, or the extent to which they had been offered and declined services. Further exploration of this is required, particularly given the high percentage of persons with a form of mental disorder represented in this sample. Difficulties accessing services for mental distress and disorder, as well as the challenges for mental health professionals in engaging those with these needs in accepting health, have been reported in recent years (RCP 2008). It has not been possible to draw any clear conclusions about whether vulnerability associated with having a mental disorder is not well understood by professionals or whether their ability to respond to it has been compromised by the availability of resource. However, in one SCR where the adult is reported to frequently refuse services the report writers comment on how clear evidence of a chaotic lifestyle and the need to respond to this were precluded by the absence of a discernible diagnosis. The report notes that although the adult had no formal mental health or learning disability diagnosis, professionals often assumed he had one or the other or both. In their findings they conclude:-

“4.18. The absence of a clear disability or diagnosable condition seemed to create significant problems of ownership between agencies. There are a number of examples where teams and managers were clear that BD did not fall within their responsibilities and then signposted the referrer to another team or agency. What was missing was any manager taking leadership responsibility in resolving this”. Dudley (2010)

In this same report it is suggested that the solution lies in identifying staff who require training to recognise who might be vulnerable.

In another SCR summary which commented on failures to recognise vulnerability (North Tyneside 2011) the visibility of the adult is commented on:-

“5.1. At the heart of this case lies the fact that Adult A was largely hidden from view throughout her adult life. Her family circumstances, her mental health and her reclusive

nature all combined to make her problems difficult to see, recognise and deal with. " North Tyneside (2011)

This is viewed in combination with errors in evaluation of her mental capacity and ability to lead an independent lifestyle. The report also suggests that each agency adopted a narrow focus on their own eligibility criteria:-

"7.2.3 Adult A's case once again illustrates the need for clearer guidance of what comprises vulnerability. Despite all the clues and markers – learning difficulties, poor mental health, chronic physical ill health, hard to reach - easy to overlook and missed appointments – none of the agencies in this case saw Adult A as vulnerable or alerted partners. This failure to recognise vulnerability continues to pose a significant threat to effective safeguarding of vulnerable people. " North Tyneside (2011)

4.5.2.b. Who were the Persons Alleged Responsible for the Abuse (Perpetrators or Persons Alleged Responsible)

Of the total (114) SCR summaries examined, information about the alleged perpetrator(s) was available in 57 (50%) of these reports. It is interesting to note that within this cohort, the alleged perpetrator(s) was referenced to be either a family member, friend or neighbours in 18 reports (30%) and paid care staff in 26 reports (44%). It is not possible to assume a similar distribution amongst the cases where the perpetrator identity was not reported. This missing information might give further insight about whether particular types of perpetrator dominate in these cases, and enable further theorising about whether professionals' concept of vulnerability takes into account the nature of these persons and their relationship to the abused. It also raises questions about whether there are mechanisms operating in the view of professionals that obscure the visibility of the adult's vulnerability to abuse in relation to particular perpetrators. For example, professionals may have vested interests in upholding a view of care settings and those working in them as being caring and not abusive. In children's services a phenomenon has been observed which has become known as the rule of optimism in working with families that abuse which bias professionals' judgement and decision making (Dingwall et al 1983). Alternatively, in what is often 'behind closed doors' in intra familial abuse does the victim's perception of the perpetrator govern the professional assessment of vulnerability or are professionals alert to denial as a factor that may increase the adult's vulnerability to further abuse?

Recommendations in the Rutland & Leicestershire (2008) SCR summary report highlights a need to consider the overall context of the individual or family:-

“4.15. Vulnerability comprises a range of factors, and can only be properly understood through an assessment of the individual/family in its overall social context. The Panel therefore recommends that: Agencies responsible for assessment should ensure that it is informed by holistic ways of viewing people and their social context, as well as by the need to assess eligibility for services”. Rutland & Leicestershire (2008)

It suggests that referrals to Social Care in 2007 would have been responded to in terms of individual eligibility which do not allow for a holistic approach to vulnerability. Whilst acknowledging that widening the criteria might have resource implications the report urges the need for definitions that encourage a more holistic evaluation stating that:=-

“4.12. The Safeguarding Adults Board should initiate a policy review, to establish whether current definitions of vulnerability are inclusive enough and whether current procedures are sufficiently well developed to enable effective responses to individuals or families subject to significant community pressures”. Rutland & Leicestershire (2008)

During the period of time (2000 - 2012) when the majority of the SCRs in this study were commissioned and subsequent summaries published, the dominant definition of vulnerability emphasised individual characteristics giving rise to the need for care services. In light of this any patterns relating to the location of the abuse also might offer insight into circumstances where abuse takes place and whether these feature in the understanding of professionals.

4.5.2.c. Where was the Abuse said to have Taken Place (Location/Setting)

As with the reported details of perpetrator identity, the location of the abuse was not reported on all occasions. Location was reported more frequently than perpetrator which might suggest that authors accord greater emphasis to this case characteristic as being of significance but in the absence of a rationale from them this is speculative. Out of the 114 SCR summaries, 101 reported the location of abuse. Of these 101, 45 (44%) referenced the location of abuse as ‘own home’ and 38 (37%) as residential/nursing care home. There is some correlation between the nature of the

perpetrator and the location of the abuse. Unsurprisingly the kinds of persons causing harm did so in locations where you would anticipate them to have contact with the adults who were abused. This is more likely to be the case in the relationship between paid carer and care setting. It is possible in cases relating to family, friend and neighbour where abuse occurs in the person's own home but this cannot be asserted with confidence as some adults also receive a care service in their own homes. Consequently, a more detailed analysis of the relationship between the nature of the perpetrator and the location of abuse is required to establish any links/patterns.

In summary, the people who appear in these reports as victims of abuse were most likely to be living in their own homes or in a residential or nursing home, most had either a learning disability or mental illness, and those that caused the harm were likely to be either, family, friends, neighbours or paid carers. These characteristics do not immediately strike the reader as people or situations where professionals would not discern signs of vulnerability and yet the need to strengthen professional understanding of abuse and vulnerability remains a recurrent recommendation across these summary reports.

4.6. Summary

This chapter has outlined the mechanism of SCR in adult safeguarding practice and critically analysed its utility for universal learning as opposed to local learning. It highlights the inconsistencies in review methodologies and report formats which I argue undermines the applicability of any learning to a wider practice audience. Nonetheless, these reviews are still promoted by governing and professional bodies as tools for learning so identifying what might be helpfully extrapolated is a current pursuit for research in this field of practice.

The chapter then reports the findings of a thematic analysis of Adult Serious Case Review executive summary reports which highlight a consistent finding/recommendation for a need to strengthen practitioner understanding of vulnerability and abuse. However, no differentiation is made in the recommendations as to whether this purports to understanding of ABUSE or VULNERABILITY. It is argued that this recommendation for wider dissemination of the learning infers that the criticisms of practitioners in these cases are also of wider relevance and application. Whilst the learning is recommended for wider dissemination the criticisms of practitioners are also inferred to be of wider application.

I concur with the views expressed by Woods & Cook (2002) that no practitioner intends to make mistakes. In other words, in order to learn the right lessons to improve practice we need to ask how did the situation look to the practitioner so that the action taken seemed like the right one at the time? This necessarily involves conversations with the practitioner in contrast to the previous approach of document analysis by a distant observer as critics have suggested that:-

“well intentioned observers think their distant view captures the actual experience of those who perform the technical task in context. Distant views can miss important aspects of the actual work situation and thus can miss critical factors that determine human performance in the field of practice”. (Woods & Cook 2002, p. 139)

So, could it be true then that in adult SCRs similar distant views risk such errors of omission? The theme of inconsistencies in identifying VULNERABILITY and the associated exhortation to strengthen practitioners' recognition and response to vulnerability was recurrent across four out of the five categories of conclusions. This deontological bureaucratic appraisal presupposes that the rules (in this case the definitions of vulnerability) are in and of themselves correct. The imprecise definition of the concept of vulnerability has been remarked upon previously by Brown (2003). What if the definitions do not reflect the decision making of practitioners and bias them towards attending to vulnerability as defined by individual characteristics (exemplified in the definition in 'No Secrets') and away from a construction of vulnerability that is based on a social model that takes account of a person's context?

This aroused my curiosity about whether this criticism of professionals in safeguarding adults practice could be asserted to be as universal as was implied. The findings and recommendation for a need to strengthen professional understanding of abuse and vulnerability infer gaps in knowledge and understanding but the nature of those gaps are not identified in these reports. This prompted me to explore how professionals from different disciplines conceptualised vulnerability in adults at risk of abuse. However, rather than do this retrospectively I chose to explore professional views through discussion and observation of current practice with existing cases. The next four chapters report on how professionals conceptualise vulnerability and what they report influences these constructs.

Chapter 5

Cues and Clues to Vulnerability – Part 1

5.1. Introduction

This chapter presents part 1 of a thematic analysis of the ‘cues and clues’ to vulnerability in Adults at Risk of Abuse (AAR) discussed by professionals, and observed in their practice being used as operators in their conceptualisation of vulnerability. It argues that professionals demonstrate a rich and nuanced evaluation of vulnerability, identifying signs related to individual characteristics and situational indicators in both the person’s context and the conduct of the Person Alleged to be Responsible (PAR).

It begins with a definition of key concepts and categories to support the discussion of these in relation to the main argument. This is that, contrary to the inferred criticism of poor professional understanding of vulnerability alluded to in the findings and recommendations of SCR reports, professionals do, in fact, have a very detailed and differentiated concept of vulnerability. This concept captures a multitude of indicators located within the characteristics of the individual but also their circumstances. In their discussion of these indicators professionals demonstrated that their understanding went beyond mere identification but included an understanding of how these features relating to the individual and their selfhood may contribute to their vulnerability to abuse.

The focus of this chapter will be the characteristics of vulnerability identified by respondents in the study which I have categorised as Character, relating to features of the individual.

Differences between the professional groups in their use of these indicators will be explored further in Chapter 7. The concept of ‘vulnerability’ is bound to that of ‘abuse’ and ‘risk’. This was evident in the frequent conflation of these concepts during professionals’ discussion of their evaluation of vulnerability. Respondents struggled to talk about vulnerability without talking about risk.

The saliency of these characteristics in the respondents’ concept of vulnerability was indicated through the triangulation of themes recurrent across the data sets. In this respect major and minor themes began to emerge. In elucidating how these are used to form a view of vulnerability I offer an insight into the ‘richness’ of professional conceptualisation of vulnerability. This is demonstrated through respondents’ nuanced operation of a multi-faceted concept of vulnerability which will be

summarised in a 3 part model in the following chapter. The importance of these signs for professionals in identifying vulnerability was reinforced by the fact that many constituted the opposite of resilience. For example, mental incapacity was often cited as an indicator of vulnerability to abuse and conversely mental capacity cited as an indicator that the person was less likely to be vulnerable and, as such, was a sign of resilience. Their rich description of vulnerability contradicts the view expressed in SCR reports that practitioners' understanding of vulnerability requires improvement. For example, North Tyneside (2011) report comments:-

"4.25. The learning point in two management reports was about improving staff understanding of who might be vulnerable and then taking appropriate action to support them". North Tyneside (2011)

The data revealed that despite their assertions otherwise, the professional groups did have a broadly shared view of vulnerability. However, variations between the professional groups were identified which suggest a distinct difference between professionals in terms of their focus on either the victim or offender when identifying signs of vulnerability. This will be discussed further in Chapter 7. Major and minor themes emerged in the way professionals talked about identifying signs of vulnerability in AAR. These were refined into further categories which I will define in the section below for the benefit of understanding the contents of this chapter and the following two. This section will also explain the relationship between the categories, themes and characteristics.

5.2. Critical Constructs – Characteristics, Themes and Categories Identified in Signs of Vulnerability

Three categories were defined from the themes emerging in the data – character, context and conduct of others.

a) Character – in this category the themes related to signs of vulnerability which were identified by respondents as residing in the personhood of the adult at risk of abuse. Whilst this term might be more readily associated with mental or moral qualities, in this study the meaning has been taken to encompass analogous concepts pertaining to constitution and attributes of the individual. These attributes included physical, psychological, emotional frailties as well as interpersonal skills and ability for self-action or advocacy. The characteristics of these themes were labelled as innate, not because they were considered as natural or inborn but more because they were constitutional, i.e. relating to the person's nature or physical/mental condition – their persona.

Themes assigned to this category included the adults' health condition, abilities in comprehension and communication, and dependency in relationship. Dependency was identified not just in relation to reliance upon others for care giving but also to a state of emotional neediness in relationship. Other themes included in the category of character related to the individual in relationship to others, whereby their role in relationship to the abuser was identified as a sign of vulnerability especially where this was related to an inability or unwillingness to recognise abuse or perceive the person alleged responsible as an abuser. Respondents also described that a person's vulnerability was signaled to them by impact on the victim or their fear of the consequences of acknowledging abuse to themselves. These included behaviours arising from shame and secrecy, which translated into loss of confidence and ability in independence of thought and action. Indicators such as these were discussed by respondents in relation to the adult's vulnerability to re-victimisation and prolonged or heightened state of vulnerability.

b) Context/Circumstance – this category denotes themes where respondents identified signs of vulnerability that related the person's circumstances rather than their individual characteristics. The themes in this category were labelled as situational signs of vulnerability. In this respect a person's status as either hospital in-patient or client of social services was the factor that signified vulnerability amongst respondents. In making this distinction from the person's health status, professionals were recognising that not all people with health challenges were in receipt of health or social care services but could be vulnerable. However, this status seemed to act as a heuristic for vulnerability. This might be explained by the fact that being in need of health or care support constitutes part of the dominant definition of vulnerability in national policy.

Themes in this category included institutional care giving, and being in receipt of services. With regard to both of these themes respondents identified signs of vulnerability which related to patterns in the practices of care givers but also in the arrangements for care provision. For example, poor discharge planning and gaps in service provision were discussed as signs of vulnerability which related to the person's situation rather than personhood (character). Characteristics of this theme relating to the provision of care also included a lack of scrutiny, monitoring and oversight (internal and external to the provider) and, as such, people who arranged and funded their services privately were perceived as being particularly vulnerable. The detection of vulnerability in relation to the location of the adult is not surprising. However, a significant theme to emerge as identifying persons as vulnerable to abuse was that of 'isolation' where loneliness, and a small or absent social network

were reported as signs of vulnerability. In this category respondent concept of vulnerability included isolation created by either living alone or living with family and prevented from wider social contact. In this theme attention was also given by respondents to social factors such as economic and social status in terms of both abundance and lack. For example, wealth was not necessarily perceived as a protective factor for the person, particularly if this was combined with a 'neediness' in relationship and seeking company in locations where others might seek to take advantage.

c). Conduct or condition of others - in this category the themes discussed by respondents related to signs of vulnerability which they identified from either the 'conduct' or 'condition' of other(s). The themes in this category were distinct from the other two in that the signs were located in the person(s) alleged to be responsible for the abuse or risk of abuse. Two broad themes emerged in this category. The first related to signs in the 'conduct' of the PAR such as grooming and targeting, controlling and coercive behaviour, as well as misuse of power in care relationships (including disregard of the rules - not following the care plan and unsafe care practices). Other signs pertained to the 'condition' of the PAR, for example, mental illness, substance misuse, poor impulse control, and in relation to some paid carer's – a lack of understanding, training or resource. However, this concept also captured the idea of 'professional blindness' as a sign of vulnerability. This was seen as vulnerability created for persons in care environments where persons who should have a critical oversight of the quality of care, operate a rule of optimism and have placed misguided, misplaced or un-evidenced trust in the care provider. Characteristics of this theme were discussed by respondents as interactive with either innate or situational signs of vulnerability.

d) Themes which occur in more than one category - There were some themes (Lack of Agency, Comprehension, Communication and Lack of Advocacy) which occurred in more than one category. This was because the characteristics within the theme were attributable to the individual and others to the person's situation or the conduct/actions of others. This is illustrated particularly in relation to the theme of 'challenges in communication' where some characteristics reported by respondents, such as communication impairment/inability to express need or give account, were innate to the individual and indicative of the category 'Character' whereas others signs were indicative of the category 'Conduct or Condition of others' because what respondents were identifying as a sign of vulnerability related to communication being impeded or obstructed by others. Similarly, some characteristics of the theme of Lack of Agency could be differentially categorised as both character and context/circumstance. Lack of agency arising from loss of independent thought/action was viewed by respondents as an innate characteristic of character whereas lack of agency by virtue of a

lack of choice or control (because others were exercising control and making choices for the adult) was considered to be a phenomenon external to the individual and attributable to their circumstance rather than personhood. When discussing a person's ability to avert abuse or exploitation respondents talked about the person's vulnerability through lack of agency in distinct ways, some of which related to characteristics of the person, some related to the person's context or situation particularly where the actions of others limited a person's freedom and ability to take independent action. Respondents talked about the person's inability to act for self-preservation in two ways. Firstly, as a matter of individual ability/inability due to mental, physical and emotional inhibitors. Secondly, as a matter of circumstance/situation which often related to the exercise of control by others through giving or withholding access to resources and information, thus limiting a person's ability to make informed choices or exercise control over their own situation. The overlaps in characteristics between the themes and categories highlighted the complexity of the phenomena and the detailed evaluations of professionals. In identifying signs of vulnerability professionals demonstrated an ability to think broadly about the causation of these features, simultaneously seeking clues in the person, their situation and the person who presented the risk of abuse to them.

Police and social workers discussed both innate and situational signs of vulnerability. Innate factors or personal characteristics reported as signs of vulnerability included mental disorder, lack of mental capacity and dependency. Common indicators of situational vulnerability included status as a patient or client (service user), institutional care setting and being in receipt of care services both within and without of care settings.

Social workers were distinct in attending to a person's inability to avert abuse when conceptualising vulnerability and often related this to the person's lack of agency. These constraints, which interfered with their ability to exercise their freedom and exert choice and control, were seen as arising either from characteristics relating to their own personhood or from the conduct of others. In identifying vulnerability arising from 'lack of agency' respondents described this in terms of physical inability to escape, emotional inter-dependency, fear of consequences in relationship, the nature of the relationship and how this operated to uphold the person's self-construct which was incongruent with their view of self as a victim and their view of the other as an abuser.

Social workers were alone in identifying homelessness as a contributing factor to a person's vulnerability. Attention to the context of the person is not unique to social workers but this feature of a person's situation may be more salient to social workers, who, in their concept of vulnerability,

may be operating a social model. A summary of the characteristics, themes and categories of vulnerability is available at Appendix 12.

5.3. Characteristics of Character.

The category of character was abstracted from the themes where the indicators of vulnerability related to the individual's personal characteristics. Both police officers and social workers indicated that an individual could have innate factors of vulnerability that are unique to them as a person and are constant regardless of the individual situation or circumstance. Both were quick to identify several common factors of vulnerability related to character that they often see in AAR. These kinds of vulnerability included adult's health condition/status, dependency, communication, relationship skills (as a matter of both character and competence), mental impairment, the nature of their relationship to the perpetrator, consequence for the client (in acknowledging the abuse) and lack of advocacy. The strongest themes to emerge in this category were a) identifying the presence of a mental disorder and the consequence of this in relation to the person's mental capacity to make decisions, b) dependency or reliance on others (not just for care or support but also emotional enmeshment), and c) lack of agency in relation to the person alleged responsible.

5.3.1. Mental Disorder and Mental Incapacity

Findings of this study suggest that mental disorder is very frequently identified as a sign of vulnerability and given detailed consideration by professionals. Furthermore, there was recognition of the need for special attention due to the lack of visibility of mental illness. This was a strong theme discussed by respondents in relation to identifying vulnerability due to personal characteristics. It was discussed as a factor in 100% of the focus groups, 100% of the interviews and 85% of the direct observations. It was given detailed attention by both police officers and social workers and was often discussed in relation to the person's mental capacity to make decisions about their own safety and risk in relation to the alleged abuse.

Differences between the two professional groups were observed in relation to the detail of their analysis of a person's mental capacity. Social workers articulated their analysis of a person's mental capacity in ways which demonstrated compliance with the law when deciding if the adult was vulnerable to abuse requiring a safeguarding enquiry and action. Police officers, on the other hand, tended to make a statement about the presence or absence of mental capacity, without such

analysis. They often used the lack of mental capacity as a determinant for further police involvement in safeguarding responses, relating this to the possibility or otherwise of progressing criminal enquiries. This difference in the way mental capacity is treated and assessed may reflect the different focus of the professional groups. Police officers were more concerned with detection and the presence or absence of mental capacity assisting in determining if a crime had occurred. Social workers were more concerned with protection, so the person's mental capacity was considered in relation to their ability to understand the nature of what had happened to them as abusive and to decide how they wanted this dealt with.

In the sample of SCR summary reports reported in Chapter 4, people with some form of mental disorder represented about 60% of the cases subject to SCR. The frequent occurrence in SCRs might suggest that people with various forms of mental disorder are poorly served in safeguarding responses, or just reflect the number of people who have a mental disorder who are also vulnerable. However, in light of the apparent under-reporting of safeguarding concerns for this population, which has been the subject of comment by others noted previously (Rose, Peabody, & Strategias 1991, Reed 1998 & 2002), this is a significant proportion of SCR case reviews. I would suggest that a simplistic explanation of this high proportion of case representation amongst SCRs might be related to the reported widespread failure to recognise and respond to abuse amongst this client population. However, in the analysis of the SCR executive summary reports it was not possible to establish if this is a function of failing to see mental disorder as an indicator of vulnerability.

Respondents in this study identified mental disorder as a sign of vulnerability and also understood how it could be hidden from sight, requiring greater effort in attending to its presence in a person at risk of abuse. As one social worker indicated in a focus group discussion:-

Social Worker No7

"You can see a physical vulnerability what you can't see is a mental vulnerability, for perhaps somebody's got a psychological impairment in some way and that may not even be diagnosed".

Mental disorder was discussed as a factor that signaled vulnerability by both police and social workers, in almost all of the direct observation sessions, focus groups and interviews. Mental disorder was often discussed in relation to mental incapacity and was the most commonly stated innate sign of vulnerability among all study participants. Dementia was the most common form of

mental disorder or reason for mental incapacity. During the direct observation sessions in the central referral unit (CRU) almost three quarters of the cases referred to CRU involved a person with dementia. Other forms of mental disorder included learning disability, schizophrenia, bipolar affective disorder and autism. The presence or absence of a mental disorder was not used simplistically as both police officers and social workers spoke of needing to understand the nature, degree or impact of the disorder.

Whilst mental disorder was the most commonly discussed reason for vulnerability, it wasn't always considered to be the most grievous. One police officer considered the issue of mental disorder in terms of impact on day to day functioning and compared this with adults requiring daily care and support. In his view:-

Police Officer 4

"Someone that goes to a support meeting every two weeks probably wouldn't be a vulnerable adult in my mind because their everyday life they can live. so somebody in counselling for example, to me isn't necessarily [vulnerable] isn't vulnerable as someone who has carers coming in, or lives in a care home, or has such additional needs to the extent that they can't live a normal life without that extra support. So that is my version of vulnerable adult".

Social Workers also considered the nature and degree of the mental disorder in assessing the possible impact of this on a person's vulnerability:-

Social Worker 35 said that,

"I think with regard to diagnosis, I think you can't ignore the diagnosis, so for example, if I got something in that said that someone had a diagnosis of severe and enduring mental illness, for example, I would want to know what phase of that person's mental illness were they actually in. It may very well be that the person has ... been stable for the last 18 months in their mental state, which would be quite different from somebody being in a cycle of deterioration where they may be a lot more vulnerable to exploitation".

This social worker demonstrated a detailed exploration/analysis of the significance and impact of the mental impairment on the person's vulnerability to exploitation. As the above quote illustrates the presence of mental disorder in isolation was not treated as a determining factor but further

consideration was given to the impact on that individual's ability to protect their self from exploitation. In their approach, by exploring the impact of the mental disorder, the social worker is demonstrating an application of the two stage test for mental capacity set out in the legislation as follows:-

1)

is there a disturbance in the functioning of the person's mind or brain (temporary or permanent) and,

2)

Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

Such an analytical approach shows complex conceptualisation as well as lawful compliance relevant to the decision making framework for progressing safeguarding enquiries and actions.

Mental disorder was often linked in professional discussions and direct observations with mental incapacity. It was seen as a critical factor in determining vulnerability and agency responses.

The impact of mental incapacity in signaling vulnerability was commonly linked to the adult's comprehension skills as the following quote evidences:-

Social Worker 13

"Capacity, capacity as well, [do] they understand what is happening to them or what their situation is at the moment"?

Distinctions were drawn between incapacitated decisions and unwise decisions. Professionals drew attention to the complex relational context of decision making for some AAR and the impact of this. Examples were offered to illustrate how decision making by the adult was not entirely cognitively driven, and that the decision to remain in exploitative relationships was influenced by other factors. The following quote illustrates how the professional conceptualisation of vulnerability takes this into consideration. They frame these factors as part of the universal experience of vulnerability as opposed to individual characteristics which mark people out as different:-

Social Worker 31

" So there's some trading in that goes on, so if you do receive love from your family, although this part of my life isn't so good this part of my life is good 'cos we're all vulnerable to a

certain extent aren't we ... but if we can make those trade offs so that I've got an okay life then that's fine, that's how it is but I suppose that with a lot of learning disability guys there isn't the ability, perhaps communication wise, to understand or do that, to rationalise to do that".

The salience of mental incapacity as an indicator of vulnerability and the attention paid to it by professionals was further evidenced in the way they used this characteristic of the person to signal resilience and an ability for self-preservation and determination by the adult. During direct observations, people who were considered to have the mental capacity to make decisions for themselves were not considered as vulnerable as those who could not. During a direct observation in June 2014, Police Officer 6 reported on an argument that had taken place within a care home between two sisters in front of their elderly father over who should have Power of Attorney because the father favored one daughter over the other. The police officer commented that the older man had mental capacity to decide who to appoint and was, therefore, not considered vulnerable and the police were not progressing this as a safeguarding referral.

Mental incapacity was a critical determinant for professional engagement of the adult in the safeguarding procedures, especially for the police, and related to their authority to act. In the officer's own words:-

Police Officer 3

"in criminal, mental capacity is erm, is the big one 'cos then it opens up offences that we can't do with people who have capacity. So that's the big one reason for us cos you can actually get some positive action".

In contrast social workers sometimes took a different focus in the safeguarding context by seeking to use their assessment of mental capacity as a justification for non-intervention even where other agencies protested the adult's vulnerability, supporting the adult's right to self-determination and service refusal. An example of this was reported in a focus group discussion:-

Social Worker 28

"when the social worker looks at capacity, that's the main thing we look at, okay, somebody's environment, you know, suggested that this person is vulnerable, and all the agencies can see that this person is a vulnerable adult, but then when it comes to social care you look at okay

this person has got mental capacity to make that decision as to the way she wants, he or she wants to live...”

The issue of service refusal was a phenomenon commented upon in a significant number of the SCRs and clearly remains a difficult and contentious area for professional assessment. It highlights the continuing dilemma in safeguarding adult practice of striking a balance between protection and empowerment. Balancing the right to protection with the right to self-determination, including the right to make unwise decision requires skilled understanding of both the principles of Making Safeguarding Personal and the Mental Capacity Act. Government policies recognise the dilemma for practitioners in balancing the needs, rights and choices of the individual and influence of individuality in the practice of safeguarding:-

“There is a delicate balance between empowerment and safeguarding, choice and risk. It is important for practitioners to consider when the need for protection would override the decision to promote choice and empowerment”. (DH 2007, p 30, para 2.50)

Other researchers (Brown 2013) have observed this practice dilemma. The solution might lie in improving the legal literacy of all professionals in this field of practice, employing the principles of cross-agency training using core and common content as described by Aylett (2009). During direct observations social workers and police officers frequently attempted to determine the individual's mental capacity to inform the safeguarding procedure for that individual.

The importance of this from a policing perspective was reflected in the comments of a CRU social worker:-

Social Worker 36

“Yes, in actual fact now I’m just thinking about the police and what I’ve learnt from the police. I have learnt that they’re more interested in the mental capacity status of the perpetrator rather than the victim, unless they’re looking at, again it’s all based on crime, unless they’re looking at neglect and the victim then has got to lack mental capacity”.

Further evidence of this focus was found in police officers’ written records where it was noted that lack of mental capacity could be a concern for both the victim and the suspected perpetrator during police investigations. Police officers recorded an incident where both parties lacked capacity noting

that the crime report was made for recording purposes only, as an individual lacking capacity would not be charged and further enquiries would not be progressed. These records often stated that:

“NFA by Police as both suspect and victim lack capacity - crime report for recording purposes only. SSD are dealing with ongoing safeguarding - no further role for CRU or CST at this stage.”

In contrast to social workers the written records of police officers’ decision making indicated that mental capacity/incapacity was asserted rather than overtly analysed by police officers. In the focus groups and interview data there were frequent reports from police officers of the saliency of either the victim’s or the offender’s mental capacity in determining police response. In the written police decision logs, citing the victim or offender’s mental incapacity as a rationale for not progressing further police action was a frequently occurring phenomenon – a rationale that was closely related to the possibility of making further criminal enquiries and securing evidence for crime detection and prosecution. It would seem that for police officers the evaluation of a person as lacking mental capacity was a quick reference for decision making about police engagement related to the determination of criminality and the possibility of criminal enquiries (a detective function) whereas, for social workers, the focus of this evaluation was about the person’s ability or otherwise to understand that what had happened to them was abusive and to decide what action they wanted to be taken about this (a protective function). The importance of this phenomenon will be explored later in relation to the influences of job role and legitimised work as influences on professional recognition and response to signs of vulnerability.

5.3.2. Dependency or Reliance on Others

Dependency or reliance on others, as a characteristic of vulnerability, also emerged as a dominant theme as triangulated across the data sets. It was discernible as a theme in 71% of direct observation sessions, and in 100% of the focus group discussions and individual interviews with both police officers and social workers. While dependency was a factor that was discussed by all participants, the reason for the dependency identified by professionals varied. It was generally framed as a loss of independent action or thought, but attention was also given to emotional dependency and relational inter-dependency. Dependency was sometimes assumed and asserted by respondents on the basis of individual characteristics, such as old age and infirmity, physical or mental disabilities. Professionals also reported that dependency could also be situational, where that adult was reliant on another and for some reason unable to leave the situation or protect

themselves from exploitation. The theme of dependency was often discussed in combination with the nature of the person's relationship with their abuser and the interactive effects of this identified as heightening the adult's vulnerability. Respondents offered examples of adults who remained vulnerable to exploitation because their reliance on their abuser made it difficult for them to construct this person as such. Other examples were offered where individuals were unwilling or unable to perceive their abuser as such because of the type of relationship they had with them, how this was defined and how it defined them. In many of the cases described the abused adult took responsibility for the behavior of the perpetrator. This level of differentiation testifies to the nuanced conceptualisation by professionals. The complex way in which respondents thought about and discussed the possible causes or reasons for dependency is illustrated in the quote below:-

Social Worker 35

"Perhaps erm, they are an older person who's dependent on another to provide that care and attention. Perhaps there is an illness which has rendered somebody unable to access the help and support they need themselves independently which has led them to be dependent on another, or perhaps there is a circumstance whereby they have been in hospital or been made homeless, therefore, they are unable to pull together the resources that they need within themselves. so a wide range of factors which have led to the person feeling less able to protect themselves..."

Many participants indicated that they saw living in a care home as a proxy for dependency, suggesting that they view dependency and vulnerability as co-terminus to one another. In a similar way, they also reported a presumption that complexity of health or social care need equated to greater dependency on others. This followed from the nature of needing to reside in a 24 hour care environment suggesting that such persons were dependent on others to meet most, if not all, of their daily needs.

Whilst residency in a care home was often associated with dependency as this signalled situational vulnerability it was not considered a stand-alone or singular determinant of vulnerability. During direct observations residency in a care setting was often used as a rule of thumb for vulnerability due to reliance on others for care and support. However, on interview practitioners articulated a more differentiated approach and combined dependency with other signs of vulnerability.

In interview Social Worker 35 illustrated this differentiated approach stating:-

“If I had someone with a diagnosis, that’s what would come through my head initially and then I think I would be looking at the level, the level of care and input they need from others around them, support and how independently were they managing their own needs. Then within all of that I’d be looking at level of dependence as well, so for example, it may be that someone resides in a residential home, well that in itself actually, doesn’t necessarily make them as vulnerable perhaps as [another person would be]”.

Other participants demonstrated that individuals could become dependent and, therefore, vulnerable even if they didn’t require a carer to meet their daily needs. One police officer indicated that the nature of the relationship with the perpetrator was said to make the person more vulnerable still, since the victim was unable to see their abuser as such because of their status as a close family member.

Police Officer 8 said that:-

“I suppose, working in here [CRU] people in residential care settings [are vulnerable]. I have also had a few of sort of domestic type, anything like family members, daughters, cousins, the person is wheelchair bound or physical disabilities. [This person] identifies the perpetrator as close family members, which is who they are most vulnerable to rather than what makes them vulnerable. Who is most likely to abuse them in a domestic setting”.

In these examples, both social workers and police officers located the signs of vulnerability in the context of the AAR. However, they differ in respect of the meaning of the context for the AAR. For social workers vulnerability relating to the person’s context was linked to their personal characteristics of vulnerability which increased their dependency on others. This was signalled by the setting in which they resided. Police officers tended to see vulnerability in the context of a person as a matter in which there was close proximity between the adult and those who would harm them.

One feature that professionals had in common with this theme was the adult’s inability to challenge the actions of the PAR, thus perpetuating their vulnerability. One participant commented:-

Social Worker 7

“They are unable to change or challenge the person who’s exploiting them through emotional or any other attachment”.

In their written records dependency was reported as a concern across a range of specialist areas. A social worker specialising in older persons and physical disability noted that a patient was vulnerable due to the high level of care she needed. This same practitioner noted:-

“According to the SA 1 risk assessment Vulnerability:- it is clear that Mrs J has high care needs due to her age and physical frailty. She is thought to have a level of dementia”.

The SA1 risk assessment is a tool to support professionals in making their analysis of risk which specifically draws attention to ‘vulnerability’ and invites the professional to record their evaluation of vulnerability as part of the risk assessment. This attention to the variety of causes for dependency (individual and situational characteristics, physical, mental and emotional) is indicative of a detailed awareness of the complex interaction of factors that operate to maintain a person’s vulnerability to exploitation. The conceptualisation evidenced in relation to this theme shows strong parallels with theoretical understanding of the cycle of abuse from the field of domestic violence, in terms of the use of power and control. The developing understanding of the dynamics of interpersonal violence in intimate relationships (aka domestic abuse) offers much insight into features which form a pattern in relationships which sustain a cycle of abuse. However, little attention is given to the dynamics of a relationship of care and how power and control might operate in such relationships promoting vulnerability to abuse. Clearly in the thoughts of these professionals how dependency might heighten vulnerability to abuse is of great importance but is something that they struggle to articulate. This may reflect the absence of a clear theoretical framework for understanding the dynamics of abuse in relationships of dependency. Understanding from the field of domestic abuse offers insights into such dynamics in intimate relationships but these may not translate effectively into understanding ‘dependency’ in relationships of care giving.

5.3.3. Adult’s Physical Health Condition

In this study deterioration in an individual’s health condition was noticed and discussed as an indicator of vulnerability for AAR. This was a frequently occurring theme in all professional groups across the data sets. Relevant observations by professionals included having regard to the patient’s physical illness or disability, weight loss, age and frailty. It was a theme in 71% of direct observations, and all of the focus group discussions and individual interviews. The prominence of this as a sign for professionals in determining vulnerability is not surprising. Poor health often

denotes disadvantage and signals a possible need for care and support from others. These features were associated with loss of function and independence and spoke to a possible need for care and support plus loss and control that positions the adult as vulnerable to exploitation. One social worker described this as follows:-

Social Worker 19

"... I suppose vulnerability can come in any shape or form, age, frailty, mental health, learning disability, where they've got an addiction which makes them vulnerable, something that takes away control from that person, takes away their independence, whether that be independent thought or action".

This view was shared by a police officer:-

Police Officer 10

"To me, it is physical disabilities, mental health, or learning disabilities where the person requires additional support from a service such as social services or mental health".

The adult's health challenges appeared to serve as a heuristic for care and support needs and interestingly were a feature of the construction of vulnerability articulated in written records. The written word was often much shorter than the spoken which further illustrates how this theme in the concept of vulnerability served as a 'shorthand' for professionals. This might be due to the striking correlation to the criteria upon which safeguarding duties operate.

The following observation was made in an Older Persons Physical Disability Practitioner's written records, *"According to the SA 1 risk assessment Vulnerability:- it is clear that Mrs J has high care needs due to her age and physical frailty".*

This statement indicates that this particular individual was considered as vulnerable and in need of a high level of care due to her health condition and status.

In the sample of SCR summary reports examined the physical health condition of the adult was a feature in almost a quarter of the reported cases. Whilst this was noticeably less than persons with mental disorder, people with these life challenges represented a significant proportion of reported cases where it was felt that there had been some fault-line in the application of adult safeguarding

procedures. As remarked upon in an SCR summary report by North Tyneside (2011) chronic physical health conditions were amongst the clues to vulnerability, and yet agencies failed to see the adult as vulnerable. They suggest that this calls for clearer guidance on what comprises vulnerability.

Respondents in this study often referred to a person's physical health condition as a sign of vulnerability. It was amongst a number of themes that professionals operated as mental short cuts in determining vulnerability to abuse. This was especially true where the theme approximated to one of the critical determinants for safeguarding responses as set out in the legislative and policy context of this practice. So, for example, where a person's poor health was thought to give rise to the need for care and support, respondents used this as shorthand to determining vulnerability as it approximates to the first criteria for defining a vulnerable adult. In 'No Secrets' (2000) a Vulnerable Adult is defined as being someone: "Who is or may be in need of community care services by reason of disability, age or illness;...". The context of professional assessment of vulnerability may also have a bearing on the apparent primacy given to these signs, which I will explore further in Chapter 8.

5.3.4. Lack of Agency – Individual & Situational

The first three themes of mental disorder, dependency and health status described above were equally strong for all of the major professional disciplines. In contrast, the theme of 'lack of agency' was a stronger theme in the accounts given by social workers compared with other professionals. Lack of agency was identified as an indicator of vulnerability by social workers in almost three quarters of the direct observation sessions and focus group discussions, and 80% of interviews.

For social workers in the study, lack of agency as a sign of vulnerability was talked about in terms of a person's lack of ability to produce a particular effect, namely inability to protect self. This was largely expressed as the adult's inability to remove themselves from the source of abuse to them. Personal agency is manifest in control over thoughts and feelings to influence action. Independence in this respect might be constrained by personal circumstance. According to participants, lack of agency operated at an individual and situational level, dependent on the factors underpinning the inability to escape. Professionals commented not only on a physical inability to escape but also how this lack of agency could derive from co-dependency in a relationship as well as a lack of resource meaning that the adult was able to exercise less choice or control in their circumstances. For some individuals, lack of agency was caused by a permanent disability that left them unable to defend themselves. In this respect there was one occasion during focus group discussion where the police

reported vulnerability in terms of the AAR's inability to physically escape or resist the PAR. There was one notable comment by a police officer during a focus group discussion. The officer recalled a series of offences/doorstep crimes relating to bogus callers or rogue traders. This officer highlighted the targeted actions of the offender and talked of the adult's lack of agency in terms of both physical limitations and fearfulness as a consequence, thus maintaining their silence on the abuse they had experienced and perpetuating their vulnerability to further offences. The officer is suggesting that physical indicators of the physical limitations of a person signal to the abuser that there is a possible vulnerability to be exploited as they are less likely to have the ability to remove themselves from the offender and, therefore, exercise agency to avert exploitation. Consequently, the outward sign of impaired physical ability coupled with the desire and intent of the perpetrator to exploit, co-exist and create vulnerability to abuse.

Police Officer 1

"... they were vulnerable in the community because I think they were targeted by individuals ... they're targeted because they could see you know the houses, the ramps, they can tell from the house that a disabled person or a person that isn't as mobile [lives there] ... it's a very easy target isn't it, they're not going to chase after you 'cos they can't 'cos of their impairment and chances are in those cases they're not going to talk because [fear of retribution]".

Lack of agency was never discussed as a reason for vulnerability in interviews with police officers. For others, lack of agency could be situational if the individual was placed into a situation that diminished their ability to defend and care for themselves. In this respect this social worker indicated that lack of agency contributed to what she referred to as her "worst case scenario" for situations leading to abuse when associated with poor care providers in formal care settings. This social worker was drawing attention to the toxic combination of cultures of abuse from which there is no escape.

Social Worker 34 stated that:-

*"Where you have got a culture that is sliding down hill and people don't really care and I actually think that it is kind of the worse scenario for me. Because you have people who should have a trusting relationship and who don't care ... **So it is quite relentless and for me it is insidious and no relent from it and [the people receiving care] cannot remove [themselves] from it.**"*

The 'it' that the social worker is referring to here is the 'culture of care' which is pervasive and potentially overwhelming for an individual leaving them feeling powerless to challenge and change the situation they find themselves in. The pervasive and persistent nature of cultures of care which are abusive erodes the individual's resilience and capacity to challenge, as it is easier to raise complaint about individual misdemeanors than those that are perpetrated by many as the victim's belief that they will be believed is undermined.

Whilst the majority of participants indicated that a lack of agency is caused by a mental or physical illness, this participant illustrated how a lack of agency could be a combination of situational and individual. She paralleled the combination of lack of agency (character) and residency in a care setting (context or circumstance) to the features of domestic abuse. Social Worker 34 detailed her experience with a domestic abuse victim by saying:-

"I think most frequently it's a combination of the environment that they're in and the relationship between the alleged perpetrator and the victim.... so it's the relationship between those two people. And with the service user on service user incidents and the domestic violence, the people in those residential settings can't get out of those residential settings and a lot of the time domestic abuse victims don't feel that they can get out of that environment as well".

The social worker here is drawing attention to the parallels between service user on service user abuse and domestic abuse, where there is an interaction between the nature of the relationship between victim and perpetrator and the setting in which the abuse takes place. There is a sense, in both situations, that the adult is unable to remove themselves from the situation and consequently the people that are the source of harm.

Whilst this common feature of an inability to remove oneself from the context in which the abuse is occurring bears some similarity, in these different life circumstances the inhibitors for people experiencing domestic abuse are more complex than the direct comparison suggests.

The difference between professional groups in their attention to the person's lack of agency as a sign of vulnerability might be explained in relation to their professional roles and responsibilities bounded by the operating legislation. Section 42 Care Act makes the duty of enquiry in safeguarding adults a Local Authority duty. As agents of the Local Authority the responsibility for making this

determination rests with social workers. Consequently, a lack of agency approximates to an inability to defend oneself against abuse or exploitation, confirming the criteria exercised for Local Authority duties have been met. From a police perspective the victim's ability to protect themselves from abuse is irrelevant at the initial stages of their decision making. As Police Officer 4 pointed out:-

*“Yeah, but I think that is partly because **from a criminal point of view the vulnerability doesn't matter because they are a victim whether they are vulnerable or not so actually we have to see if it is a criminal matter or not**”.*

The distinct difference between the professional groups in relation to this indicator of vulnerability reflects the marked differentiation in lawful obligations. National and local guidance set out a mandate for information sharing. The Care and Support Regulatory Guidance (2017) is relatively silent on the procedures of initial planning requiring cross-agency discussion. However, the current guidance from the National Policing Improvement Agency (2012) does seem to encourage police involvement in initial planning/strategy discussions, the purposes of which are to share information in support of the Local Authority making a decision to progress a Section 42. It is worthy of note that during a nine month period involving 114 incidences of observations of referral evaluation and responses by staff in the CRU, I observed only one multi-agency strategy discussion to share intelligence and jointly agree and plan the response to the referral. This leads me to conclude that whilst information sharing is apparent in this setting, joint decision making on the response to safeguarding concerns is not embedded. Consequently, lack of agency as a sign of vulnerability to abuse is likely to remain predominantly a single agency indicator.

5.3.5. Nature of Relationship to the Perpetrator

The nature of the relationship with the perpetrator was a notable characteristic in SCR summary reports with a third of reported cases identifying the person alleged to be responsible as either a relative, neighbour or friend. This part of the chapter explores how professionals attended to this in their recognition of an adult's vulnerability and identifies the complex inter-relationship between multiple dynamic relationship factors observed in the reports of professionals. The detailed attention given to this feature of the AAR vulnerability supports my assertion that their conceptualisation is very rich and well informed.

This study found that professionals reported the AAR's relationship to the PAR played a significant role in their determination of how vulnerable that individual was to the abuse. Participants held the view that a close relationship to the abuser often exacerbated the victim's unwillingness to report or even perceive the abuse. Police Officers and Social Workers both discussed how the nature of the relationship signified vulnerability to them in terms of proximity and access to abuse, intra-personal influences for the AAR including guilt, shame and taking responsibility for the PAR. They showed insight into how the nature of the relationship supported the mechanisms of abuse in terms of the effect upon the AAR's ability to acknowledge the PAR as abusive and to accept intervention from external agencies which meant the AAR remained in a position of vulnerability to repeat victimisation.

These professionals demonstrated an understanding that a person's inability to take agency was impeded not just by characteristics of the individual (physical inability to escape), or issues of dependency or reliance for care provision but by the 'nature' of the relationship which means that in order to perceive themselves as a victim of abuse and the person responsible as a perpetrator of such abuse they may need to disentangle themselves or even change their construct of themselves or view of self. Their strong attachment to defining themselves by a primary role, e.g. parent or grandparent, interferes with their ability to see the PAR as an abuser rather than child or grandchild according to respondents in this study. This is how the nature of the relationship contributed to their vulnerability to abuse and re-victimisation. Respondents' understanding of vulnerability extended beyond just identifying the PAR as a person with whom the victim had a close relationship but also to theorising about how the nature of the relationship interfered with the victim's agency and subsequent heightened vulnerability.

Whilst professionals were not explicit about the use of theory to inform their understanding of vulnerability to abuse, the phenomena they observe (dynamics of abuse in intimate partner abuse) are well articulated in the literature on domestic violence (Pence & Paymar 1993, Dutton 2006), and it is noteworthy that the circumstances where they seem to be translating this understanding are situations of intra-familial abuse/risk of abuse. There was often an overlap between the nature of the relationship to the PAR and the relationship skills of the AAR where the inter-play between the character and competence in the way the adult managed relationships and the nature of the person with whom they were in a relationship of abuse was remarked upon as signaling vulnerability particularly to repeat victimisation. This was especially true of intra-familial abuse. Professional's use of theory may not have been evidently conscious but I would suggest it was nonetheless

competent. Their thinking about vulnerability demonstrates an understanding of how social beliefs about relationships support the exercise of power and patterns of coercive control in relationships of abuse.

Participants reported incidences of family members or valued friends exploiting or abusing their clients, and their clients reluctance to either acknowledge the abuse or accept intervention to stop it. Police Officer 1 spoke about this with the following example:-

“... a particular lady I dealt with who was vulnerable but couldn’t see it herself because it was a member of the family, it was, it was almost like she didn’t want to acknowledge what was going on although it was blatantly obvious there was, I knew that she was being mistreated, ... but obviously she didn’t see that because of who it was, she didn’t see that because that would be an assault”.

The same phenomenon was observed by Social Worker 9 who reported in a focus group discussion

“... especially if it’s a relative, those relationships I think, that’s the [problem], someone’s ability to identify that person as an abuser.”

Both professional groups referenced intra-personal aspects of the victim which impacted on this, acknowledging the complex inter-personal dynamics operating to maintain the AAR position of vulnerability and victimhood.

Social Worker 9 reported an incidence where she believed a woman felt fear and guilt in reporting the abuse by her son.

“I also think guilt is another thing ... a lady I support in T had a son who was very aggressive with her ... she was involved with the domestic violence team at T police station. But this lady was scared of her son, ... she was frightened of him, she used to have to get out of the house, ... but it took a lot of persuasion ... to get her to get him out of the house, and then to change her locks so that he couldn’t get back in. And it was a lot of hard work, ‘cos she felt guilty ‘cos it was her son and she shouldn’t be doing that to her son”.

Participants often interpreted the AAR's lack of action in terms of emotional consequences. There were examples of the influence of family loyalty from both professional groups. The following quotes illustrate this:-

Police Officer 1

"Yeah because of that person's loyalty that couldn't be happening because of who that person was and they wouldn't do that".

Social Worker 8

"It's complex family dynamics. Grandparents with a huge sense of loyalty ... and were put through every type of abuse but mistakenly believed that they were helping her. The grandparents were in their eighties ... [they suffered] physical abuse, emotional abuse, financial abuse. One of the things that make people vulnerable is the nature of the relationship."

Varied consequences of the abuse for the abused was reported as a sign of vulnerability as it was associated with the victim's reluctance or inability to act in the interests of their own protection and thus render themselves vulnerable to further abuse. These consequences included fear, loss of a valued relationship, loss of income, housing or care, shame, and secrecy. Several participants indicated that fear of the consequences of acknowledging abuse prevented their clients from seeking help. There are parallels between these perceived consequences and those reported by people who experience domestic abuse as barriers to leaving a violent relationship. This theme was present in 43% of focus groups. Social Worker 4 commented on the stigmatising effects of such consequences and in the case of her own client she commented that the consequence in acknowledging abuse was a loss of pride or of social standing.

Social Worker 4 said:-

"It's also about pride and about not wanting to lose face. If somebody does actually recognise that someone is ripping them off there is the fear of alienating that person but also embarrassment of admitting it. ... they feel they can't say 'cos they'll lose face and they'll lose the person's support, friendship, perhaps the social standing".

Police Officer 2 echoed the statements of Social Worker 4 by saying that embarrassment was a big reason people were unwilling to report abuse. She indicated that it was difficult for people to admit that they had been scammed or tricked. This participant indicated that:-

"I think there's a series going on across the whole of the county where people are ringing up elderly vulnerable adults telling them they're a Met Police Officer and they're investigating their bank, ... [telling them] you've got thousands of pounds which is counterfeit money and you need to go and withdraw it, we'll send a taxi, give it [the money] to them and then we'll put your real money back for you. And they do and the embarrassment for client, everything that surrounds that, that goes with that, it's horrendous".

Professionals often discussed these themes in terms of the interactive effects between them which built a picture of vulnerability that attended to the dynamics operating for the victim in relation to themselves and the PAR. These signs were woven together, inextricably linked in the narratives of the victims which professionals teased apart by deconstructing the accounts in their search for clues that conveyed vulnerability to abuse. This was noticed where they observed that the adult's 'need' for relationship outweighed their need to be free from abuse. In their discussion of the nature of the relationship between the AAR and the PAR professionals demonstrated an understanding of vulnerability that was cognisant of both the inter and intra personal effects of these relationships which perpetuated the cycle of abuse and vulnerability.

5.3.6. Inter-Personal Skills – A Matter of Character and Competence

A distinct but related minor theme emerged in relation to the way people were perceived by respondents in terms of how they 'do' relationships. These signs of vulnerability were not limited to intimate personal relationships and encompassed non familial relationships.

This issue of relationship skill was commented on in 7% of direct observations, 71% of focus groups and 10% of interviews. In the interviews and direct observations this phenomenon was commented upon less frequently. It should be noted that case content for these data sources related to a duty environment where it is less likely that this level of understanding of interpersonal functioning will be explored due to the fast pace of decision making. In contrast the focus group data drew upon professional experience based on continuous relationship with clients, thereby enabling

professionals to understand more about how individuals managed in relationships and the skills or deficits in skill that they brought to these relationships.

The poor quality of skill in managing relationships, particularly social awareness, was identified by professionals. They saw people as falling into one of two groups. Some they regarded as having the ability to read the motivations of others but who chose not to acknowledge it (trustworthy persons), and others they saw as lacking the ability to read the motivations of others and so were taken in by their actions (gullible persons). Respondents directly referred to Type 1 persons as too trusting, but Type 2 have been categorised as gullible by me using the concepts identified by Greenspan et al (2001). Features associated with Type 1 (character) included unwillingness to recognise the abuse, loyalty to the perpetrator, feelings of responsibility for the abuser and an acceptance of or accommodation to the abuse. Those associated with Type 2 (competence) included being unaware of risk (linked to cognitive ability), inability to recognise abuse and poor insight into other's motivations (gullibility).

Social Worker 1 also indicated that she found that a willingness to trust others could be a significant vulnerability factor when it was found in excess. Social Worker 1 indicated that being unable to judge the trustworthiness of other people put her clients at risk. She indicated this by saying:-

"I think the other thing for me is, it's around, it's just one factor but it's people's trustworthiness of other people".

In the written records of a learning disability specialist, the social worker noted how a mentally capacitated individual was unable to resist the abusive conduct of an associate due to his pliancy and amiability. The social worker recorded that:-

"Ch has on many occasions demanded money from Co and has not paid him back. She has also demanded expensive phones and iPads. Co has capacity to make decision with regards to this incident but he is very vulnerable and easily led because he likes to please others".

During a direct observation session in August 2014 the following was recorded in the field notes showing the social worker's subtle search for the meanings in the reported conduct of this AAR.

“Social Worker 36 reports that she thinks he is vulnerable due to Parkinson’s health condition, which he can’t manage that independently, he recognises that he needs support, seems a bit embarrassed at lending money. He is vulnerable because without the support and intervention of the registered manager to minimise the risk of further exploitation he is unlikely to be able to say no. His vulnerability is mitigated by the supportive actions of others and his acceptance of this support and advice. He is vulnerable because of his reliance on others to notice and intervene for him”.

In the above example the social worker demonstrates an increasingly nuanced approach in her reported conceptualisation of the person’s vulnerability, starting with the identification of his health condition and presumed loss of independent functioning, thus positioning the adult in a relationship of dependency. In her assessment the social worker adds to this the adult’s response to any prevailing abuse in terms of the consequence for him (embarrassment) and an absence of support or advocacy from his son. The adult’s vulnerability is framed in terms of his continued reliance on others to notice the potentially abusive actions of others as he appears unable or unwilling to construct this view of others himself. This conceptualisation of vulnerability as an interactive operation of multiple features was typical in the study of these professionals, especially where the adult evidenced poor relationship skills.

5.3.7. Challenges in Communication for the Adult

Disruption in an individual’s ability to communicate effectively was discussed as an indicator of vulnerability to abuse in 57% of focus groups and 28% of direct observations. Vulnerability arising from communication impairment was, surprisingly, discussed solely by social workers. They ascertained two separate forms of communication impairment – communication impairment (related to individual abilities) and communication impediment which variously related to either the context such as failures to facilitate supported communication (context) or obstruction of access (conduct of others). Nonetheless, participating social workers asserted its importance for them in determining an adult’s vulnerability.

Social Worker 10 indicated that:-

“communication is the key really, or the fear of being able to communicate honestly or otherwise, or the ability to communicate accurately or otherwise”.

Social Worker 26 echoed these sentiments, indicating that if people can't communicate they are put in a vulnerable position, and that communication difficulty can often be exacerbated if they are not surrounded by people who are willing to make an extra effort to communicate effectively with the individual.

Social Worker 26 indicated that:-

"They have difficulty communicating either ... through physical disability and in particular people who can't use language, you know, spoken language and erm, think quite often I've come across failings, where people don't want to put in that extra effort to communicate in a way they are more able to communicate with, you know, picture boards and you've got sign language, people who don't speak English get interpreters,"

Conversely, the ability to communicate was also viewed as a protective factor and antithesis to vulnerability in some direct observations. In a direct observation session during June 2014 the researcher made the following field notes:-

Social Worker 13 reports on referral regarding married older couple who had gone into nursing care home. On admission some of his medication has been recorded on her MARS sheets and so administered to her and he did not get his medication. The 89 year old woman had dementia but she is able to communicate needs clearly ...

Once again, the degree of discernment demonstrated by social workers in the variety of ways that communication might be impaired/impeded pertaining to both individual characteristics and conduct of others, challenges this idea that professional understanding of vulnerability requires strengthening.

The difference in attention given to this feature of vulnerability between social workers and police officers could be explained in relation to the way the professional groups perceive their role in safeguarding responses. For police officers, communication impairment may be considered once the officer has identified that a crime is to be detected and thus has defined a role for themselves in relation to the adult at risk of abuse. Social workers are employed by an agency which has a lead role in safeguarding. A key principle is that of making safeguarding personal which necessitates engagement with the AAR to determine their wishes and feelings in relation to the allegation of abuse which might explain their attention to this aspect of vulnerability.

5.4. Summary

In Chapter 4 the analysis of SCR reports identified that a theme across these SCRs was a perceived need to strengthen practitioners' understanding of abuse and vulnerability inferring that practice understanding in this respect was deficient in some way. This chapter is the first of three which examines what signs of vulnerability professionals talked about in relation to assessing adults at risk of abuse. These signs are organised into three categories to make their conceptualisation of vulnerability manageable. The chapter starts by defining the categories and themes and focuses on the key themes or clusters of characteristics, as identified by professionals relating to personhood/individual factors which have been categorised as 'Character'.

It is argued that in this category of character, professionals attended to an extensive range of characteristics demonstrating a highly differentiated and nuanced concept of vulnerability relating to personhood. In their concept of vulnerability (reported and observed) they showed an understanding that transcended mere identification of the signs and were able to discuss the meaning of such indicators in relation to those particular signs. This was particularly noticeable in their discussion of the nature of the relationship with the person alleged to be responsible for the abuse where they considered how the person's view of self, their position of reliance or dependency on that person, the setting in which the abuse was taking place and the victim's ability to exercise control in this setting, plus the emotional consequences of acknowledging the abuse interact dynamically in causing that person to be vulnerable to abuse in their view.

The strongest themes to emerge in this category were a) identifying the presence of a mental disorder and the consequence of this in relation to the person's mental capacity to make decisions, b) dependency or reliance on others (not just for care or support but also emotional enmeshment), and c) lack of agency in relation to the person alleged responsible. Social workers, in particular, articulated their analysis of the person's mental capacity using a functional test approach which demonstrated complex conceptualisation as well as lawful compliance relevant to the decision making framework for progressing safeguarding enquiries and actions. Social workers' focus in this was of a protective nature in determining to what extent the person might need support from others to make decisions in the interests of protection from risk. Police officers also made frequent reference to a person's mental capacity which they reported to be a key determinant for them in

whether or not there should be further police involvement which hinged upon the pursuit of criminal enquiries. Their focus was of a detective nature.

Historic definitions of vulnerability have focused on characteristics of the individual. The construction of vulnerability which places a focus on the individual has been criticised for the failure to attend to the circumstances that give rise to vulnerability (Fitzgerald 2009). If these definitions and criteria act as the primary guide for practitioners it might be expected that their concept of vulnerability shows a similar tendency. The next chapter explores how professionals' concept of vulnerability is informed by indicators arising from the person's circumstance or context.

Chapter 6

Cues and Clues to Vulnerability – Part 2

6.1. Introduction

This chapter presents part 2 of a thematic analysis of the ‘cues and clues’ to vulnerability in Adults At Risk of Abuse (AAR) discussed by professionals, and observed in their practice being used as operators in their conceptualisation of vulnerability. It adds to the argument that professionals demonstrate a rich and nuanced evaluation of vulnerability, identifying signs related to the both individual characteristics and situational indicators in both the person’s context and the conduct of the Person Alleged to be Responsible (PAR).

The focus of this chapter will be the characteristics of vulnerability identified by respondents in the study which I have categorised as Context or Circumstance, relating to features of the person’s situation. As with the category of character, the strength of the themes in respondents’ concept of vulnerability relating to context was indicated through the triangulation across the data sets. Once again professionals described a range of indicators that they attended to in assessing someone as vulnerable to abuse. Major and minor themes emerged in the analysis. Professional recognition and attention to signs of vulnerability related to a person’s context suggest that their concept of vulnerability encompasses individual and situational signs, extending beyond the operational definitions which guide and govern their practice.

Professionals also demonstrated that they gave consideration to vulnerability arising from the conduct or condition of the persons alleged responsible. Police officers, in particular, often reported signs of vulnerability which they identified not on the personal or situational characteristics of the individual abused but rather in the behaviour or motivation of the abuser. Whether the locus of vulnerability was attributed to either person or setting, the characteristics of vulnerability were seen as being external to the individual. Again, the interactive effects of a person’s context in relation to the person alleged responsible was discussed by respondents demonstrating a holistic assessment of person, place and perpetrator in conceiving the causation of vulnerability.

The clusters of characteristics of vulnerability bear some resemblance to Rightland’s (2003) clusters of risk characteristics (Dispositional or Personal factors, Contextual or Situational factors). Using this

as a conceptual framework, an emergent model of vulnerability is proposed to make this manageable conceptually.

6.2. Context or Circumstance of the Victim

The official policy guidance 'No Secrets' (2000) that underpinned public services adult protection responses for 15 years used to define a 'vulnerable adult' as follows: 'A person who is 18 years or over and who is or may be in need of community care services by reason of disability, age or illness; and is or may be unable to take care of, or unable to protect him or herself against significant harm or exploitation'. This definition formed the basis of decision making and is likely to have become entrenched in the psyche of professionals. The definition was criticised as being pejorative (Fitzgerald 2009) in as much as it locates vulnerability in the characteristics of the person.

Drawing on the social constructionist approach similar to the social model of disability (Oliver 1983), Wishart (2003) argued that vulnerability to abuse is a consequence of the effects of the world the person inhabits as opposed to the individual characteristics of impairment. In this way vulnerability to abuse is re-constructed in terms of the individuals' situation or circumstance. Whilst the wording in the Care Act (2014) removed the potentially stigmatising reference to personal characteristics it still attaches the concept of abuse with need for care and support.

Others (Brown et al 1999) have suggested that there is confusion about what constitutes vulnerability and the causation of abuse, and that many safeguarding policies infer that vulnerability to abuse is a product of personal impairments. They argue that these ways of constructing the term vulnerable adult ignore the influence of structural inequalities as a social constructionist model would promote. In the context of these legal and policy definitions it might be expected that signs of vulnerability arising from the person's circumstances or the behaviour of the PAR might not feature in professional conceptualisation of vulnerability. The findings of this study refute that and assert that despite these definitional constraints the understanding and conceptualisation of vulnerability to abuse is informed by professionals' knowledge of these factors.

In identifying the signs of vulnerability that professionals discussed, themes emerged relating to the person's context or circumstance or what I have termed their *Position (situation or circumstance)* rather than their *Condition (individual characteristics)*. On a perfunctory level, participants indicated that it was possible to mitigate vulnerability by removing the person from the circumstances causing

them to be vulnerable. However, there was also recognition that in a practical sense, this was significantly more complicated. A multiplicity of factors within the person's context was recognised as signs of vulnerability, many of which were considered to be pernicious and insidious.

Furthermore, the interactive and circular operation of individual and situational vulnerability was commented on. Examples of this were commonly described by participants in relation to older persons whose status as a resident of a care home put them in a position of contextual vulnerability which, coupled with their physical or mental health needs (individual vulnerability), served to limit their capacity to exercise choice and control. In such circumstances the absence of social support and external advocacy was seen as significant in them remaining vulnerable in the care home. In the experience of these professionals the archetype of the adult most vulnerable to abuse was someone who had a significant mental impairment which rendered them dependent on others to meet all aspects of their daily living needs, unable to initiate help from others, unable to communicate complaint and without access to advocacy, being cared for by services where there was a lack of scrutiny or oversight by others and unable to remove themselves from that setting. This archetype exemplifies the layered approach to vulnerability in the minds of the professionals which taken together increased the 'tariff' of vulnerability.

6.2.1. Social Isolation

Isolation was a dominant theme in relation to the person's circumstances in respondents' discussion about signs of vulnerability. In fact, for some social workers they identified isolation as an overriding factor in identifying a person to be vulnerable. Isolation was discussed in terms of a lack of social connection to others, loneliness and being un-befriended. It was commonly associated with residing in institutional care where access to former social networks was limited. Isolation was seen to be a significant factor in increasing an individual's vulnerability. It was discussed or observed in 50% of direct observation sessions, 100% of focus groups and 60% of interviews.

Social Worker 26 indicated that, as a social worker, isolation was something that she paid particular attention to when assessing vulnerability. She drew attention to how isolation could operate to increase vulnerability, not just through the absence of support but also how being in need of care or support, which is not available to a person through friends and family, puts people into the position of a 'virtual friends group.' This observation demonstrates this social worker's insight into the operation of potential abuse through professional boundary breaches, where the circumstances of

the individual and their care provision come together to create a situation, intended or otherwise, where a 'friendly carer' then becomes a 'friend who cares'.

Social Worker 26 stated in a focus group discussion that:-

"... I do see isolation as very big vulnerability, you know people with very small social networks rather than coming into contact with someone who seems like .., they've got a good connection to their local community, perhaps through a faith group, or if it's the family that seem to be looking out for them, although I was just saying you come across some very vulnerable people who don't seem to have many people in the world or contacts and if so all the social contacts they've got is through provision, services that they are reliant on then I automatically think that that person might be a bit more vulnerable to abuse or targeting of others".

Others construed isolation as arising out of the individual's impairment and the consequences of this. Social Worker 35 indicated that isolation was a factor that increased an individual's vulnerability by saying:-

"And I guess another vulnerability is something that is within themselves so, for example, a learning disability which has led someone to be dependent on others or it may be someone who perhaps is very isolated from others or a matter of personality, so a wide range of factors which have led to the person feeling less able to protect themselves".

Both social workers and police officers identified how loneliness and isolation operate to sustain people in relationships of abuse and how abusers capitalise on this to prevent the person getting access to help or exercising a different choice.

Police Officer 1 spoke about how fear of isolation might prevent a victim from making complaint to the police:-

"...cos you can have someone who, if that's all they've got, then they become vulnerable because the person who's looking after them, that's all they've got, so it's that fear of isolation if they do speak up against them..."

Social Worker 7 related a case where the actions of others kept the adult in isolation from others which alerted him to the adult's vulnerability. He stated in a focus group discussion:-

“ We’ve had a couple of cases where we’ve had individuals who’ve been prevented t accessing what they’ve wanted to do by their parents who’ve made decisions about them, that is without them and have prevented them from having access to people from outside of the family home ... or have been controlling of who the individual will speak to outside of the family home and to resist outsiders ... to allow them a voice so the sign of vulnerability is in the obstructive or constraining behaviours of the perpetrator”.

Again, this feature of vulnerability is not considered in isolation by the professionals and this interactive ideation is typical of what has been observed previously, suggesting a complex, multi-layered interpretative approach to the conceptualisation of vulnerability. Their understanding of the impact of isolation was evident in the inter-relationship between this and a lack of advocacy which heightened the un-befriended person's vulnerability.

The absence of an advocate was seen to increase an individual's vulnerability in 7% of direct observations and 30% of interviews. In circumstances where an AAR was unlikely to be able to comprehend the events in relation to themselves advocacy was considered to be a protective factor and the lack of it an indicator of vulnerability as the person is unable to advocate for themselves.

Social Worker 35 indicated the importance of having advocates, but also the importance of those advocates and the system around them understanding and comprehending the situation.

Social Worker 35 stated:-

“... if I receive something in that says that for some reason a person doesn't have another person to address their needs on their behalf or alongside them I think, for me, that is one of the most significant factors and it is something I would pick out in the interaction”.

6.2.2. Status of being a Patient or Client

An individual's status as a recipient of health or medical patient or social care services was a reoccurring reported reason for determining vulnerability. This status of being either a patient or a client was discussed in 36% of direct observation sessions, 43% of focus groups, 60% of interviews

with social workers and 20% of interviews with police officers. During direct observations the absence of comment on this feature of vulnerability may relate to the particular case characteristics of the referrals at that time. In their talk about vulnerability professionals took their lead in identifying vulnerability from the person's status as a patient or client (circumstances of being in receipt of formal services) not merely as having a defined health challenge. Professionals operated this status of being a hospital inpatient or client of social services as a shorthand for 'vulnerability'. Vulnerability was presumed on the basis that the adult met service eligibility criteria and exemplifies the 'rule bound eligibility driven' approach to determining vulnerability.

Social workers were more likely to consider patient/client status as an indicator of vulnerability than police officers. They also indicated that they would not treat this indicator as a definitive factor for vulnerability. It served more as a cue to them to make further enquiries to understand how this status might impact on their vulnerability to abuse. In this way the social worker's resistance to construing people in such categorical ways illustrated the operation of the policy making power that Lipsky (1980) described as being within the gift of Street Level Bureaucrats. The Social worker's autonomy was exercised in the discretion she could use in the construction of her concept and by adopting or rejecting a categorical approach to evaluating the person's vulnerability. This social worker contrasted this approach to her colleagues in health whom she considered operated a paternalistic approach in the operation of this label. This participant indicated this by saying:-

"I think that we all come at it from our own perspective. I struggle with Health's view that everyone is a patient, and failing to sort of actually see people actually as having an ability to express their [own lifestyle choices]".

In contrast, some police officers indicated that they believed simply the act of becoming a patient made an individual vulnerable. Police indicated that when someone became a patient at a hospital they were relying on another for their care and that was a vulnerable position.

One police officer indicated that:-

"just going into hospital, regardless of having surgery, just going in and becoming a patient makes you vulnerable because you're reliant on [someone else for your care]".

The context for this professional conferred a degree of reliance on others and a disempowering lack of control. In this way professionals began to evidence a view of vulnerability as a universal part of

the human condition. Situational vulnerability is something that we might all encounter irrespective of our personal characteristics. This concept parallels some of the changes witnessed in English law when amendments to the Safeguarding Vulnerable Groups Act (2006) following the implementation of the Protection of Freedoms Act (2012). This heralded a shift of focus, removing the association of the term vulnerable adult with personal characteristics and placing it in relation to particular settings. This legislative change re-framed vulnerability in terms of the type of 'regulated activity' provided, which included provision of health care, so the emphasis was on the person's context rather than their individuality.

6.2.3. Homelessness

The issue of homelessness was not a significant feature in the SCR summary reports. In fact, only 1% of cases sampled were in reference to persons considered to be rough sleeping.

The small percentage of reported cases that featured homelessness as a characteristic of the adult's circumstances would suggest that vulnerability due to homelessness is not a significant feature in the understanding of professionals. However, few, if any, street homeless people are in receipt of mainstream health or social care services.

In this present study homelessness emerged as an identifiable feature of vulnerability reported by professionals. Homelessness was discussed as an indicator of situational vulnerability in 60% of interviews with social workers, and was observed to add to vulnerability in 21% of direct observations. It is quite noticeable that homelessness as an indicator of vulnerability should emerge as a theme unique to social workers. This would suggest that social workers, at least, understood the issue of homelessness as an indicator of vulnerability.

One could speculate that social workers are more likely to have studied psychological theories in the course of their training, including Maslow's hierarchy of needs. For these social workers the absence of security of tenure for accommodation was a fundamental issue in ascribing vulnerability. One participant reported that homelessness was one of the first things she considered when assessing vulnerability highlighting it as a feature of saliency and primacy in her thinking.

In the Social Worker 36's own words:-

"That's what they will be looking at first in vulnerability I think. Housing, has the person got housing, we've had referrals come through that a person is vulnerable because they are making them homeless."

There was an understanding that homelessness made someone vulnerable to abuse because of the associated absence of resource to promote self-protection.

In Social Worker 35's own words:-

"I guess there are a number of [factors that contribute to vulnerability] ... perhaps they've been made homeless, therefore they are unable to pull together the resources that they need within themselves"

The issue of homelessness also arose during direct observation sessions. Field notes from November 2014 detailed the social worker's report of an older lady who left her care home which one would expect to be secure housing, to receive hospital care, and when she was released from the hospital the care home refused to accept her back. Notes from this observation session illustrate the impact for the family who are sometimes secondary victims from this kind of conduct:-

"Female Social Worker reporting on referral received on a 99 year old female in residential care. Referral made by CQC having received information from a family member expressing concerns about the care of the client. Care home refused to take client back after absence of only six hours to undertake hospital visit and assessment.... Family member very distressed at home's refusal to take her relative back"

This level of reporting of homelessness as a sign of vulnerability was surprising in light of the few number of safeguarding referrals made in relation to the population of homeless persons. Street homeless people are noticeable by their absence in the demographics of safeguarding referrals.

6.2.4. Institutional Care Provision

In the sample of SCR reports institutional care settings represented 50% of the locations in which abuse had taken place. Within these, in 25% of cases health or social care personnel were identified as the perpetrator. If professional conceptualisation of vulnerability to abuse failed to consider this contextual factor then the need to strengthen their understanding in this respect could be reasonably argued. However, this was not the case with professionals in this present study, in fact institutional care provision was a strong theme, especially in the focus group discussions. This theme was observed across 86% of focus groups, 30% of interviews and 7% of direct observations. The difference might be explained by context in which the assessment of vulnerability takes place. Institutional care may not have been a feature in the direct observations as these took place in a duty environment where assessments are conducted within 48 hours based on limited information and without the same access to the extent of local intelligence about service providers and particular settings. Whilst professionals in this duty context would have access to information about quality ratings by the regulators, they would not have the same level of contact with local providers that participants in the focus groups would do. Focus group participants would be able to directly observe service settings and receive feedback from clients and other observers which would help them to form a view about the culture of care.

Vulnerability relating to institutional care was framed by participants in terms of under resourcing, institutional care practices and cultures of care, as well as the outcomes of these on an adult's conduct recognising the perpetuating effects of institutionalised practices on vulnerability to further exploitation. Attention was also given to the unintended consequences of institutional care which intensified individual vulnerability through the increased exposure to the company of others whose ability to manage their own behaviour may be compromised in some way, and social isolation. From the focus group discussions the following commentary by social workers illustrates the construction of this theme:-

Social Worker 29

“Vulnerability can be institutional, the institutions provided all of the care and there's very little contact with the outside, and people are very vulnerable, yeah culture”.

Social Worker 11

"... and environment, especially with people with challenging behaviour, we put everyone with challenging behaviour in the same environment and then the abuse is perpetrated you know through [exposure to others who can't self-regulate and present a risk of harm]".

In interview Social Worker 37 spoke about this in greater depth as a selection of quotes from this interview elucidate.

Social Worker 37

"Yeah, so thinking about service user on service user incidents in places such as dementia units and C House [C House is a facility for people with learning disability and challenging behaviours], people haven't got insight into what they're doing and the consequences of what they're doing, not able to weigh that up, people get very agitated with each other and that results in escalation of challenging behaviour and that, you know, they sometimes hit each other unfortunately, erm , and some of the triggers may be they can't cope with lots of noise around them and a crowded environment....."

And also because, the other thing is staffing levels, you know, staffing levels are quite low, and it's training of the staff as well, how to deal and recognise the triggers sometimes....."

And is there a culture in those staff as well.... there's a culture that develops and other members of staff don't feel that they can actually challenge these staff who have been there, new manager went in and found it al."

All of the above serves to demonstrate a thorough grasp of the mechanisms at work in institutional settings which make people vulnerable to abuse. Whilst this theme predominantly featured in the discourse of social workers, the toxic nature of institutional settings was not unnoticed by police officers who reported and were observed to look for clues of vulnerability in the histories of incidents related to such settings.

The attention paid to the notion of institutionalisation and its impact on vulnerability should be no surprise if professionals have a good understanding of the nature of abuse and vulnerability. The issues of power and powerlessness in these settings has been rehearsed in the discourse on the relationship between exclusion, marginalisation, discipline and punishment by authors such as

Goffman (1961) and Foucault (1997), and with further critiques from the analysis of NHS enquiries (Martin 1984) all of which pre-date the implementation of formal safeguarding policies in the UK.

6.2.5. Poor Quality Care Service Provision

A similar theme was poor care service provision as this encapsulated signs of vulnerability where an adult was in need of care and support but not necessarily receiving it in a formal care setting. Participants drew attention to poor service planning (particularly in relation to hospital discharge), poor quality provision, gaps in service and lack of choice and control. These might appear obvious factors to increase vulnerability to abuse, but professionals in this study showed an understanding beyond the obvious. In their conceptualisation of vulnerability due to poor care provision they drew attention to the heightened vulnerability of adults receiving private care (self-funders). They suggested that the absence of State scrutiny signalled less resilience in comparison to others receiving services commissioned by a public body where external oversight of quality would exist.

In their thinking about vulnerability professionals simultaneously considered both the presence and absence of protective factors or indications of resilience which is a complex cognitive task. It is much easier to conceive of something through its positive presence rather than through an absence. These professionals were thinking about vulnerability not only in terms of features that were present but also features that were absent.

6.3. Conduct or Condition of Others

McCreadie et al (2008) attempted to explain the discordant views of practitioners about what constitutes a vulnerable adult in relation to ambiguities inherent in the policy definitions. The difference of views were evident and distinct in locating the locus of vulnerability in either the person or their situation/circumstance. As mentioned previously, Brown et al (1999) proposed that some of this definitional confusion could be countenanced if definitions attended to the origins of and vulnerability to abuse in the individual's environment or the perpetrator's behaviour rather than their individual impairment.

The findings of the present study are that professionals are attending to signs of vulnerability associated with the conduct of others in the way they think about vulnerability to abuse. This was particularly true of police officers but also noticed in social workers. Their conceptualisation was not

constrained to the behavior of others but included the 'condition' of the PAR. In this way they attended to signs which included aggression, alcohol dependency, drug misuse, a lack of self-regulatory behaviour (no insight or poor impulse control), carer stress, carer lack of knowledge, carer with own health problems and the PAR's history of abuse to others. Characteristics of Conduct in the other which were identified as signifying vulnerability for the AAR included, controlling or coercive behaviour, misuses of power/professional boundary breach, unsafe care practices, poor leadership, manipulating information, failure to report abuse/safeguarding concerns, failure to deliver care, creating dependency and professional disregard due to disbelief. While this is not an exhaustive list of behaviour that could impact on another person and make them vulnerable, the data indicated that these were common or likely scenarios witnessed by participants.

Police officers were more likely to identify vulnerability in the controlling or coercive behaviour of others and spoke of the AAR as being 'targeted'.

Police Officer 1 expressed it like this:-

"... they were vulnerable in the community because I think they were targeted by individuals within their catchment area ... they're targeted because they could see, you know, the houses the ramps, they can tell these characteristics from the house, you can tell that a disabled person or a person that isn't as mobile".

This view was supported by a colleague who recognised that environmental signs might identify an adult as an easy target for those with an intention to exploit.

Police Officer 3 commented:-

"Sometimes the places that people are living as well, sometimes people with a learning disability living on a Council estate and local youths targeting them because they are seen as vulnerable because they are open to manipulation".

Social workers, by comparison, tended to focus their attention on abuses of trust within a relationship and ill-equipped care providers as the following quotes reveal.

Social Worker 36 stated in interview:-

“Still getting quite a lot of those ‘cos there is that reliance on that person or co-dependency, you know, they put all of their trust, they may be family members and yet they are vulnerable from those people because they don’t behave appropriately towards them”.

Social Worker 37 offered this insight:-

“Inadequate staffing and poorly trained staff increase the cared for adult’s vulnerability as [the carer is] unable to meet the need appropriately ... and otherwise good and skilled carers not resourced to carry out their task”.

6.4. Dynamic Concept of Vulnerability which considers the Interaction between Signs Identified from a Person’s Condition (Innate Signs) or from their Position (Situational Signs)

The evidence so far confirms that a simple binary model of vulnerability which locates the signs within either the person or their situation fails to capture the dynamic operation of the evaluation of vulnerability which not only took account of account signs that relate to the conduct or condition of the PAR but also commented on the links between the nature of the relationship and the context of contact between the AAR and the PAR.

In an interview one social worker summarised this:-

Social Worker 37

“I think most frequently are the, it’s a combination of the environment that they’re in and the relationship between the alleged perpetrator and the victim”.

The interaction of signs of vulnerability, both personal and situational, has been a recurrent way of discussing vulnerability amongst these professionals. However, ‘interactive’ effects in the causation and maintenance of vulnerability were also understood in terms of the relationship between past and present events. During a direct observation session in November 2014, Social Worker 35 reported that she believed an individual to be vulnerable, both because of his history of abuse and because he was currently living in his car. According to this participant, these social circumstances

made her client more vulnerable than he otherwise would have been. In the following field notes, made during the direct observation session, the social worker makes this observation:-

“Social Worker 35 reporting on referral received for a 55 year old male amputee and multiple health problems, wheel chair user. Adult reports having depression. States he has been mentally abused and physically abused by his wife. Slapped and pushed back in his wheelchair and gets ‘put down every day. States he is living in his car”.

Whilst other commentators have suggested that the operation of a social model of abuse is compromised by the difficulties arising from confused understanding and definitions of abuse and vulnerability, the findings of this study indicate that professionals give much thought to how a person’s social circumstances might influence their vulnerability, including issues of disadvantage and discrimination that are structural in nature. In this study professionals discussed signs of vulnerability in a person’s social circumstances in terms of living conditions (including living with family carers), access to support, social status, economic status and housing circumstances (availability and location).

The present study did not overtly explore the individual professionals’ rationale in the way they constructed their view of vulnerability so it is not clear what models informed their thinking and if this was a function of conscious or unconscious competence. Nonetheless, the signs to which professionals give attention are indicative of their operation of a social model of abuse in their conceptualisation.

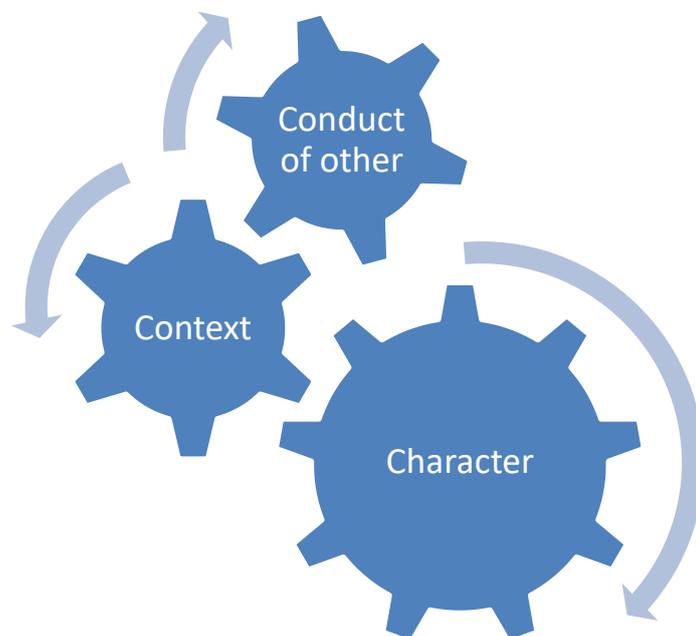
For respondents in this present study the concepts of risk and vulnerability were often considered simultaneously and were sometimes conflated in their thinking. They were sometimes understood as opposite ends of a continuum. Brearley (1982) points out that vulnerability is a risk related concept and assigns its similarity in usage to the terms hazard and danger. However, he highlights that in common usage there is a slight distinction as ‘vulnerability’ refers to someone who is susceptible to loss: hence loss is a possibility, whereas ‘being in danger’ refers to the likelihood of danger; hence loss is a probability. The inter-changeable use of the terminology and overlap in concept is not surprising when the language of risk is explored.

Rightland et al (2003) commented that researchers often focus on clusters of characteristics of risk or categories to make this manageable conceptually. They identified clusters delineating a typology of risk factors that included:-

- Historical or Developmental factors.
- Dispositional or Personal factors.
- Symptom(presenting issues) factors.
- Contextual or Situational factors.

The clusters of characteristics of vulnerability emergent in this study evidence strong parallels with Rightland’s typology of risk factors. The typology of vulnerability is outlined in the figure below.

Figure 1. Tri-Partite Interactive Conceptual Model of Vulnerability



This tri-partite interactive conceptual model of vulnerability was observed to be operating irrespective of the bias towards individual characteristics evident in definitions used in law and policy.

6.5. Summary

This chapter has explored the signs of vulnerability that professionals identify in thinking about vulnerability as it arises from a person’s situation rather than their personhood. It adds to the previous chapter in confirming the breadth of indicators attended to by professionals in forming a

view about an adult's vulnerability to abuse. The themes identified in relation to context bore some similarities to some of the contextual features of the circumstances of persons reported in SCRs, particularly in relation to setting. It is argued that professional understanding of vulnerability as indicated in the person's circumstances is well understood and attended to by professionals who gave a detailed rich description of situational indicators of vulnerability.

Dominant definitions of a vulnerable adult in law and policy in England & Wales focus on vulnerability in terms of individual characteristics. If professional conceptualisation is governed purely by such definitions it might be argued that their concept is limited by these definitions with a subsequent focus on signs located in the individual rather than their situation. In this case, the message from SCR summary reports that vulnerability is poorly understood might be explained by a failure to consider situational signs of vulnerability in favour of individual signs. Professionals in this study reported many and various signs of vulnerability indicated to them from the person's circumstances.

As was the case with characteristics identified relating to the individual, professionals demonstrated that their understanding was more complex than sign identification. In their thinking they frequently articulated the interactive effects of these signs of vulnerability. Further cognitive complexity was evident in their search for and identification of vulnerability through the positive presence of some features and the absence of others.

Vulnerability was also construed in terms of cause and effect in relation to abuse and features of a person's situation were discussed this way. For example, isolation was discussed as a factor in both the causation of vulnerability and as a consequence. It was also thought about in terms of impact in as much as 'loneliness' and social isolation in the context of care need might create the circumstance where the person's care provider becomes viewed by them as a 'friend'. This creates the risk of 'professional boundary breaches' leading to abuse in the relationship whether by accident or intent. Differences between the professional groups were less marked in relation to situational signs of vulnerability, except in relation to signs within the conduct of the PAR. Police officers were more likely to identify signs of vulnerability for the adult victim in the coercive and controlling behaviours of the PAR whereas social workers tended to see these signs in terms of abuses of trust or ill-equipped care givers.

Both professional groups identified signs of vulnerability indicated in the person, their circumstances and the conduct of the abuser. Both used a dynamic approach which considered the interactive effects of these various signs in evaluating the person's vulnerability. However, there were differences between them in the focus on these signs. In the next chapter I will explore professional differences further in terms of professional focus on either victim or offender.

Chapter 7

Cues and Clues to Vulnerability – Part 3

7.1. Introduction

This chapter presents part 3 of a thematic analysis of the ‘cues and clues’ to vulnerability in Adults At Risk of Abuse (AAR) discussed by professionals, and observed in their practice as informing their conceptualisation of vulnerability. It adds to the argument that professionals demonstrate a complex and competent understanding of vulnerability identifying the iterative and blended approach to combining signs when evaluating vulnerability. The data revealed that despite their assertions otherwise, the professional groups did have a broadly shared view of vulnerability. During focus group discussions participants often reported that other professionals had a different view of vulnerability from themselves, but they often showed a number of commonalities in the signs of vulnerability they identified. However, some differences between the professional groups were identified which suggest a distinct focus on either the victim or offender in their search for those signs.

It is argued that the victim/offender focus can be explained in terms of role differentiation between police officers and social workers which are aligned with the detective and protective components of safeguarding activity. There were also observed differences of approach relating to the context in which evaluations took place in terms of duty work versus ongoing case work. Theories of decision making models, outlined in the literature review, and the operation of heuristics are explored for interpretative value. However, the differences may be explained entirely in terms of professional identity. Consequently, this chapter acts as a bridge to the next which discusses what else is operating in the professionals’ decision making for responding to identified signs of vulnerability to abuse.

The chapter starts by elucidating professionals’ approaches to building a picture of a person’s vulnerability and the dominant concepts informing this in combination with one another, suggesting some signs of vulnerability feature more frequently in their thinking. It goes on to outline the differences between the professional groups in their focus for sourcing the signs and seeks to explain this in terms of professional identity and role differentiation.

7.2. Combining the Signs of Vulnerability – “I’m Reluctant to Attribute just one...”

The title above draws on a quote from a social worker who when asked in interview what were the most significant signs amongst all that she had articulated. Her response typified that of almost all participants who described their concept of vulnerability as an evolving process, a *process* rather than an *event*. They spoke of collecting the cues over varying periods of time. In the words of two social workers during focus group discussions:-

Social Worker 10..

“... you don’t always actually get told all the information, that’s kind of part of your learning and dealing [with the person] you unearth new bits of information.”

Social Worker 4

“... quite often you go into a situation, perhaps when you just go in and you walk in the door and the first few words are spoken, you’re listening, you’re looking, you’re smelling, you’re just, your senses are on overdrive ... you then try to build a picture, what is it, what is it that’s wrong because there’s something very wrong..”

This social worker exemplifies what Ferguson (2016) has described as the ‘deeply embodied practice’ (p. 67) of social work during family home visits where all the senses come into play in seeking to understand the worlds of those who occupy these spaces.

Interview participants also described more than one sign of vulnerability, and often combined those signs of vulnerability in ways that mirrored their colleagues of the same profession revealing patterns in the combinations.

The most frequently listed signs of vulnerability across both professional groups were dependency and mental capacity. Police officers were most likely to list dependency, mental capacity or age as signs of vulnerability. Only social workers indicated that illness, disability or poor social skills were signs of vulnerability. The professional groups did show differences in the number of signs they used in combinations. Police officers listed between one and three signs of vulnerability, while social workers listed one to six signs of vulnerability. Social workers more frequently combined the following signs of vulnerability – dependency, mental incapacity, isolation and illness. An example of the types of combinations from the analysis of interview transcripts is available at Appendix 14.

It is not surprising that professionals adopted this approach of piecing together various signs of vulnerability to build their overall picture of the person at risk of abuse. It is interesting to note that whilst there were some shared understanding of vulnerability across the professional groups there were also some notable differences between the professional groups in what I have termed victim or offender focus. It was found that police officers tended to focus on the offender, which might explain the smaller number of signs discussed by them in relation to the adult at risk. In particular, the police focus on the mental capacity of the victim or offender was a key determinant for them, as discussed in earlier chapters.

Both professional groups attend to situational signs and, as such, vulnerability is constructed in terms of both the condition (innate) and position (situation). Differences between the professional groups showed in the ways they combined the categories. The dominant combination amongst social workers was a combination of **Condition - (Innate signs located in the Character & Competence of the Adult)** + the **Position** they find themselves in (**Situational signs identified in the Context of contact with the abuser**). In contrast the dominant combination amongst police officers was **Position – (Situational signs identified in the Conduct of the abuser) + Position (Situational signs identified in the Context of the abusers contact with the adult at risk)**.

In this analysis of the interview data (tabulated in Appendix 14) it is difficult to ignore that signs of vulnerability such as 'lack of agency' or 'conduct of others' do not appear in these combinations. These have been reported elsewhere in the data as being of particular importance in informing the conceptualisation of professionals. This might be explained by the small number of persons involved in the interviews in comparison to the larger number of persons and data used to form the 'signs of vulnerability' themes.

Earlier in this chapter I argued that professionals have demonstrated a conceptualisation of vulnerability that is rich in description, highly differentiated and operates on an interactive and additive approach to build a bigger picture. Despite this, their concept of vulnerability illustrates what Spiers (2000) described as an etic rather than emic approach. Etic approaches view vulnerability as susceptibility to harm, something which may be externally evaluated and quantified in some way. The emic approach relates to the state of being threatened, requiring a more qualitative evaluation usually judged by the internal appreciation of the person and their situation.

Further detail of these approaches can be found in the Literature review. Emic approaches were not so evident in this study.

However, one social worker demonstrated insight into this apparent absence of attention to the lived experience of the AAR. In response to a question in interview of what signs of vulnerability she thought were given less attention her response was:-

Social Worker 34

"I think we are obsessed as a department with the physical side and we don't give any sense of people's ability to cope with what their situation is, you know, it is about it is never about how they feel about the situation".

This social worker reports being constrained by the organisation to thinking about vulnerability in etic terms despite being alive to adopting an emic approach. The absence of an emic approach lends supports to the historical critique of safeguarding procedures that drove the sector-led Making Safeguarding Personal (MSP) initiative. In response to peer challenges and the review of 'No Secrets' in 2009, two prominent themes emerged, of which one was that people (recipients of safeguarding enquiry activity and interventions) felt that they were propelled through a process over which they had little control and the other was data that the 'system' collected focused on outputs rather than outcomes. It would appear that practitioners and service users share dissatisfaction with the dominant etic approach to thinking about vulnerability. The MSP initiative arose from a new desire to take a more person-centred approach to safeguarding adults from abuse, one that seeks to understand their views and desired outcomes to determine interventions tailored to the individual and their strengths. SCIE (2014) recommend that Safeguarding Adults Boards have a role to play in considering how to embed MSP.

However, there is still a long way to go in embedding an emic approach in safeguarding adults practice as evident in early reports on performance of Councils engaged with the MSP initiative. ADASS (2015) identified their standards of current and desired practice. Most described themselves as being at a Bronze level, which included working with people as soon as concerns are raised about them to identify the outcomes they wanted. This principle, whilst laudable, fails to consider whether any prior decision has been taken to exclude an adult from safeguarding based on an etic approach.

Principles of MSP could support an emic approach to evaluating vulnerability but it remains to be seen to what extent this operates amongst professionals as part of the referral decision. It should be noted that the data gathering period for this study largely relates to the period 2013 - 2015 and it is unlikely that the principles of MSP would have been embedded in practice at this time. Consequently, the outcomes of this study may not be a reliable indicator of current practice.

This is important because it helps us to understand how a social model of vulnerability might struggle to prevail where the focus of the concept of vulnerability is individual rather than situational causation. The person centred and outcome focused approaches promoted by the MSP initiative should make it possible to adopt an emic approach, which takes account of the adult's lived experience. However, the current pressures on public resources and a legal mandate, which is predicated on criteria that do not explicitly encourage this approach, may conspire against professional practice which seeks to apply a socially constructed conceptual model.

It has been argued that the data supports the view that in their conceptualisation professionals see vulnerability as a complex, context bound and contingent phenomenon. The next section of this chapter explores what else influences professionals' responses to signs of vulnerability.

7.3. Professional Differences in their Victim or Offender Focus for Signs of Vulnerability

Whilst the professional groups shared commonalities in their conceptualisation of vulnerability there was one theme to emerge from the data which distinguished the two groups and that was their respective focus in attending to the signs. It is argued that the victim/offender focus could be explained simplistically in terms of the role differentiation of police and social workers between the detective and protective elements of safeguarding activity. However, this focus cannot be explained entirely in terms of professional identity.

7.3.1. Offender Focus

The data triangulated across all four sources indicated that police officers were more likely to focus on the offender rather than the victim in identifying signs of vulnerability to abuse. Whilst this was particularly noticeable amongst police officers, the attribution of indicators of vulnerability in the conduct or condition of others was also observed amongst social workers. During interviews both police officers and social workers described how they attended to the conduct or condition of the

alleged offender/abuser in considering whether safeguarding responses were required. Direct observation and written records revealed that the abuser was often discussed in combination with the status of the adults at risk as either a patient or client. An assessment of the abuser was factored into an individual's vulnerability.

This offender focus amongst police officers was not an indication of their lack of concern for the victim (as often they would try and direct the adult to an appropriate service), but rather related to their reported primary purposes of their job role. Police officers indicated that they relied on specialised services to assist individuals experiencing situational vulnerability. When asked about how they handle situations of abuse, police indicated that the first steps they took were often to investigate the situation and individuals surrounding the abuse. If an elder was being abused, for example, police indicated that their first step would be to investigate the care home. Police Officer 4 indicated this by saying:-

"If we look at abuse in sort of a care setting for example, we would have to look at the care home, other reports of that care home, also looking at the individual's history as well. In terms of they themselves, [if they] suffered abuse previously they could be abusers. ... they have been in they have been abused that would suggest some vulnerability so yeah, certainly their history, or as I said, the history of the care home. Individual previous history of abuse and residency in care setting with previous history if abuse or poor care".

This quote indicates that part of determining vulnerability to abuse for this police officer was to investigate past reports filed on behalf of the abused or to investigate past actions of the abuser. In this way, the police officer is determining vulnerability, but in a way that is focused on criminal actions and history. These police officers also investigated the context of the abuse, i.e. the setting in which it occurred, considering whether there was a history of abuse in the setting as well as any history of the individual being abused and whether this had also occurred in a similar setting.

Similar statements to the one above were made by other police officers, demonstrating a pattern of behavior that separated police officers from other types of service professionals. One police officer indicated that he too would approach a situation of potential abuse through the criminal history of those involved. Police Officer 4 indicated that:-

"I always check the carers. Say for example, allegation of theft against a carer, who goes into a house before just run it through our system to see if we have any trace, because we are very quick to write things off too. This old dear has just lost it, actually it doesn't mean it hasn't been stolen it just means they can't remember it, but at some point we have to think what evidence have we got but if this person has got previous for it....."

This response was unique to police officers where the intelligence gathering related to the conduct of the offender or PAR. Police officers have access to information systems that permit the storage of information about offenders as befits their detective functions. Information systems used by other agencies do not have such facilities or authorities, as such storage would not be compliant with their obligations under the Data Protection Act 1999.

However, the approach was not unique in relation to the settings of abuse and social workers similarly attended to background information about past or current histories of abuse and evaluations of standards of care when assessing the AAR vulnerability in that setting. Field notes from direct observations recorded the views of Social Worker 34 as follows:-

"[Person's] Vulnerability [is because this is a] secure hospital setting for people with mental disorder under detention of the Mental Health Act. It is the environment that makes them vulnerable and their own behaviours because they are unable to manage their own behaviour due to learning disability or mental illness, staff need to protect, and we know that this setting fails to protect people adequately"

7.3.1.a. Vulnerable Offenders and the Risk to Others

Social work focus on care settings was especially true when presented with cases of service user on service user abuse. The quote below illustrates how this social worker sought to interpret the context of care in examining the causation of harm and vulnerability to further exploitation in a care setting. She describes how multiple persons lacking insight into their own behaviour living together creates vulnerability to abuse due to their misunderstanding of each other's behaviour and responses, which lead to escalating increasingly challenging behaviour. Additionally, the physical environment contains other stressors that trigger harmful behaviours towards others. This close proximity of multiple persons unable to manage their own behaviours promotes an environment of heightened irritability and poor impulse control creating the perfect storm for abuse to prosper:-

Social Worker 37

“Yeah, so thinking about service user on service user incidents in places such as dementia units, people haven’t got insight into what they’re doing and the consequences of what they’re doing, not able to weigh that up, people get very agitated with each other and that results in escalation of challenging behaviour and ... they sometimes hit each other unfortunately, ...”

Police officers in this study also demonstrated a propensity to assess the vulnerability of the offender. This represents a shift in focus relating to the offender from someone whose conduct made others vulnerable to abuse to someone whose personal characteristics made them vulnerable themselves. However, the police officers’ thoughts were still governed by crime detection. In their assessment of the offender as ‘vulnerable’ they focused on the mental incapacity of the offender which was crucial in deciding to progress further police enquiries/actions or not. As the quote below illustrates, if the victim lacks mental capacity but the offender has mental capacity to understand and co-operate with the criminal justice system then police action may progress for the purposes of crime detection. The favoring of crime detection over adult protection is a distinguishing feature between the professional groups and will be explored further in this chapter in relation to job role/definition and organisational priorities as sources of influence on conceptualisation of vulnerability. There were very few occasions when other agencies indicated that they assessed the offender’s vulnerability and where this did occur it was largely in relation to persons in the role of unpaid carer.

Police Officer 5 indicated the importance of assessing offenders as well by saying:-

“It has to be the capacity thing that I keep coming back to. But to be honest, police wise, that is our starting point to protect ... However, if one doesn’t have capacity then that changes our view on it, if they don’t both have capacity again it changes our decision so if the victim doesn’t have capacity but the offender has capacity we’ll look to prosecute the offender because they know what they’re doing but if it’s the other way round we won’t ... and if neither of them have got capacity then it’s not in the public interest”.

Police Officer 3 supported the view that mental capacity was a key determinant for police involvement. He stated:-

... in criminal, mental capacity is erm, is the big one 'cos then it opens up offences that we can, that we don't have with people who have capacity. So that's the big one reason for us 'cos you can actually get some positive action".

Police Officer 4 offered an explanation which also lent support to the idea that the police focus on the offender and the mental capacity of the persons involved was related to their justification for their involvement in the case. This participant relayed the role of the police as being set apart from support for which he suggested there were other specialised services to intervene. According to this participant, police were offender focused because their primary role was to process and investigate the offender. In this way the needs of the victim appeared secondary in their thinking. This participant stated that:-

"If this a criminal matter ... the vulnerability of the victim doesn't impact on that because it is either a crime or it is not. It doesn't matter whether that person has got vulnerabilities or not, they are a victim but is [primarily] whether they are a victim of crime ... so that is probably why we focus more initially on the offender because that's how we can get involved because we are not a support agency".

As stated earlier in this chapter, it was not that police officers lacked concern for the vulnerable adult but simply that they didn't see that they had a role to play. Police Officer 1 supported Police Officer 4's statement that police interaction with vulnerable individuals was limited to a strict adherence to the limitations of their job. This participant indicated that, while a police officer may want to advocate further on the behalf of a vulnerable individual, they sometimes can't do more than initially detain and question that alleged abuser. Police Officer 1 indicated this by saying:-

"And I think that links in with what you said ... earlier about the case conferences where there's no prosecution because the amount of times we get told ... you don't need to go to that case conference because you've done your bit and you're not taking it any further, the police involvement is finished ... we don't go to that case conference because as police officers what do we get out of that?"

The observation of an offender focus amongst police officers observed and self-reported in the data was supported by the reflections of other professionals who confirmed experiencing this approach in

their contact with the police. There was an acknowledgement that this difference might be driven by job role and topic knowledge/expertise.

Social Worker 36 indicated that:-

“I think it’s about their approaches, variations have come about because of the discipline they are in. So a police officer is looking for a crime, has a crime been committed ... maybe that’s too simplistic”.

Social Worker 34 agreed with Social Worker 36, in that she believed police officers often had a view that was based on their job role, which is to assess and prevent crime and enforce the law, which by nature focuses on the offender.

Social Worker 34 said that:-

“I think that we all come at it from our own perspective. Police, I am not sure that I really understand totally. They are looking at it purely from a sort of has a crime been committed, can we get a case to court. And I kind of understand that because that is their area of expertise”.

The influence of job role relation to offender focus in both recognition and response to vulnerability will be considered further in Chapter 8.

7.3.2. Victim Focus

While police officers tended to have an offender focused approach to assessing vulnerability, social workers tended to take a victim focused approach. This observed difference in emphasis was demonstrated across all four data sources. When describing individuals as vulnerable to abuse, social workers tended to primarily focus on the individual being assessed, rather than on a potential offender. The exceptions were where the offender was also considered to be a ‘vulnerable adult’.

I have argued that the difference in focus may be a function of professional orientation. Police officers looked for ways in which vulnerability could influence and be influenced by criminal behavior and wider public safety. Social workers, on the other hand, approached vulnerability from

a protective stance. Social workers expressed a priority for protecting an individual rather than seeking justice for a crime. Social Worker 34 indicated how she, as a social worker, assessed and addressed vulnerability, attending to both individual and situational signs of vulnerability, saying:-

“I would be interested in sort of the nature of [the adult’s] physical health, their mental health, their situation in terms, are they experiencing some sort of crisis, ... As well as mental health, I am probably looking at that. Probably any learning difficulties, any condition identifying, medical condition that would kind of trigger they may have areas that they would need support”.

Another social worker echoed this sentiment. They indicated that they would examine the individual they were assessing for evidence of that person’s vulnerability. This participant indicated that they would examine that person’s physical and mental state for signs of vulnerability and would make a decision based on how that person was coping with the situation they were in.

Social Worker 35 stated that:-

“The first thing [I would look at] ... it relates to somebody not being able to protect themselves from something that’s happening outside of themselves perhaps. So, for example, somebody has experienced some [trauma] but has not been able to protect themselves in any way from this happening. Perhaps they are an older person who’s dependent on another to provide that care and attention. Perhaps there is an illness which has rendered somebody unable to protect themselves or made them less able to access the help and support they need themselves independently ... therefore, they are unable to pull together the resources that they need within themselves”.

Another participant indicated that, like police officers, he would look at the victim’s surroundings to help assess vulnerability. However, rather than looking for offenders, as the police indicated, this participant looked at the situation as it related to the victim. While the participant was examining the victim’s surroundings, the attention was still primarily placed on the individual rather than on outside forces.

Social Worker 34 indicated that:-

"[I would look at] their ability to kind of function in society, whether they are at risk of others and easy targets if they live in, say, a supportive living environment then there would be a bit of a network around them but if they go to some dodgy area of town or something like that ... Linking that with their network as well because if they are probably living there they probably haven't got a good social network either of family and friends".

The difference of approach was acknowledged by Police Officer 4 who, whilst reporting some commonalities, also suggested a degree of confusion and ultimately cited his deference to social care personnel as the persons with the expertise in identifying vulnerability.

This participant stated:-

"Like I said, there seems to be a lot of confusion between vulnerability in terms of adult services and vulnerability to mental health I think we all pretty much sit on the same side of the fence to say what is and what's not. Clearly the experts in the field are adult social services I think so that is why it is good that they are here because we will defer to their knowledge ultimately".

The predominance of victim focus by social workers might be explained in terms of the protective bias of social workers over the detective one. Social workers have operated social welfare decision making in the best interests of incapacitated adults since the implementation of the Mental Capacity Act (2005) in 2007 and are increasingly familiar with using this legislation to support interventions in the welfare interest of the adult. It is much more common territory for them than their colleagues in the police. Despite the difference in focus on offender and victim characteristics both professional groups demonstrated an ability to identify signs of vulnerability across multiple domains. Lipsky's (1980) work on street level bureaucracy offers a possible explanatory model for this variation in focus across the professional groups.

7.4. Commentary/Conclusion

Lipsky (1980) applied the term street level bureaucrat (SLB) to frontline workers in the public service sector. This term encompassed many frontline workers but it is evident that the roles of police

officers and social workers, like those in the present study, were central to the development of this paradigm. Lipsky (1980) argued that frontline workers were not merely implementers of policy but creators of policy in their actions as they seek to navigate the context and constraints of their work environments. He identified five characteristics of the structure of work noteworthy for understanding the influence street level bureaucrats hold 1. who they are and their status in an organisation (frontline workers); 2. with whom they interact (clients and citizens); 3. the inherent discretion they wield; 4. the autonomy they necessarily have; and 5. the policymaking power they derive from their position, discretion, and relative autonomy. Participants in this study were able to act with relative autonomy in making decisions about which persons they would process under the safeguarding procedures. In giving consideration to the policy definitions and criteria for response they exercised discretion over whom to include and exclude. Whilst they evidenced an emic concept of vulnerability for persons at risk of abuse, which encompassed individual and situational signs of vulnerability, they spoke of constraining their responses to an etic approach as guided by definitions of a vulnerable adult in law and policy. There were other factors which influenced their responses which showed how the linear relationship anticipated by safeguarding policy directives was being over written in frontline decision making. Practitioner reference to their own service eligibility criteria was one way in which they were able to restrict their versions of vulnerability and to exclude situational signs of vulnerability from their concept, thus limiting the scope of persons to whom they would give a safeguarding response. As one practitioner appositely put it:-

“Situational stuff goes out of the window if they don’t meet the eligibility criteria”.

Working in the context of limited resources SLBs often have to decide how to devote and distribute their time, exercising discretion over whom to simply process and whom to employ more time-consuming skill with. For both professions there is some autonomy to operate situational rather than categorical compliance with work rules and procedures. However, in times of limited resource a tendency towards categorical compliance may prevail which could help our understanding of this role-boundaried differentiation of focus. In the present study the exercise of discretion by professionals in relation to their observance of organisational priorities was evident in the detective and protective focus which differentiated the professional groups. Participants spoke in terms of job role and priorities in deciding to engage with a ‘vulnerable adult’ as part of the safeguarding procedures. The police, in particular, paid an overriding attention to crime detection and identified the protective needs of adults as the responsibility of other ‘support’ agencies.

This chapter has reported on the similarities and differences between professional groups in evaluating vulnerability. Police officers and social workers both evidenced an approach to assessing vulnerability that looked to build a picture of the person's vulnerability by attending to and combining signs of vulnerability identifiable in both the person and their situation. This interactive way of conceiving of vulnerability is further evidence of the complex understanding of vulnerability in these professional groups. This approach to evaluating vulnerability, derived from the collation of multiple indicators, is not necessarily surprising but what was of interest were the differences between the two professional groups that emerged in the focus they took in searching for those signs.

Police officers evidenced a marked focus on the conduct of the person alleged to be responsible as part of the situational signs they attended to. This approach was not exclusive to police officers as social workers also looked for signs in the conduct or condition of the PAR but their primary focus was on signs of vulnerability in the victim themselves.

The differences between the professional groups identified have been explored in terms of professional orientation. This approximates to a police focus on detection and a social work focus on protection but this is too simplistic an interpretation and demands further examination. The next chapter examines some of the things professionals have reported as influences over their response to vulnerability rather than their recognition of it in AAR. Chapter 8 will develop this theme, exploring what was found regarding the influences which constrain the professional responses to signs of an adult's vulnerability to abuse.

Chapter 8

Recognising Vulnerability is one thing, Responding well that's a Different Matter. Influences on Recognition and Response to Signs of Vulnerability

8.1. Introduction

This chapter explores the reported influences on the professional approaches and responses to their conceptualisation of vulnerability in the Adult at Risk (AAR). Previous chapters have detailed what informs their concept of vulnerability. This chapter reports on what professionals described about 'how' their concepts are constituted and what influences this. A thematic analysis identified two major themes in the data relating to professional approaches and responses to the signs of vulnerability. The themes are categorised as 'occupational rules' and 'methods or mechanics of enquiry'. It is argued that the differences observed between the professional groups reported in Chapter 7 are tied to professional role and work environment rather than their professionals' understanding of vulnerability to abuse. Lipsky's (1980) theory of street level bureaucracy and ideas about the exercise of discretion provides a conceptual framework for these interpretations. Decision making theories offer insights into the governance of the rules based approaches observed.

Section 2 reports on the thematic analysis of the reported influences on professional responsiveness to signs of vulnerability in adults at risk of abuse and the categorisation is developed. The themes of these main categories are explored in the next sections of the chapter. Using Lipsky's theory of street level bureaucracy as a conceptual framework these influences are discussed in terms of the operation of discretion in professional decision making.

Section 3 looks at the theme of occupational rules which influence response to vulnerability and suggests that competing rules interfere with professional response to signs of vulnerability to abuse in the adult population. It argues, like many others, that SCRs fail to take account of how the 'rules' are experienced in practice as a way of explaining the disconnect between professional understanding of vulnerability and their response to it, suggesting that the recommendations for a need to strengthen practitioner understanding of abuse and vulnerability are partially informed.

Section 4 looks at approaches or ways of identifying signs of vulnerability and explores how professional differences impact on the way professionals approach their concept of vulnerability which reflect a detective or protective focus. These constraints are reported as being related to job role and employing the organisations objectives and priorities.

8.2. Recognition of Vulnerability and Responses to it – The Former Cannot Presume the Latter

Recognition and response to signs of vulnerability showed individual variation amongst professionals as expected, even amongst practitioners of the same professional group. However, patterns emerged in the data indicating that social workers and police officers have distinct methods for *recognising* and *responding* to vulnerability. The two themes that emerged were categorised into ‘occupational rules’, pertaining to characteristics such as job role, agency priorities and service eligibility criteria or ‘Methodologies/Mechanics of approach’ pertaining to the ways information was ascertained to inform the view of vulnerability. The influence of job role and agency priorities informed their understanding of legitimate work. These influences were remarked upon by both professional groups. There were also commonalities between the professional groups in the sorts of limiting factors which related to job role and agency priority. These included service eligibility criteria, lack of authority to act in the form of legal mandate, lack of resource and lack of expertise. In respect of the methodologies of approach, both professional groups reported and were observed to be engaged in information gathering. Differences between the two major professional groups were noticeable in relation to the reported use of intuition in identifying signs of vulnerability. Social workers were unique in their reported use of intuition.

Methodologies/Mechanics of approach broadly described two methods of soliciting information. The first related to ‘how’ professionals gathered signs of vulnerability which included information gathering from multiple sources and combining the signs and the operation of intuition. Professionals talked about building a picture by gathering information from multiple sources, drawing on tacit knowledge to fill gaps in their understanding or using tacit knowledge to overcome time pressure to formulate a view of vulnerability. The second referred to the other influences on ‘how’ professionals attended to signs of vulnerability which included time restraints for decision making, as well as experience and expertise. Unsurprisingly professionals reported key influences on the concept of vulnerability to include personal and professional experience, and dominant theoretical frameworks for understanding. Expertise was discussed in terms of available intelligence about a person or service but also about personal competence derived from being either a specialist safeguarding professional versus a generic practitioner in the respective professional discipline.

Occupational rules described a collection of themes pertaining to influences which had a regulatory impact on both recognition and response to vulnerability but these were more frequently discussed as influences on response to vulnerability rather than their conceptualisation of it. Themes here included job role, service expectations and eligibility criteria, resource allocation and authority to act. Participants reported that significant influences on their approach to vulnerability were a sense

of authority and autonomy to act or intervene and consideration of whether there was a legitimate role for them in responding to the identified vulnerability that was endorsed by their agency and seen as a priority. In this respect frequent reference to service eligibility criteria was made to help define the response to vulnerability accorded with their defined job role and their employers' requirements of them. Their belief about whether or not their superior officers (police and social work) would endorse their involvement as 'legitimate' work was a key factor in exercising discretion over response to any signs of vulnerability they observed.

An ability and authority to respond at times interfered with recognition of vulnerability to abuse – in other words 'If I can't do something about it then I can't see it'.

8.3. Occupational Rules which Influence Professional Response to Vulnerability

“Situational stuff goes out the window if they don't meet the criteria.....”

8.3.1. Job Role, Service Eligibility Criteria and Organisational Priorities

As Ash (2013) observed, serious case reviews (SCRs) and other inquiries rarely explore the work environment and the impact of this on practice decision making. Often the focus is on whether the practice was compliant with policy and provides little insight into how the 'rules' are experienced by the frontline worker. As Lipsky (1980) asserted, understanding this is necessary if we are to understand why policy is not always implemented as the policy makers intended.

A strong theme emerged in the data illuminating the perceived constraints on professional response to vulnerability. These included job role, eligibility criteria, service expectations and resources limitations. Whilst it is not surprising that these were reported as significant influences on professionals there were some interesting similarities and differences between the professional groups in terms of how these impacted on responses to adults vulnerable to abuse and the ways they approached seeking and recognising signs of vulnerability.

The exercise of discretion was evident across all professional groups and served to support their engagement or otherwise in safeguarding enquiries and actions. In doing so participants from both professional groups indicated that they were limited in their safeguarding ability by service eligibility criteria, a lack of legal mandate to act and lack of professional authority. Social workers tended to refer to constraints specifically in terms of an adult's eligibility for their service whereas police officers tended to frame this in terms of the priorities of the agency they worked for and what was perceived as legitimate work for the police to undertake. These factors bear no relation to the working criteria for progressing safeguarding enquiries in relation to persons who have been

identified as vulnerable and at risk of abuse. This meant that it was perfectly possible for the professional to have and operate a very detailed, complex understanding of vulnerability but for their responses to be governed by 'other rules' relating to beliefs about job role definition and agency priorities. And so, commenced the 'battle of the rules'. Unequivocal compliance with certain occupational rules, which were seen as defining 'legitimate work', meant a loss to the exercise of situational discretion in applying the 'rules of safeguarding adults from abuse' defined by policy and law.

Social workers spoke in terms of 'service eligibility criteria' as defining what was considered as 'legitimate' work. For many of them the overwhelming driver in deciding to progress formal safeguarding response was contingent upon 'eligibility criteria'. This overrode any conceptualisation of vulnerability to abuse that included situational factors in its formulation. Their construction of vulnerability is strongly influenced by what they believe to be the key drivers of their job role and work activity that is legitimised by the agency.

Police officers reported that the priority of their role was to serve and protect. They viewed their role in terms of crime detection and prosecution and often stated that they had no role to play in safeguarding an adult if a crime had not occurred as they weren't a service agency. This demonstrates that police officers locate their primary function in safeguarding in detection rather than protection. Police construction or conceptualisation of vulnerability pivots on offence identification (detection) hence their offender focus in attending to signs of vulnerability. The primacy of agency objectives is summarised in the words of Police Officer 6:-

*“Doesn't it depend on what objectives your organisation's for? we can all read off what a definition is, that's quite easy to do and go by it but our objectives for our organisation is to protect and prevent individuals, protect victims, prevent people being harmed, serious harm, those are all our objectives, **ultimately that is what we're there for erm, is to lock people up**”*
(Bold Italic – my emphasis)

In terms of eligibility criteria, Police Officer 4 indicated that he could only take safeguarding measures if an action met the criminal threshold. Suspicious or risky situations, if not criminal, were not situations in which a police officer would necessarily intervene. Police Officer 4 described this in the following way:-

“You know if it meets the criminal threshold then absolutely it is, but we have to now be so much more careful about how we use our limited resources”.

This serves to illustrate how police officers limit their involvement in safeguarding adults from abuse to detective rather than protective activities. What was also of interest was that in some cases police officers had a broader approach to vulnerability than was captured by the definitions used to operate safeguarding adults activity under the Care Act 2014 and this related directly to definitions pertaining to victims of certain crimes. For example, Police Officer 10 indicated that police had specific eligibility criteria as to who could be considered a vulnerable adult.

Police Officer 10 said that:-

“Well we in, in Police, in general policing terms we would class any victim of domestic abuse as a vulnerable victim but that is not the same as a vulnerable adult so we have an additional, they get an enhanced service if you are a vulnerable victim, which you could be if you are a victim of hate crime, if you are a victim of DA but, ... that is not the same as being a vulnerable adult”.

This view of vulnerability was related to the construction of vulnerability in law under the Youth Justice and Criminal Evidence Act 1999 which details the typology of victim entitled to enhanced services. This definition/criteria is distinct from the definitions/criteria adopted to trigger a safeguarding response and referral to Local Authority Social Care Services.

This is interesting because it illustrates the confusing landscape of the legal and policy context of this work and how this gives rise to difference in recognition and response to signs of vulnerability in the adult population. The detective focus of police involvement was reinforced by some police officers who indicated that the best way they could ensure the vulnerable were safe was to make sure other appropriate agencies were aware of it.

Police Officer 5 indicated that aside from it not being a police officer’s role to determine vulnerability they were bound to follow procedure by stating that:-

“we all have to do in the same way”.

This police officer indicated that there was, at least to some extent, a procedure that limited what he was able to do in any given situation. By referring the adults to the correct agency, this police officer was directing the individual towards the care they needed whilst staying within the boundaries of his expertise and jurisdiction, or legitimate work. Legitimate work of the police was seen as being limited to the progress of criminal enquiries (detection). They did not identify a role for themselves in the protection of the adult other than to signpost them to other services. Despite their ability to identify and understand vulnerability there was a distinct view that this was not a policing priority

and that, on the whole, they would be guided by social workers who they perceived to be the experts in determining whether an adult was vulnerable or not.

During a direct observation one police officer demonstrated this during an interaction with a social work colleague by commenting that, in terms of determining whether an adult was vulnerable or not, he would accept the view of social services, stating:-

“... if you guys say he’s a vulnerable adult then he’s a vulnerable adult because you are the experts in this”. (Police Officer 4)

This police officer’s feeling of a lack of expertise was reflected by other professionals in relation to their ability to conceptualise vulnerability. However, the findings reported in Chapter 7 suggest that professionals in this present study across both disciplines, including those who reported themselves as less expert, have developed a body of knowledge and skill which they apply in a nuanced way. They consider a number of inter-related signs and show an understanding of the meaning of these in comprehending the adult’s vulnerability to abuse.

The lack of expertise in safeguarding adults discussed by police officers must not be confused with a lack of understanding about the landscape of adult health and social services which has many pathways. This contrasts with police officers’ experience of working with children’s service where there is a single pathway for access to social care services. One participant indicated that he and his colleagues were occasionally confused on the appropriate services to refer vulnerable individuals to. He indicated that:-

“I think that is sometimes where it gets confusing for us is ... physical disability in adults who are not elderly tend to go to adult services and then mental health conditions go to mental health and that big problem we have here is that we don’t know which mental health centre to use”.

Another participant agreed with the above assessment, adding that more training could be useful in addressing the issue. While more training wouldn’t remove the job limitations placed on police officers, this participant indicated that it would, perhaps, allow police officers to work more efficiently with other agencies with increased understanding, especially in relation to determining an adult’s mental capacity.

Police Officer 1 indicated:-

"I think there probably needs to be more discussion about what capacity is and what it entails and the varying degrees of capacity. That's something I think we are bad at and probably need input"

This officer's comment about training is interesting given the observed absence of this essential understanding in the National Policing Curriculum on Protecting Vulnerable People. This is particularly striking given the saliency of this sign of vulnerability in police understanding of vulnerability and their decisions to become involved in safeguarding enquiries. Job role definitions were also reported to be significant for social workers in defining work activity that is legitimised by their employing agency. It is possible that social work conceptualisation of vulnerability pivots on welfare intervention (protection) hence their victim focus in attending to signs of vulnerability.

Social workers reported that their service eligibility criteria placed constraints upon their responses to adults they believed to be vulnerable to abuse. This approach was reported despite there being no reference to 'eligible' needs for care and support in Section 42 Care Act 2014 (criteria to determine the duty to make safeguarding enquiries for adults at risk of abuse). One social worker stated.....

"... so the first thing we look at in the mental health team, is do they have eligible needs, would they meet criteria for secondary mental health services. I'd imagine the learning disability service will have its own criteria and the older people's service will have its own criteria still". (Social Worker 8)

The magnitude of this influence in overriding any attention to signs of vulnerability related to the adult's situation rather than their personhood was best illustrated by the same social worker who stated.....

"Situational stuff goes out the window if they don't meet the criteria, lucky to get a decent signposting, so I think if they don't meet the criteria for service, 'cos we're not commissioned to provide that service, adult protection [doesn't progress]".

The overriding influence of service eligibility criteria is significant in light of the Care Act 2014 criteria for safeguarding enquiries. The Care Act 2014 removed the term 'vulnerable adult' but is still hinged to an adult's need for care and support. I would argue the criteria still encourage a focus on individual rather than situational factors in the construction of being 'At Risk' of abuse. There is a sense in which the response is governed by the worker's belief that this is something his service 'can

do something about' and, if not, then the default position is to search for other services to respond. This was echoed in focus group discussions, particularly the two mental health groups where workers talked very candidly about 'making it another agency's problem' when faced with persons they believed failed to meet their service eligibility criteria and, thereby, attract a safeguarding intervention from themselves. In interview one social worker summarised this effect as follows:-

Social Worker 36

"Yes, I think sometimes if you haven't got a response to something you tend not to want to look at it."

Eligibility criteria help to define the limits of legitimate work for social workers. The exercise of discretion evident here is to give primacy to the adult's eligibility for a service from them over response to the adult's vulnerability to abuse. Whilst social workers recognise an adult's vulnerability to abuse they sometimes felt their service was ill-equipped to respond. Despite the demonstrated capability of professionals to conceptualise vulnerability in very rich and complex ways, their adherence to criteria driven decision making in responding to vulnerability to abuse means that abuse or risk of abuse acts as the first gatekeeper to safeguarding services. The idiom 'Do not pass go, Do not collect £200' translates to 'Do not see abuse, Do not regard signs of vulnerability'.

Another example of the exercise of discretion was also evident in the operation of the criteria for a Section 42 safeguarding enquiry itself. There was evidence of their predominant use of 'eligibility criteria' to prioritise abuse over vulnerability. In both focus group discussion and direct observation professionals demonstrated this abuse first approach, relegating considerations of vulnerability to a secondary place in the professionals' evaluations. This approach closely allies itself with the eligibility criteria for a Section 42 enquiry. It provides a mandate for professional response and, therefore, legitimises professional response. As summarised by Social Worker 5:-

*"...and that's your question you're looking at the definition of a vulnerable adult but the starting point is the definition of abuse so you look at, you know has abuse taken place, I mean you know, is there significant harm has this person suffered significant harm , yes or no, and then you move to actually, are they a vulnerable adult ... **the question of abuse comes in for me first and then the vulnerable, the vulnerability second**". (Bold italics my emphasis)*

The approach described above risks missing opportunities to act for the prevention of abuse rather than protection in response to its occurrence. If professional responses to vulnerability to abuse are constrained (even if only in the minds of the professionals themselves) by what constitutes

legitimised work then such missed opportunities are likely to prevail. I would argue that the methodologies of SCRs in adult safeguarding have failed to examine this kind of context to decision making which has been promoted in Children's reviews (SCIE 2009). Consequently, the SCR summary reports give no attention to whether the reported lack of understanding of abuse and vulnerability by professionals is as a result of an exercise of discretion by frontline practitioners. Their use of discretion was in favour of occupational rules to override adherence to safeguarding policy. This is particularly worthy of note given the historic absence of a statutory duty to safeguard adults in England & Wales until 2014. The implementation of this statute in 2015 coincided with the primary period of data collection in this study (2013 - 2015).

The influence of job role over professional response to vulnerability in AAR was also evident in explanations offered by professionals who identified differences between the professional groups in their initial contact with a member of the public. This is illustrated in Police Officer 2's comments to a social work co-participant during a focus group discussion:-

Police Officer 2

"is that because of the way you first meet whatever client base you guys work with 'cos from our perspective something has happened for us to be there? so having gone there for whatever reason we assess the situation and then we might think oh do you know what, this person is vulnerable".

The participant quoted above suggests that police officers and social workers differ in the usual mode of contact with the public by their respective professions. Police officers' contact is usually precipitated by an event (crime possibly constituting abuse) – something has happened, whereas social work point of contact tends toward assessment of need which may focus attention on need and vulnerability. Lipsky (1980) refers to how people come into contact with Street Level Bureaucrats not as volunteers and are quickly identified as clients, victims, suspects by a process he calls people processing. This normative approach to classifying people who come into contact with the different professional groups supports the distinction between them with the police adopting a detective focus and social workers a protective focus.

One of the features of cases subject to SCR reports is 'chronicity' and with the above approach to decision making there may be lost opportunities to gather and record intelligence about chronic patterns particularly in relation to individuals who don't meet any service eligibility criteria. The difference of approach between police and social workers was discussed in relation to their initial contact with the public. The mode of contact with social work implies a preventative approach to

anticipated events whereas the mode of contact with police officers implies a reactive approach to existing or current events. The concept of safeguarding adults refers to the promotion of well-being whereas the concept of Adult Protection refers to responding to an abusive incident(s). In the context of current resource limitations, public bodies will often be constrained to what they have to do (duties) rather than what they can do (powers). Whilst one of the key principles of safeguarding adults practice is the principle of 'Prevention', the approach of professionals outlined above would indicate that this principle may be given lower priority over 'Protection' or even seen as a luxury in times of resource restraint.

8.3.2. Law & Policy – Authority to Intervene

As would be expected legal implications and obligations were reported by both professions to have an influence on their responses amongst other things.

As social worker 31 put it:-

"...it's my profession that gets in the way of my judgement of vulnerability because there's lots of different things there isn't there ... resource issues, obviously legal implications but there's all these different things going on in your head when you're formulating that decision isn't there"?

Previously, in the example given by a police officer regarding how they would assign all persons experiencing domestic abuse to a category of vulnerable adult yet not consider all of them as requiring a response from adult safeguarding services, we saw how the concept of vulnerability as constructed in law had a bearing on professionals' concept of vulnerability. However, the implications of law and policy were primarily discussed in relation to the professionals' authority to intervene. There are parallels here with the rule bound responses related to eligibility criteria. This is not surprising given that for both professional groups their individual and agency authority to act are framed in terms of legal criteria which constitute their duties and powers. The limitations of lawful authority were presented by participants as statements of the status quo.

Social Worker 26 articulated this as follows:-

"... we're always looking around, where do we get our permission from now, ordinarily it would be the adult that we are working with, that's where we seek to get our permission from so it has to be that they want this and work in partnership with us, the one time you can intervene without their permission is when you're using the Mental Health Act or the Mental Capacity Act, and this lady, if we've considered that she's not got an enduring mental health

problem and she's got capacity to make these decisions, no matter how unwise they seem, as an agency we have no permission to intervene".

Safeguarding adult practice operates within a context of law and policy and professionals in the present study understood this when considering their responses to vulnerability in AAR. In contrast to their discretionary use of service eligibility criteria, here professionals were describing an inability to exercise discretion in the absence of rules which supported their actions. They felt constrained in being able to respond due to the limitations of lawful authority where the permission to intervene could not be secured from the adult.

8.3.3. Resource Limitations

Reductions in personnel have been a feature across the public sector workforce over recent years and it is, therefore, not surprising that workers should cite limited resources as a constraining influence on their response to adults vulnerable to abuse. In Lipsky's (1980) Street Level Bureaucracy Theory he identifies working in the context of limited resources as a factor supporting the exercise of discretion as workers have to decide how to devote their time. However, in the context of the central referral unit (CRU), professionals operate with significant autonomy. It was particularly interesting to note the comments of one police officer working in this environment who reported that, in contrast to her peers out on area, she felt liberated in her decision making about police responses to adults vulnerable to abuse as she had no responsibility to resource the police enquiries. As such she was able to make 'resource blind decisions'. This contrasting position serves to reinforce Lipsky's assertion about how front line workers are able to exercise discretion which impacts on how they interpret and employ policy.

The Police Officer's comment was made within the context of a working environment which focuses on screening new referrals and signposting any onward investigative activities to colleagues out on district/area. Commenting on the impact of the work environment this officer stated:-

Police Officer 10

"So, I don't think it has changed my view on vulnerability, as such, but it just is a lot easier for me to make a commitment to a joint investigation and allocate it to PPU because I haven't any additional pressures outside of here. That is the difference between here and on area."

Limited resource was a theme that emerged frequently among police officers and occasionally among social workers. Police officers indicated that they had to exercise strict control over the allocation of police time. One police officer indicated that the police were often unable to prioritise

a victim of abuse for police response unless such activity was likely to lead to the arrest and detention of an offender. This participant indicated that:-

Police Officer 4

“You know there is no point in police doing a joint visit to a victim if we are never going to deal with the offender. If it is purely a quality of care issue, and again not to be selfish about police time being more important, but it is not our job. You know if it meets the criminal threshold, then absolutely it is, but we have to now be so much more careful about how we use our limited resources.”

A paucity of resource was also an issue that arose during the direct observations. A police officer was overheard to say that, due to the lack of funding available to them, police will only do what they have to do rather than what they can do to assist the vulnerable. This police officer indicated that he felt unless legislation requires certain practices, or police force policy requires a certain action, then it would not be implemented because of the scarcity of resources. The officer drew comparisons between children and adult safeguarding practice in relation to police involvement where the former had a legal mandate for joint police and social care response and the latter did not.

For social workers the impact of limited resources also operated as a constraining factor on their recognition of abuse. They described the interactive impact of limited resources and professional recognition and response to vulnerability. This was debated in detail in one particular focus group discussion. The following excerpt from that focus group illustrates how in crisis situations, with limited care provision, professionals might fail to consider the wider risks of abuse to the individual in those environments. The accommodation need amidst crisis overrides the professionals' consideration of what is the most suitable environment for the adult and limits their recognition of the perverse outcome of increased vulnerability to abuse in this new setting. Dogmatic adherence to process, coupled with limited resource in times of crisis, serves to create the perfect storm where people with challenging behavior are placed in environments that then expose them to greater risk of abuse. Participants suggest that market forces in social care provision limit the range of service responses and, thereby, contribute to the creation of vulnerability to abuse in their client populations. This is enabled by creating circumstances in which service providers may be more inclined to accept referrals that they should decline due to their need to fill beds in order to sustain business continuity and viability. The following excerpts from a focus discussion illustrates this as follows:-

Social Worker 31

"I can see what S is saying 'cos when we've got an emergency and we're looking for a placement for someone with challenging behavior. ... yeah, thinking about it when I give you the agreement that, yeah, I'll fund it I don't think God are we making that person more vulnerable because we're now putting in a home, I don't".

Social Worker 32

"And also because of our processes and procedures now they have to come in a certain category of homes, we have to put them in those certain categories of home don't we".

Social Worker 31

"Yeah we have to follow that but no, now what's just come into my head is I don't think, I follow the proper processes 'cos I have to I have no choice but I don't think to ask is this person going to be more vulnerable there, what would I do with them if they are? You don't have time to do that do you, if it's tonight you have no choice, if it's Friday night

Social Worker 33

"But the market place is like that and the onus is on the provider, you know we can't negate, you know, if they are putting somebody into a risky situation, they know what the dynamics are".

8.3.4. Summary

The exercise of discretion is a central feature of Lipsky's SLB and more recent researchers (Ash 2013). In this section of the chapter the examples from the discourse of professionals illustrate their use of discretion in the face of limited resources in two different ways with differing outcomes for the public. There have been many examples of how police officers have to decide how to devote their time, drawing on the absence of lawful mandate as a justification. Their compliance with work rules and procedures contrasts with what Lipsky asserted is the more common use of their autonomy to exercise situational compliance. However, one officer demonstrated how the work context liberated her from operating situational compliance with work rules and how being able to apply categorical compliance was to the benefit of the adult.

In the case of this police officer a 'resource blind' approach enabled her to adopt a purist approach to the criteria which favored the involvement of specialist police personnel (PPU) for vulnerable victims of crime. The Police Officer's use of discretion was illustrative of how, in the absence of work

place demands to allocate the ongoing investigative work, it was possible to observe categorical compliance with service criteria. This worker was relieved from the exercise of situational discretion as they did not have to manage the resource consequences of their decision.

In the social work example, the impact of resource limitation had an effect on their risk assessment. The degree of choice available to them led to decreased attention to the perverse outcomes of decision making. The response to vulnerability from threatened homelessness created vulnerability to abuse due to the possible unsuitability of the environment which exposed the adult to a significant number of others with challenging behaviour. However, during a time of crisis the service options were limited and so a hierarchy of vulnerability was operated in the decision making of the social worker. Contrary to the rational evidence based approach to decision making that the public might expect to be operated, this social worker demonstrated how attempts to apply the principles of successful decision making recommended by Beckhard & Harris (1987) are compromised by the working contexts. The degree of choice available affects the worker's ability to consider the wider effects and possible perverse outcomes of their decisions. The discourse of this social worker about this real case dilemma is illustrative of the exercise of discretion which Lipsky argued could not be removed from the everyday practice of SLB due to the complexity and uncertainties of working in human services.

SCRs have been observed (Ash 2013) to rarely consider the impact of work environments. There is an obvious and apparent dissonance between the complex conceptualisation of vulnerability and subsequent responses that fail to attend to further indicators of vulnerability as perverse or unintended outcomes of managing risk and vulnerability. In this case it would seem that, in order to cope with the uncertainties of competing need, a hierarchy of vulnerability emerges. It is possible that they are making a judgement about interventions based on probabilities and possibilities which translates as 'Vulnerable from Homeless' = probable risk versus 'Vulnerable to abuse by increased exposure to others with challenging behaviour in the accommodation available to address the homelessness' = possible risk. This kind of probabilistic mental model was described by Gigerenzer (1991, 1996) as a one reason decision making style. The combination of human crises and resource limitations demand immediate responses and might encourage a worker towards such a 'fast and frugal' heuristic.

8.4. Methodologies of Approach to Recognising Vulnerability, Information Gathering and Ways of Knowing – Evidence and Intuition

8.4.1. Introduction

The use of intuition was exclusively reported by social workers. This approach to recognising signs of vulnerability is illustrative of recognition-primed decision making described by Zsombok & Klein (1997). The differences might be explained in relation to the dominant paradigms of the professional groups and respective training and work modus operandi. Such an interpretation could be overly simplistic and at risk of stereotyping as intuition is not exclusively the province of social work. Police officers may well operate this decision making approach but do not reference it as explicitly as social workers. The professional groups also showed marked differences in their written articulation of vulnerability. This difference can be explained in terms of the role-boundaried activity indicative of the detective/protective foci of the respective disciplines.

Information gathering was a core activity for all professionals in forming a view of the adults' vulnerability. The methods or mechanics of this activity varied across the professional groups in terms of type and number.

8.4.2. Intuition

Intuition was a theme that emerged amongst participants who were social workers as a mechanism for identifying signs of vulnerability. It was discussed by social workers as a factor in their approach to assessing vulnerability in 50% of the focus groups and 40% of interviews. While participants didn't claim intuition to be the exclusive domain of social workers, it was noticeable that this theme was not evident among police participants.

The detective/protective difference between the professional groups has been noted previously in the victim/offender focus. The tasks of detection and protection demand different styles which may reflect the dominant paradigms of the job roles. Police focus on detection requires an evidence based approach. The traditions of this within policing services might explain why police officers did not report the use of intuition. The respective focus of the two professional groups was reflected in the written records of their decision making. As has been evidenced from police commentary previously, the police do not place a priority on determining vulnerability as a service objective, their primary focus is crime detection. This was evident in police decision making logs. In over 100 logs examined there was no explicit reference to an assessment of the victim's vulnerability.

Social worker's, on the other hand, are charged with making the decision to exercise safeguarding enquiry duties and are necessarily concerned with attending to the person's ability to protect themselves from exploitation. Their documentation contains specific prompts to encourage an articulation of vulnerability. Despite this, amongst the social care case records examined there were a significant number of cases where no such record was evident.

Table 5 below shows the distribution of case records exhibiting explicit evaluation of the AAR vulnerability.

Table 5. Recording of Vulnerability in Written Case Records

	Police	Social Care Learning Disability	Social Care Mental Health	Social Care Older Persons & Physical Disabilities
Total number of records reviewed	32	17	25	24
No of records with explicit record of vulnerability	0	6	7	11
% of records with explicit record of vulnerability	0%	35%	28%	46%

The methodologies of SCRs in adults safeguarding have historically been reliant upon Independent Management Reviews, a paper based review to evidence their agencies involvement. Written records form the articulated views of the professional. However, the nature of intuition or tacit knowledge is that it is accumulated knowledge which is not under conscious control. Intuition is sometimes referred to as the immediate apprehension of the mind without reasoning (Concise Oxford Dictionary) or understanding without rationale (Benner & Tanner 1987). In this current age of evidence based practice there has been a widely held view that professionals should not be making decisions (and in particular clinical decisions) based on intuition. Accepting that what we intuit is difficult to articulate then it is not difficult to see how this might not form part of the records, especially if this approach to evaluation and decision making is not endorsed as legitimate practice.

In Children's Services there has been recognition that this is a flawed methodology for understanding the dynamic operation of professional understanding and skill in these cases. The evidence from the present study suggests that the written record conveys a far from complete picture and if relied upon as the major source of information then it is hardly surprising that authors of SCRs would conclude that practitioner understanding of abuse and vulnerability requires strengthening. I would argue that the systems approach to SCRs, advocated by SCIE from their developments of SCR methodologies in Children's Safeguarding following the Munro report, which acknowledged the absent voice of the practitioner, would provide better access to a more holistic understanding of practice. Adults safeguarding has been slow to adopt this change.

In the present study, social workers made frequent reference to the use of intuition in forming a view about a person's vulnerability. Participants who spoke of intuition or "gut feelings" indicated that their intuition encouraged them to further investigate a case when there might have been few indications of abuse. For some of these participants, intuition was often the first clue that something was wrong, and that feeling led them to explore further and eventually corroborate their concern. This would validate the use of intuition as what is described here would seem to support the implementation of what has become known as 'professional curiosity'. The use of intuition by social workers might be explained by the application of social work values in terms of sustained concern for their clients and the 'protective' focus of their engagement with the public.

One participant said that intuition could be especially useful in situations where the victim could not explicitly say what had happened to them. The inability to recognise your own vulnerability or that what is occurring to you is in fact abuse is not an uncommon feature amongst victims of abuse.

Social Worker 2 stated:-

"Sometimes they can't say [they are vulnerable], you can have gut feelings, ... There can be something that with a bit more [you can find out], you might not screen it in straight away, but it's there at the start and you perhaps want to get some more information about [the situation]".

Social Worker 4 agreed with the statements made by Social Worker 2, indicating that when she is first assessing a case, often there is so much information to process that her initial impression of the situation is often based on a gut feeling, or on her intuition. Social Worker 4 explained this phenomenon by saying:-

"Quite often you go into a situation, perhaps when you just go in and you walk in the door and the first few words are spoken, you're listening, you're looking, you're smelling, you're just,

you're senses are on overdrive and your gut feeling you then try to build a picture, what is it what is it that's wrong because there's something very wrong, and then it's unexpected, ... quite often I think quite a big trigger that something is very wrong is comments made out of context ..."

Social Worker 10 was more explicit about the features of intuition, commenting that she often relied on body language or social cues to learn more about a delicate situation.

Social Worker 10 described this by saying:-

"I pick up body language sometimes not making eye contact, you ask them a direct question but they have to get the answer from the partner".

It is possible that the element of intuition described by other social workers could be related to body language and social cues, as was the case with Social Worker 10. However, these observations rarely form part of the written record: even if the professional is able to recall what informed their overall impression it is rare that this is recorded. Nonetheless, the use of tacit knowledge is still valued by professionals who are often dealing with complex human problems where simple evaluations and clear cut solutions are not readily available. In such situations, professionals might draw on tacit knowledge to fill in the gaps in order to try and make sense of a situation. One participant explained the usefulness of intuition where she had incomplete information. This participant reported that they often deal with clients who are a known entity and, as such, they have all the relevant information to make an informed decision about the individual's vulnerability. In situations where social workers don't have all the information, or don't know the individual, then intuition enabled the social worker to make a decision drawing from their past experience and knowledge.

Social Worker 32 said that:-

"I still think there's an element of gut reaction, ... If it's a client that we're unaware of you're going along on your own but at that same time you know, ... we'd be making a decision on what we're going to do based on our own internal reasoning and have we come across anything similar to this".

The role of experience in the use of intuition was remarked upon by another social worker who attributed her gut feelings to her experience assessing vulnerable individuals and evaluating different types of potentially dangerous situations. This participant indicated that intuition was part of how she made the decision to proceed on a case immediately, rather than waiting and allowing it to develop.

In Social Worker 36's own words:-

"...call it experience, intuition. It sort of happens automatically, if you know what I mean. I'm not quite sure, but I think it's possibly my experience and, as I say, a certain amount of intuitiveness about a situation might make me think, oh yes I need to look at it this way..."

This social worker worked in a specialist unit where assessing vulnerability to abuse was a daily occurrence so their level of experience would be greater than most. The lack of expertise that some reported as a factor impeding their assessment of vulnerability may well be a function of experience and exposure. This might mean that the operation of fast and frugal heuristics in determining vulnerability was less available to them than to practitioners with greater experience.

The use of intuition in a busy duty environment was particularly interesting. The assessment of an adult's vulnerability to abuse necessitates timely decision making if protective actions are required. Where decisions were necessary under time constraints, or with limited information, professionals described 'intuition' as a default position. This was illustrated by one social worker who indicated that he relied on intuition when he was required to make a quick decision. This participant also believed that his intuition was informed by his experience working the job, and that he drew from past situations and clients when he had to make a quick decision.

In Social Worker 12's own words:-

"... a lot of things you do on the hoof, when under pressure, and you use your knowledge and your history and experience in terms of people that you've met and things that you've done and situations that you are familiar with".

These participant reports appear to show that in recognising and assessing vulnerability intuition operates as a short cut in identifying cues of vulnerability in circumstances where there is limited opportunity or time pressure to assess and decide whether an adult is sufficiently vulnerable to warrant further safeguarding intervention. This became apparent during the direct observation of practitioners in the CRU, where decisions to progress a referral or not were required within a 24 – 48 hour time frame. In this context practitioners could be observed to be using a typology of case characteristics which supported quick decision making based on single indicators. As one participant indicated, if the adult is in a residential care home, as far as vulnerability was concerned, they didn't look much further than that but made a presumption of vulnerability on the basis of having care and support needs requiring such accommodation. This could have been interpreted as a simplistic conceptualisation of vulnerability. However, on further exploration through interviews the same

practitioners were able to provide a rich description of their conceptualization of the adult's vulnerability which, in the duty work context, had been reduced to one or two features.

In such circumstances the written recordings of decision making are likely to reflect the truncated version of vulnerability rather than the detailed and differentiated understanding that underlies these broad brush indicators. They are a partial insight into what was influencing the professionals' thoughts and actions at any particular time as others who proposed the 'systems' approach to SCR's in children's services have commented on (Fish et al 2008). This approach advocates an exploration of all variables that may influence frontline workers' efforts to engage with the public including procedures, tools and aids, working conditions and resources

8.4.3. Information Gathering

Information gathering was a core activity reported and observed across both professional groups. However, there were differences between the professional groups in the number and type of sources utilised to access information. Participants search for further information is another indication of the comprehensive approach to evaluating vulnerability that has been argued in this thesis. Whilst the paucity of information from others is reported to drive this information gathering activity, their conduct supports the idea of an 'additive' approach to conceptualising vulnerability by gathering the clues and combining the cues to vulnerability as was reported on in Chapter 7. This contrasts with the 'one reason' kind of decision making observed during direct observations. Even where a single 'attention grabbing' feature or characteristic of vulnerability was remarked upon during practitioners' discussion of their evaluations of incoming referrals to the CRU, what was also observed consistently was additional information seeking suggesting that practitioners were not content to assess someone as being vulnerable to abuse on the basis of single indicators.

Social workers indicated that their approach to assessing vulnerability and risk often involved initial information gathering. Many participants indicated that the initial information they received often lacked the necessary details of the case that would allow them to make an informed judgment on the level of vulnerability an individual faced.

Social Worker 35 indicated this by saying:-

"I guess when I get a case in I immediately start to do a risk assessment and I guess that's where I start to cluster that information largely, that initial risk assessment. But quite often, the information we receive initially is fairly poor so you make, you make these searches..."

Police officers also indicated that they used information gathering to help ascertain an individual's vulnerability. Male Police Officer 5 indicated that police officers are often required to act quickly with very little information, and the necessity of those quick judgments meant that mistakes could be made and then rectified when enough information was gathered to more clearly see the entire situation. Police Officer 5 described a situation where he and a colleague had to revise their initial judgment after gathering additional information.

Police Officer 5 said that:-

"My point being ... we used to do the male cave man thing and go, well bloke's got to be the offender [in a domestic violence situation]. I think a similar thing does creep in when you talk about vulnerability, we do make some judgments, which we have to do, but based on very little information sometimes ... but in a lot of the AP stuff we have the ability to obtain that information I think".

During the direct observation field notes indicate that police officers sought further information through the interrogation of a single information system accessible only to themselves. In other words, they curtailed their information search to intra-agency intelligence sources.

Police Officer 8 provided an example of this on interview:-

*"We have warning systems on the Police system, we would always, if something came in from *** from adult protection we would look at the referral received and then we would look at the victim mmm and then we would go to the warning signs".*

Social workers were observed to seek information from multiple sources both intra and inter-agency, including internal and external databases, websites and telephone discussions with various professionals in health and social care in community and in-patient services. For example, following a report of possible service user on service user assault within a care setting field notes recorded ancillary activity by Social Worker 37 to inform her evaluation of the adult's vulnerability and the presence or absence of protective factors within the setting. Field notes indicated that Social Worker 37 checked the CQC website and reported that the CQC inspection report indicates all standards were met at the last inspection. (Suggesting that a care environment where good care delivery is a protective factor, thereby, reducing vulnerability to abuse).

Once again this search for information from multiple sources serves to build a picture of a person's vulnerability by searching for signs identified from either their personhood and/or their circumstance.

8.5. Summary

In this chapter I have discussed the reported constraints on professional response to signs of vulnerability. Using Lipsky's model of Street Level Bureaucracy (SLB) as a conceptual framework I have argued that, where these constraints are a function of the legal and policy context, professionals report being limited in their exercise of discretion. However, the other constraint upon their response to vulnerability and abuse relates to their beliefs about what constitutes legitimised work of their professional groups and their employing agencies. These factors are more accessible to participants use of discretion and tended to be used to support exclusion from further safeguarding activity rather than inclusion. Service eligibility criteria were cited as a reason to exclude an adult from a safeguarding response by the professionals' particular agency and professionals described an exercise of discretion driven by their understanding of what resources their agency had to contribute to the solution. As one social worker put it:-

"Is this something my agency can do something about or is it someone else's problem to solve?"

It might be expected that faced with ambiguous definitions and a lack of clarity about threshold criteria to support decision making in adult safeguarding practice participants might exercise discretion in deciding who to respond to. I would argue that for these professionals this is where they defaulted to the frameworks of service eligibility criteria and agency priorities as these provided a frame of reference for their exercise of discretion.

Despite the rich and differentiated concept of vulnerability evident amongst the professional groups these constraints of service eligibility criteria and agency priorities influence professional understanding of their authority and autonomy to act. The primacy of work role and agency priorities means that professionals tend towards the operation of an a-priori decision which may preclude their concept of vulnerability to abuse, particularly for persons who fall outside their professional or agency authority to act. For social workers the primary question was 'is it abuse' and for police officers 'is it a crime'. In both cases these 'first' questions influenced whether or not any further consideration was given to the adult's 'vulnerability' and especially their 'vulnerability to abuse'. In summary, whilst professionals were able to articulate a very detailed and comprehensive understanding of 'vulnerability' to abuse – seeing it did not equate to acting in response using the framework of adult safeguarding procedures. Recognition is one thing – response is yet another.

Chapter 9

Discussion and Conclusion

9.1. Introduction

In this thesis I have argued that, in contrast to the implied criticisms from the findings and recommendations of multiple Serious Case Review (SCR) executive summary reports, the concept of vulnerability in Adults At Risk of Abuse (AAR) is well understood by professionals working in safeguarding practice. They demonstrate a differentiated and nuanced approach to constructing their concept, drawing upon a multiplicity of factors/characteristics which I have categorised into three main typologies – character, context and conduct of others. An explanation of the ‘failures’ identified in SCRs has been offered in the separation of professional recognition and response to vulnerability. It is suggested that the latter is governed by other factors which fail to legitimise the conceptualisation of vulnerability demonstrated by professionals in operating the formal safeguarding procedures.

This chapter will summarise the findings of this study and synthesise these within existing research and theory, identifying its limitations and contributions. It is divided into the following sections :-

- What was researched and how.
- Main findings and arguments linked to existing research and theory.
- Limitations of the research and recommendations for future developments.
- Unique contribution of this study to this field of practice research.

9.2. Research Question and Methods - Revisited

The motivation and interest for this area of research stemmed from a professional curiosity which has been developed over time as a practising social worker and multi-professional practice educator. In these work roles I read and disseminated the findings of Serious Case Reviews (SCRs) related to adults. It was impossible to not notice the recurrent themes across these adult SCRs, a similar phenomenon has been observed in children’s reviews. Many of the findings and recommendations highlighted areas for improvement by practitioners. However, in contrast to the changes in methodologies witnessed in the conduct of child death reviews (SCIE 2009), the methodologies of adult SCRs rarely capture the voice of the practitioner. The inference of these findings was an implied failure on behalf of practitioners to understand the nature of abuse and vulnerability in AAR.

This study sought to fill the gap in our knowledge by exploring how professionals think about vulnerability and reconsider the findings of SCRs in the light of this. Consequently, this study was primarily interested in what signs of vulnerability practitioners employ when assessing the risk of abuse/exploitation in adults and what contextual factors have a bearing on the conceptualisation and subsequent responses.

The principal research question was "How do police officers, health and social care practitioners conceptualise vulnerability when assessing adults at risk of abuse and how do these conceptualisations vary across the professional groups"? The secondary question was "How can the findings and recommendations of SCRs be informed by this"?

This research was conducted as part of a self-funded PhD study and received no external funding. Whilst it is important to acknowledge that there were pragmatic reasons for choosing to conduct this research within the workplace, more importantly it enabled me to exploit my 'insider' position. This provided me with knowledge of the practice and access to established networks to create a sample of participants. This pre-existing proximity to practice and the people supported the creation of trust at both an agency and individual level. This would be significant in gaining access to professionals and promoting openness from participants to explore their perspectives in the light of the criticisms detailed in the SCR reports.

Furthermore, the interpersonal skills (particularly interviews skills) developed in practice are readily translatable into the chosen methodologies. Drawing information together from multiple sources, including what is heard, read and observed, is a well-trodden path for social workers. These work skills lend themselves to a number of qualitative research strategies. However, as van Heughten (2004) observes, there is a risk of biased reporting in the 'insider' practitioner research approach. This can be guarded against by self-awareness, honesty and reflection within an accountable relationship. In this study, the skilful probing questions from my supervisors were especially pertinent and ultimately supported this shift in my thinking that moved me from a positivist to a relativist approach, returning me to a paradigmatic position more resonant with my social work values, and ultimately shaped the choice of methodologies to ensure a close fit to the research question.

The grounded theory approach was a natural selection for this study as it sought to understand the world of the participant without imposing pre-existing ideas or expectations. Miller & Jones-Harris (2005) argue that grounded theory approaches are best suited to answer questions relating to questions about beliefs, attitudes or personal experience. A mixed qualitative methods design was

chosen to support an interpretivist approach which in the analysis brought together data from a number of routes to access the practitioner by hearing, seeing and reading what they did. For this reason, research activities included focus group discussion, interviews, direct observations of practice in the work place and reviewing written records of practice decision making.

Using the insider researcher position I was privileged to access some very candid discourse from professionals participating in the research.

9.3. Conceptual Confusion - Background and Context to the Study

This study commenced with an acknowledgement of the 'confusing and ambiguous' nature of the term 'vulnerability' in adult safeguarding practice echoed amongst academics, researchers, professional sector leads/bodies and campaign organisations. This was thought to underpin the discordant views expressed by practitioners about what constitutes a 'vulnerable adult'. The dilemma in policy and practice was succinctly summarised by Brown et al (1999) as follows:-

"... there is a central confusion about what constitutes vulnerability and what causes abuse – in many adult protection policies vulnerability to abuse is assumed to be a product of the individual's impairment and not their environment or the perpetrator's behaviour. This goes against the grain of the social model of abuse as well as of disability, which would emphasise structural inequalities such as gender, race and poverty as contributory factors. Hence, many would argue that victims of abuse are universally vulnerable because of their experiences of abuse and should be treated in policy and practice as a seamless group". (Brown et al 1999, p. 9)

Brown's argument was echoed in the call for clarity by the Association of Directors of Adult Social Services...

"We need clear national definitions to give consistency. The term 'vulnerable adult' is currently subject to different interpretations by different agencies according to guidance issued to them to support their core business. There is also a public expectation about who and what the term 'vulnerable' means. All of which has the potential to lead to or exacerbate confusion and misunderstanding. The definition should enable everyone, not just practitioners, to understand who a 'vulnerable adult' is". (ADASS 2009, p. 2)

This conceptual confusion forms the backdrop for this research study. We know very little about how professionals conceptualise vulnerability in practice, and how they make sense of this apparent confusion when making decisions 'on the frontline'. In his theory of street level bureaucracy, Lipsky

(1980) argued that these frontline workers become the ultimate policy makers through their exercise of autonomy and discretion in decision making, whilst others (Howe, 1991) assert that the exercise of discretion is constrained amongst public sector workers by the operation of law and policy. This research draws upon these theories in seeking to interpret the differences between professional recognition of vulnerability and their responses to it.

9.4. Main Findings and Arguments

In the midst of this confusing context this study sought to explore how practitioners conceptualised vulnerability in assessing adults at risk of abuse and to understand the findings and recommendations of SCR summaries in the light of this. This study found that professionals had a very differentiated and dynamic conceptual model of vulnerability which took account of both individual and situational sources of vulnerability as well as their interactive effects. This is indicative that professionals were operating a social model of vulnerability. I found that professionals exercised discretion in their operation of competing occupational rules and favoured some rules over others having the effect of screening themselves out of safeguarding enquiries and interventions.

In operating a social model of vulnerability the professionals in this study evidence a holistic approach, unlike the definitions in law and policy which emphasise the characteristics of individuals and have been criticised (Fitzgerald 2009) for not capturing the situational aspects of vulnerability. Professionals operating within this policy context and the current eligibility driven service criteria are limited in their capacity to respond creatively to the vulnerability they see. The findings of SCRs, as reported in the summaries, do not show any attention to these structural constraints on professional practice.

I would argue that without providing greater freedom and discretion in decision making for professionals in adult safeguarding practice, from the rule bound criteria driven practice that prevails, the operation of a social model of vulnerability will remain an aspiration not an implementation.

9.4.1. Serious Case Review Reports – Fallible Findings from Faulty Formulas?

In the course of this study difficulties were encountered in gaining access to full SCR reports. Where these were available publicly they were not available in full. Further access requests met with co-operation from most but not all local and metropolitan authorities. The desired transparency in publication to support the dissemination of learning to the wider safeguarding communities in the UK, despite the exhortations of Flynn (2010) and others for a coherent strategy for collation and

dissemination, remains a work in progress. However, work has now commenced on improving the quality and use of the newly named Safeguarding Adults Reviews (SARs) through the collaboration of SCIE and RIPfA at the request of the Department of Health.

My experience and my subsequent analysis of the reports concurs with the findings of Manthorpe & Martineau (2011) in respect of idiosyncratic construction of reports despite their common purpose, and it echoes the views expressed for the need for standardisation which would make the data they contain more amenable to meaningful interpretation. The report summaries I analysed varied considerably in quality and quantity. The length of reports varied from four short paragraphs of two to three sentences, each providing little or no demographic case details, to comprehensive detail extending over 75 pages. This lack of consistency undermined the quantity of data available in conducting the analysis of case characteristics. For example, information about the Person Alleged Responsible (PAR) was only reported in 50% of the reports analysed.

My thematic analysis of case findings and recommendations identified inadequate recognition and response to vulnerability by practitioners as one of the top five themes to emerge. These themes bore similarities to the findings of Manthorpe & Martineau (2011) but used a sample size more than five times of that study. The issue is voiced most loudly in a recommendation contained in a report from North Tyneside (2011) as follows:-

“Adult A’s case once again illustrates the need for clearer guidance of what comprises vulnerability. Despite all the clues and markers – learning difficulties, poor mental health, chronic physical ill health, hard to reach - easy to overlook and missed appointments – none of the agencies in this case saw Adult A as vulnerable or alerted partners. This failure to recognise vulnerability continues to pose a significant threat to effective safeguarding of vulnerable people”. North Tyneside (2011)

The limitations of SCR methodologies have been rehearsed in Children’s Services since the review undertaken by Dr Eileen Munro (2011). This review led to the development of the ‘learning together’ systems approach (SCIE 2009) which seeks to understand the context of practice decisions and the voice of the practitioner. The findings of my study support this view and endorse a move away from the distant views taken from observations through paper based reviews. My research found written records to be an unreliable source of information as record writing lacked any consistent format or was silent on the issue of assessed vulnerability, as reported in Chapter 5.

In Chapter 4 the thematic analysis of SCR executive summary reports identified themes in the findings and recommendations relating to practitioner understanding of vulnerability. These reports

infer that the underlying errors of judgement in cases that have tested the adult safeguarding system are as a result of deficits in practitioner understanding of abuse or vulnerability.

The present study found that professionals working in adult protective services from many disciplines had a differentiated concept of vulnerability to abuse and a nuanced approach to assessing this in adults at risk of abuse. Their conceptual model was dynamic and explored the inter-relationship between characteristics that fell largely into three domains including individual, situational characteristics and the conduct or condition of the PAR. This blended approach to constructing their concept of vulnerability meant that vulnerability was not seen as a matter of either the individual's Condition (innate vulnerability) or Position (situational vulnerability) but an interplay between the two, with the conduct of others as an added domain which operated like a volume switch that turns the noise up on vulnerability. This finding refutes the suggestion that improvements in practice are to be found in strengthening practitioner understanding as they have demonstrated a highly differentiated and nuanced approach to evaluation of vulnerability.

Vulnerability is a bounded concept in risk assessment. The categories of characteristics of vulnerability evidenced in the concept of participants in this study demonstrate strong parallels with the approaches to risk assessment noted by others. In their work Carson & Bain (2008) noted the following two approaches or levels to understanding risk – 1) factors associated with the individual and 2) the context or situation within which they live and interact, their social circumstances.

Safeguarding adults from abuse is an area of public service work which is strongly governed by law and policy. In the UK the foundational Government guidance document 'No Secrets' (2000) exemplifies policy, which prescribes and defines vulnerability based on individual characteristics. More recent guidance (Care & Support Statutory Guidance 2017) within the lifetime of this study has retained this focus and locates signs within the person, although there has been some expansion with the inclusion of signs in the situation pertaining to organisational abuse. Police guidance (NPIA 2012) is unique in how it organises signs into a binary model identifying signs located in the victim and those located in the offender.

Theoretically the mandates of law and policy should prescribe the practice of public servants and it would be reasonable to expect these to underpin the thinking of professionals and govern their actions. The evidence is that the definitions of vulnerability in safeguarding adults policy do not constrain the thinking and understanding of professionals in the field. This study has shown that they have an expansive concept of vulnerability. However, despite this comprehensive understanding of vulnerability it was not surprising to find that professional understanding of

vulnerability did not govern their response to it. In his theory Lipsky (1980) sought to explain why policy implementation might differ from the intentions of the policy makers. Lipsky argued that understanding was to be found in the context and constraints of the work environments of frontline workers who he claimed were not merely implementers of policy but generators of it too. This was achieved through the actions of these workers as they sought to navigate the dilemmas and constraints of the real work environment. One of the characteristics of what Lipsky called the 'structure of work' was the worker's inherent discretion and their autonomy to exercise this.

The present study found discretion operating amongst professionals, who drew upon service eligibility criteria and organisational priorities in determining their involvement or otherwise, in safeguarding enquiries. The rules which govern safeguarding responses, i.e. the criteria for Section 42 enquiries, and the definitions of vulnerability and abuse are not the only set of rules that govern the work environment of the professionals involved. Faced with limited resources, professionals exercised discretion in favour of other occupational rules. These rules were based on their understanding of legitimate work for their job role and employing organisation's objectives and priorities. Eligibility criteria became a justification for non-intervention by their service and a reason to pass responsibility to others. A distinct 'detective/protective' split between the professional groups existed which accorded with job roles. Whilst such an approach is not surprising, it lends strength to the view that assessment of risk and vulnerability in safeguarding vulnerable people from abuse is best undertaken jointly. In the proposals for a multi-agency safeguarding hub for safeguarding children Boulton (Cooper 2011) asserted that such arrangements would enable a more consistent approach. The outcomes of the present study would suggest that it may also encourage a more comprehensive and integrated approach.

Adult safeguarding practice is a developing area amongst professionals in health, social care and the criminal justice services, and practice research is still in its infancy in comparison to other related fields. Consequently, a discrete theoretical understanding of adult abuse and vulnerability is not yet formulated. Participants in the present study did not specifically articulate theoretical concepts underpinning their conceptualisation of vulnerability but in their discussion of vulnerability in AAR they spoke about concepts and understanding from allied fields, for example, domestic abuse, institutionalisation and social inequalities models. The tripartite conceptual framework of vulnerability - character, context and conduct of others – offers support to the argument that the understanding of vulnerability by both police officers and social workers might reasonably be conceived as a social model of vulnerability. Their understanding takes into consideration signs of vulnerability identified in both the individual and their situation, and treats these as interactive

factors contributing to vulnerability unlike the historic definitions of a vulnerable adult detailed in the policy guidance 'No Secrets' (2000).

However, whilst these professionals showed that their concept of vulnerability took into account both individual and situational vulnerability there was little sign that they considered vulnerability from the perspective of the adult's lived experience. As highlighted in Chapter 7 the absence of an emic approach is illustrated in the criticisms of safeguarding policy during the review of 'No Secrets' (AEA 2009, ADASS 2009), which prompted the development of the Making Safeguarding Personal initiative to capture the person's internal appreciation of their situation in safeguarding procedures. I would argue that policy definitions have encouraged an etic rather than an emic approach to evaluating vulnerability. It is conceivable that future SARs might comment on professional understanding where such an approach has not been applied.

Crucially, when speaking about their concepts and the application of these in safeguarding practice, participants called attention to the fracture between their ability to recognise vulnerability in AAR and their ability to respond. Whilst obstacles to response were acknowledged to include an absence of permission from the adult themselves and a lack of professional authority to intervene, a greater emphasis was placed on constraints pertaining to legitimised work discussed in the form of job role definitions, agency priorities and service eligibility criteria. These three themes emerged as the critical decision rules operating across the professional groups.

The findings concur with the views expressed by others including Ash (2013) who, when seeking to identify the realities and constraints faced by social workers in implementing policy to protect older adults from abuse, also drew upon Lipsky's theory of SLB as an interpretative framework. I would argue, like Ash that the SCRs pay little attention to the cultural context and consequently fail to understand how the rules are experienced by frontline workers and influence how policy is implemented. Instead, policies are reviewed, re-drafted and renewed, staff are re-trained and 'lessons' are 'learned' again.

Clark-Daniels (1995) found that social workers decision making about elder mistreatment was influenced by resource rationing in terms of access to service support. In a similar way, participants in the present study repeatedly rehearsed the effect of an adult's eligibility for services from their agency as a significant influence on the way they approached vulnerability in AAR. Ellis (2011) described different micro-environments acting upon social work decision making, including managerialism and professionalism. The dominance of managerialism in the discourse of professionals about vulnerability in AAR serves to illustrate and explain the dissonance between a

rich understanding of vulnerability and a limited response. For this reason signs of vulnerability which cannot be responded to by the professional by reason of professional authority or organisational legitimacy are sometimes disregarded or discounted.

Lipsky (1980) suggested that frontline workers grapple daily with cognitive dissonance, which is inherent in their work, as their concepts of public service are challenged by what Lipsky describes as 'a corrupted world of service' (Lipsky, 1980, p. xiii). This is a world where they encounter ambiguous policies and resource limitations. Central to Lipsky's theory is the operation of discretion in decision making by SLBs which effectively creates the policy they carry out. This makes the frontline worker the final creator of policy in practice as they seek to navigate a method of implementing policy against the backdrop of work pressures and uncertainties. This is especially true where policy is ambiguous. An oft-cited Lipskian quote sums up the process: "... the decisions of street level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out" (Lipsky, 1980, p. xii). The ambiguity of adult safeguarding policy in the UK, and difficulties with definitions of abuse and vulnerability, have been remarked upon by others (McCreadie 2002, Brown & Stein 1998). To date we have known little about the relationship between how the concept of vulnerability is operationalised by frontline staff in safeguarding practice.

Lipsky also proposed that the discretion of SLBs was shaped variously by the degree of freedom in decision making that was permitted by the agency. Lipsky's theory offers an interpretative framework for the findings of the present study. The implementation of safeguarding adults policy pivots upon the operant thresholds employed by professionals making these decisions. I have found that the ambiguous definitions of vulnerability have been problematic for the practitioner involved in protecting adults from abuse. However, I would argue that the problem is not a matter of their lack of understanding of vulnerability but more to do with defined job roles and the contextual constraints of legitimised work by their employing agencies. The 'thresholds' for progressing their involvement in safeguarding enquiries and interventions, have been conflated with and predicated upon the adult's eligibility for a service by their agency and match to the 'client specification'.

I would suggest that the gatekeeping function of eligibility criteria might be operating as a mechanism of psychological defense for professionals to protect them from feeling overwhelmed should they decide to respond to all those that they conceived as vulnerable to abuse. The findings of my study concur with the views of Ash (2013) who discussed this defense to dissonance in terms of a 'cognitive mask', which both protects and distorts. Borrowing from Ash's concept the 'mask of defense' is required to protect the professional from the cognitive dissonance when using their

concept of vulnerability to recognise vulnerability to abuse it does not mean using it to inform their response. The mask is comprised of a weave between defined job role, agency priorities and service eligibility criteria (legitimised work). In this way the practitioner is able to protect themselves against an overload of work available from the identification of vulnerability to abuse and thus ration their responses.

For police officers in the present study this kept their focus on ‘offence detection and prosecution’ as legitimate work for them in safeguarding adults from abuse, whereas for social workers a different tariff was active, which curtailed responses to those persons with prescribed vulnerabilities that could be categorised as fulfilling a ‘service eligibility’ criteria. It is possible that this mechanism serves to limit professionals in applying the principle of prevention in favour of the principle of protection. Recommendations in the SCRs summary reports, which infer a need to improve practitioner understanding of abuse and vulnerability, also imply that a response to recommendations might make such adverse outcomes in safeguarding practice preventable. Whilst ‘seeing’ the ‘accident waiting to happen’ the ‘doing’ of something in response is constrained. Participants talked about this in terms of the features of their work context or what Lipsky described as ‘a corrupted world of service’ (Lipsky 1980, p. xiii). In order for professionals to apply the social model of vulnerability to abuse of adults in practice, the policy makers might do better to ‘describe’ rather than to ‘define’ vulnerability thereby leaving more room and permission for the frontline practitioner to operate a concept of vulnerability which takes account of and is responsive to the dynamic relationship between individual and situational signs or characteristics.

As Judge Munby emphasised when minded to avoid a definition of a vulnerable adult, characteristics of vulnerability should be considered *‘descriptive, not definitive: indicative rather than prescriptive.’* (Munby 2006)

9.4.2. Complex Concepts – Combining the Individual (Condition) and Situational (Position) in Signs of Vulnerability

As noted, the SCR findings and recommendations often reported a need to strengthen practitioner understanding of vulnerability and abuse. However, they do not differentiate between these two concepts so it has not been possible to identify whether this recommendation applies equally to practitioner understanding of both concepts. The presumption of policy is that where abuse is identified then adult safeguarding actions would be prompted. In the same way it might presume that where vulnerability to abuse is identified that similar responses are initiated. Where they are not, the inference from SCR findings is that this is as a result of practitioner failures to recognise

vulnerability – to see the signs. However, the findings of the present study indicate that professionals from a number of disciplines are alert to a multiplicity of signs of vulnerability and aware of the interactive effects of these to engender vulnerability to abuse in adults. There was some concordance between the signs identified by participants in the present study and those reported in other studies. Fulmer et al (2005) sought to identify which factors were of greatest significance in elders with a confirmed diagnosis of neglect. Indicators of abuse that concur with those reported by Fulmer include cognitive status, functional status, social support and personality/character.

There were also similarities between the signs identified in the present study and those detailed by Greenspan et al (2001) who developed a model of vulnerability in younger persons with developmental disorders which sought to identify elements of personal competence as an antithesis to vulnerability. Greenspan suggested that the interactive effect of personal and environmental factors combined to promote, or protect people, from vulnerable outcomes. Central to the model are the concepts of credulity and gullibility, pertaining to the individual's social competence. Participants in the present study identified signs of vulnerability as a function of a person's character to include unwillingness or inability to perceive the PAR as an abuser, which approximates to Greenspan's signs of social incompetence. Additionally, like Greenspan, participants in the present study understood vulnerability of this nature to be heightened when personal circumstances which constrained their social competence (e.g. reliance or dependency on others) were combined with the conduct of others who were positioned to take advantage of such naivety.

Even stronger parallels were evident between the characteristics of vulnerability for AAR identified by participants in the present study and those identified in Forbes-Parley's (2007) study of staff working with adults with learning disabilities. The characteristics associated with vulnerability which showed commonality across both studies included inability to understand, inability to communicate, inability to protect oneself, neediness and reliance on others, lack of skill and the status of being cared for. The similarities observed across both studies with regard to the signs of vulnerability recognised by professionals, improves the confidence in the trustworthiness of the present study's findings.

The blended approach of professionals who simultaneously attended to both individual and situational signs of vulnerability could be conceived as a social model of understanding vulnerability in action.

However, the present study also found that a practitioner's response to vulnerability to abuse was not governed simply by their construct of vulnerability. This finding echoes the observations made by Johnson (2012). She set out to study and collect information about multi-agency adult protection activity in Scotland but in the course of this observed the lack of co-terminosity between practitioner constructs of 'abuse' and 'adult protection'. Johnson's report offers a post hoc commentary as the original data set did not set out to examine the relationship between the two concepts. She illustrates that evidence from practitioners in her study contradicts the 'policy' presumption of a linear relationship in that adult protection would follow from 'abuse' identification. The present study purposefully explored the question of 'other influences' on professional constructions. Although the identified influences were reported to mostly affect practice responses, professionals also indicated that these constraints limited the degree of differentiation they might operate in attending to signs of vulnerability. Organisational constraints such as agency priorities and service eligibility criteria served to reduce the shutter size on the metaphorical lens of practitioner gaze on vulnerability. They somehow short circuited the professional's otherwise expansive view of vulnerability. As discussed in Chapters 7 and 8, for police officers this meant that the detection of crime was their primary concern and vulnerability as such didn't matter. For social workers their view of vulnerability was limited if the person didn't meet the service eligibility criteria.

9.4.3. Seen Through a Glass Darkly – Eligibility Criteria and other Constraints on Responding to Vulnerability to Abuse

In Chapters 5 - 7 of this thesis a detailed exposition of the professional concept of vulnerability is reported highlighting the subtleties of discernment operated in their construct. We saw this in Chapter 6 where I described how practitioners were using an interactive combination of signs of vulnerability, from three domains – character, context and conduct of others. However, the primacy of conceptualisation as a determinant for action in progressing safeguarding responses is challenged by other influences operating in the world view of practitioners. As Johnson (2012) observed in relation to the concepts of abuse and adult protection, a similar lack of co-terminosity was observed in relation to the concepts of vulnerability and adult protection, which contradicts the 'policy' presumption of a linear relationship between understanding and action. The overriding governance of criteria in driving decision about action was summarised appositely in the quote from one practitioner as follows:-

“Situational stuff goes out the window if they don't meet the criteria.....”

The quote above illustrates how professional recognition and conceptualisation of vulnerability was not the primary determinant for response. This would suggest that it is not a question of *not seeing/recognising* vulnerability but more one of *not responding* as the limitations of resource encourage professionals to exercise discretion to limit their involvement, guided in their thinking by what they consider to be legitimate work defined by job role and organisational priorities.

The observed difference between the understanding of vulnerability and their responses to it by the participants in this present study echo the observations of Baldwin (2000), who remarked on the influence of knowledge, values, experience and the use of discretion as factors impinging on the policy implementation in practice. Lipsky's model of SLB and the operation of discretion offers an interpretative model for the reported influences by practitioners. Professional discretion of participants in the present study was affected through use of frameworks such as organisational context, job role definitions and agency focus of eligibility criteria in the gatekeeping of resources. These were reported by professionals to support their rationales for response limitations in the face of perceived vulnerability in adults the professionals encountered. As commented on in section 8.4.1., in the battle of 'rules' that govern public sector work these professionals exercised discretion in favour of some rules over others to determine their involvement in responding to signs of vulnerability given the prevailing limitations on resource, primarily their own time.

This thesis argues that to understand the findings of SCR's about practitioner understanding of vulnerability there has to be an understanding of the context and other influences which have a bearing on decision making in practice. Findings of the present study in relation to the complex constructs of vulnerability used by practitioners contradict the views found in some of these summary reports about a need to improve practitioner understanding of vulnerability. Similar arguments have been made by Galpin & Parker (2007) who recommended that the process of understanding adult abuse and policy needs to take into account professional knowledge and ideologies as these reinforce and validate practitioner recognition and response. They proposed that "policy makers need to have greater understanding of the different organisational and professional groups, and how these might shape their understandings of the content of policy and terms such as vulnerable adult and adult protection" (Galpin& Parker 2007, p. 13).

I would argue that this understanding needs to be extended to consider the constraints of the working context of professionals in this field of practice. Policy presumes a linear relationship between the identification of vulnerability to abuse and safeguarding responses. The inferred criticism in SCR findings and recommendations suggests a poor understanding of vulnerability and abuse. I would argue that professionals exercise discretion about response to vulnerability as they

are operating in work environments where there are competing sets of rules. In the context of resource limitations, primacy is given to occupational rules which are perceived by them as legitimised work. These are construed in terms of job role definitions, service eligibility criteria and organisational objectives and priorities. Consequently, whilst professionals have a very comprehensive understanding of vulnerability and are able to identify both individual and situational signs of vulnerability, their responses to what they 'see' are constrained through this operation of discretion. This was particularly noticeable amongst police officers who took an offender focus in identifying signs and a 'detective' approach to engagement in safeguarding responses defined by the detection and progression of criminal enquiries.

The influence of the work context of professionals as described in the paragraph above might suggest to policy makers that it would be better to describe rather than define vulnerability and that changes are required which endorse or legitimise practitioner responses that liberate them from the rule bound eligibility criteria driven approaches to decision making reported by these participants. However, I do not say this from a position of ignorance of the function of criteria to gate keep access to public resources. Consequently, I recognise that this may not be a politically persuasive argument in light of current fiscal adversities and increasing pressures on public service resourcing, especially personnel resource.

9.5. The Argument in Summary

- ❖ Serious Case Reviews and their public reports have developed a certain gravitas. The imperative to disseminate their findings and for lessons to be learned infers that these lessons have wider application beyond the local level at which they are conducted. If not this, then the associated media coverage raises their status in the minds of many practitioners.
- ❖ Amongst the many recurrent themes to emerge from numerous executive summary reports has been the recurrent finding and recommendation for the need to strengthen practitioners' understanding of vulnerability and abuse, inferring a deficit amongst professionals in this respect. The definitions of vulnerability and abuse in safeguarding adults practice have historically been subject to criticism with suggestion (Brown et al 1999) that there is confusion about what constitutes vulnerability.
- ❖ Through speaking with professionals, observing them in practice and examining their written records I have found the professionals in this study had a very differentiated and dynamic concept of vulnerability in relation to adults at risk of abuse. Their conceptualisations

encompass both individual and situational sources of vulnerability using characteristics which I have categorised as Character, Context/Circumstance and Conduct/Condition of others. Their concept of vulnerability to abuse within the adult population took into account the interactive effects of these characteristics in understanding the overall vulnerability of the adult and operating the criteria for progressing safeguarding enquiries.

- ❖ However, I also found that professionals' recognition and understanding of vulnerability were not the only influences on how professionals responded to these 'cues and clues' to vulnerability. Obstacles to response were discussed in terms of constraints within the workplace including job role definitions, agency priorities and service eligibility criteria. These three themes emerged as the critical decision rules operating across the professional groups. Where competing rules existed professionals exercised discretion in favour of these rules which legitimised their involvement.
- ❖ Strengthening safeguarding responses which guard against weaknesses in recognising and responding to signs of vulnerability to abuse might be better achieved through liberating professionals from the eligibility driven rules based approaches to decision making, endorsing their concept of vulnerability and supporting judgements to intervene based on this. Additionally, adherence to perceived agency priorities shackles the professional response to adults who are vulnerable to abuse and limits creative collaborative working between different professional groups.

9.6. Research Questions Re-Visited

In Chapter 3, I outlined the study aims and the rationale for the methods of enquiry adopted. I would re-assert that the design was a good fit for the research questions by briefly re-visiting these in relation to the key findings.

The study aimed to:-

1. Identify and describe how safeguarding adults practitioners conceptualise vulnerability.
2. Identify and describe what else affects their conceptualisation and subsequent response to signs of vulnerability to abuse.
3. Understand and analyse the recommendations of SCRs in the light of this.

The principal research question was "How do police officers, health and social care practitioners conceptualise vulnerability when assessing adults at risk of abuse and how do these conceptualisations vary across the professional groups"? A secondary question was "How can the findings and recommendations of SCRs be informed by this?"

The in-depth discussion with professionals through focus groups and interviews has provided a rich description of the factors that professionals report inform their concept of vulnerability in adults at risk. These have been categorised into three broad domains – Character, Context and Conduct of others to make them conceptually more accessible. The differentiated approaches of all professional groups, particularly their attention to situational signs relating to both the settings and persons responsible for abuse, is such that it might be conceived that professionals are operating a social model of vulnerability when assessing AAR of abuse. This is in contrast to the definitions in past and current law/policy which have been criticised for taking a focus on the individual and not the circumstances which give rise to vulnerability. Further evidence of both individual and situational factors in the operation of the concept was derived from direct observations of practitioners engaged in live decision making where many of the factors described in focus groups were observed to be utilised in the understanding of vulnerability by safeguarding professionals.

A difference between social workers and police officers was observed and reported in what was termed 'victim focus' or 'offender focus'. This was explained in terms of the 'protective' and 'detective' difference associated with the respective job roles. The examination of what practitioners said about their work offered insights into similarities between the professional groups in relation to other reported influences on their responses to the identified signs of vulnerability in the AAR. These were related to service eligibility criteria and job role limitations and requirements of their employing agencies.

These findings reported in Chapters 5, 6 and 7 are set against the inferred weaknesses in practitioner understanding of abuse and vulnerability which was reported as a recurrent theme in Chapter 4. In Chapter 8 it was argued that professionals have a complex understanding of vulnerability and that the dissonance between their conceptualisation of vulnerability and their responses to it are a function of the contextual constraints of their work environments in terms of what is legitimised work endorsed by their employing agencies. These serve to constrict their view of vulnerability by giving ascendancy to how the service they work for can respond. These conclusions strengthen the arguments that others (Flynn 2010, Munro 2011) have made about the need to adopt a systemic approach to the conduct of SCRs in order to report not only on what was done but also to give understanding and speak meaningfully to the interpretation of these events by taking account of the

context of their occurrence. It is a rare professional in human services who seeks to conduct an ill-informed and poorly performed work task.

9.7. Limitations of the Research and Recommendations for Development

The nature and purposes of qualitative research are inductive rather than deductive. There is no suggestion that the findings of this study offer a causative explanation to refute the findings and recommendations of the SCR reports. The findings point towards an explanation of the findings of SCRs where the systems approach has not been adopted. Current work that the Department of Health has commissioned from SCIE and RIPfA aims to improve the quality and use of safeguarding adults reviews (SARs). It aims to draw together and develop an online library of open access resources on the SCIE website containing reviews, reports, guidance and tools to support practitioners working in safeguarding (www.scie.org.uk/consultancy/safeguarding-reviews-audits - accessed 07-10-2017). A National repository of SARs and the employment of a systems approach to SAR methodologies would assist future research to re-visit and review these findings to test this theory further in the future.

It is recognised that research is vulnerable to the influence of the values and beliefs of the researcher and consequently the research cannot be entirely value free. This will be evident in the theoretical models used to support the interpretations offered. Lipsky's SLB theory offers a supportive explanation of the mechanisms that operate in the implementation of policy into practice which take account of the challenging circumstances in which professionals in human services have to work and make decisions. This offered a conceptual framework to counter the inferred criticism of practitioners emerging in the themes of SCR findings. It is, therefore, important to recognise that as an existing practitioner and practice educator I have a vested interest in the learning that can be derived from SCRs and a concern with the validity of their findings.

Validity in this study was approached through methodological triangulation. However, it has been argued (Bryman 2012) that the data from different qualitative methods, such as in-depth interviews and focus groups, cannot necessarily be considered equivalent as one concerns itself with the private views of the individual and the other the public views of the individual. In this study there were a couple of risks in relation to the focus group discussions despite the use of a semi structured approach. The first risk was the presence of a dominant voice, and the second was the presence of a dominant theme. For this reason the strength of a theme on the basis of frequency counts within any particular focus group could not be relied upon. Consequently, the thematic analysis of signs of

vulnerability was developed by examining the recurrence of themes across data sets to improve the credibility of the findings.

Regrettably, due to time constraints, the planned activity of mixed focus group discussion to explore respondent validation of the findings was not completed within the time of writing this thesis. Consequently, it has not been possible to test whether the representation of professional conceptualisation of vulnerability resonates with the views of participants in the study. Further testing of the concepts with other (non-participatory) representatives of the professional groups would also have tested whether the findings were generalisable.

The sampling methods in this study were purposive which might undermine the generalisability of findings. Participants were purposively selected as they were likely to yield helpful data related to the research question and not necessarily achieve representativeness. However, participants were occupants of professional groups operating to common policies and procedures employed nationally in the UK. Consequently, they shared some common frameworks for operating their decision making with other professionals in their sample population.

In the data analysis there was also a risk of researcher influence in interpretation during the coding of the data and subsequent categorisation. Once again, this is where respondent validation of the reported model of vulnerability and the associated characteristics of the assigned categories would have proved useful in testing the findings. It was observed that signs were often combined as professionals pieced together their picture of the adult's vulnerability. However, the present study has not explored any patterns in the combinations of signs, although it has been possible to observe a difference between the professional groups in the number of signs combined in their concept of vulnerability. Retrospectively there was a missed opportunity during direct observations to observe whether the interaction between professional groups in the context of the multi-agency referral unit had any influence on the number or types of signs. Further research could attend to this through case study analysis in single discipline and mixed discipline cohorts.

The focus of the present study was of professional conceptualisation of vulnerability in AAR. I have elucidated the signs that professionals use to conceptualise vulnerability, i.e. what they think makes people vulnerable to abuse and exploitation. However, in terms of understanding what does make people vulnerable to abuse, and thereby strengthen professional understanding of vulnerability in this context, perhaps a way to extend this in the future would be to address this question to the people who perpetrate the abuse. Asking them what signs of vulnerability they attend to in

identifying victims might help us to have a better understanding of what actually makes people vulnerable to abuse as well as what professionals think makes them vulnerable.

9.8. Contribution of this Study to Research and Practice

In this study I have adopted the position of 'insider researcher' which I would suggest has been both a weakness and a strength. It has enabled me to access otherwise difficult to access professional groups and establish an empathic approach that has fostered a great degree of candid response from participants who I would suggest have been very honest and transparent in their responses and positive in their engagement with the study.

This unique access to multi-professional views of current safeguarding practitioners adds to a relatively small but important body of literature on practitioner views on vulnerability of adults at risk of abuse. Unlike previous studies, my research has solicited views of vulnerability in relation to the whole adult population and not limited itself to the study of one adult client group.

The present study provides insight into the key signs which operate in cross disciplinary professional conceptualisation of vulnerability in Adults at Risk of abuse and proposes a tri-partite conceptual model to make vulnerability more conceptually manageable for practitioners. The model encompasses signs of resilience as well as vulnerability to support multi-professional assessment of AAR of abuse. In practice this is a small contribution but if the descriptors can be incorporated into documentation that supports practitioner decision making and guide people away from a criterion-based evaluation of vulnerability there are possibilities for encompassing the ever present broader view of vulnerability which extends beyond existing service eligibility criteria. For social workers in particular, service eligibility criteria are necessarily going to be guided by the Care Act 2014 eligibility criteria. In determining eligibility the Local Authority must consider three conditions, the first of which is that the adult's needs for care and support arise from or are related to physical or mental illness or impairment and NOT caused by other 'Circumstantial' factors. A 'descriptive' rather than a 'definitive' approach to conceptualising vulnerability would create permission for professionals to operate a concept of vulnerability which takes account of and is responsive to the dynamic relationship between individual and situational signs or characteristics. Supporting practice judgement which adopts this social model of vulnerability creates space for professionals to shake the shackles of bureaucracy, as has been previously recommended in the review of children's SCRs.

Munro (2011) has argued previously for a de-bureaucratisation of social work decision making in child protection in favour of supporting practice judgement. In adult safeguarding this might be better achieved by providing descriptions of vulnerability that are indicative rather than definitive.

Whilst I acknowledge that this will not overcome the operation of discretion in deferring to alternative occupational rules, such as service eligibility criteria, I would argue that it would support the exercise of practice judgement to give greater credence to professional assessment of vulnerability which is not tied to individual characteristics. Failure to do so will emanate in a practitioner position where....

“Situational stuff goes out the window if they don’t meet the criteria.....”

References

Action on Elder abuse (1995) 'New Definition of Abuse', London: Action on Elder Abuse Bulletin (May - June 1995, Issue no. 11).

Action on Elder Abuse (2004) *Hidden voices: Older People's Experience of Abuse*.

Action on Elder Abuse (2009) *Response to the consultation on the review of 'No Secrets': January 2009*.

ADASS (2005) *Safeguarding Adults. A National Framework of Standards for good practice and outcomes in adult protection work*.

ADASS (2006) *Vulnerable Adult Serious Case Review Guidance - Developing a local protocol*, London: Association of Directors of Adult Social Services, at <http://www.adss.org.uk/publications/guidance/vulnerableadult.pdf> (accessed 28 August 2008).

ADASS (2009) *Response from the Association of Directors of Adult Social Services to the consultation on the review of the No Secrets Guidance* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_102499.pdf (accessed 4 June 2012).

ADASS (2010) *Vulnerable Adult Serious Case Review Guidance – Developing a local protocol London*: Association of Directors of Adult Social Services.

ADASS (2015) *Report on project from 2104/2015* www.adass.org.uk/media/4653/making-safeguarding-personal-report-findings.pdf (accessed 25 January 2018).

Adler, P A & Adler, P (1994). *Observational techniques*. In N K Denzin & Y S Lincoln (Eds.), *Handbook of qualitative research* (p. 377 – 392). Thousand Oaks, CA: Sage Publications.

Adult Support and Protection (Scotland) Act 2007 www.legislation.gov.uk/asp/2007/10/contents/enacted (accessed 28 October 2017).

Alaszewski, A and Manthorpe, J (1998) 'Welfare Agencies and Risk: The Missing Link?', *Health and Social Care in the Community* 6(1): 4 - 15 .

Alaszewski, H, Parker, A and Alaszewski, A (1999) *Empowerment and Protection*. London: Foundation for People with Learning Difficulties.

Angelou, M https://www.brainyquote.com/authors/maya_angelou (accessed 1 November 2017).

Angrosino, M V and Mays de Perez, K A (2000) *Rethinking Observation: From Method to Context*. In: Denzin, N K and Lincoln, Y S, Eds., *Handbook of Qualitative Research, 2nd Edition*, Sage, Thousand Oaks, 673 - 702.

Applebaum, P S et al (2001) *Re-thinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence*. New York, NY Oxford University Press.

Appleton, J (1994) The concept of vulnerability in relation to child protection: Health Visitors' perceptions. *Journal of Advanced Nursing*, 20, 1132 – 1140.

Ash, A (2013) *A Cognitive Mask? Camouflaging Dilemmas in Street-Level Policy Implementation to Safeguard Older People from Abuse*. *British Journal of Social Work* (2013) 43, 99 - 115.

Aylett, J (2008) *Learning the lessons in training from abuse inquiries – findings and recommendations*. *The Journal of Adult Protection*, Volume 10, Issue 4, p. 7 – 11.

Aylett, J (2009) *A model and strategy for multi-agency adult protection training in Kent and Medway*. *The Journal of Adult Protection*. Volume 11, Issue 1, 13 – 20.

Baker, A (1975) *Granny bashing*. *Modern Geriatrics*, 5, 8, 20 - 24.

Bakke, W E (1959), "Concept of social organisation", in Haire, M (Ed.), *Modern Organisation Theory*, John Wiley, New York, NY, p. 16 - 75.

Baladerian, N J (1997) *Recognising Abuse and Neglect in People with Severe Cognitive and/or Communication Impairment*. *Journal of Elder Abuse and Neglect*. 1997; 9, 2; ProQuest Psychology Journals.

Baldwin, M (2000) *Care Management and Community Care: Social Work Discretion and the Construction of Policy*, 2000 Aldershot Ashgate.

BASW (1977) *The Social Work Task: A BASW working party report*, BASW.

BASW (2012) *The Code of Ethics for Social Work. Statement of Principles*. cdn.basw.co.uk/upload/basw_113325-10.pdf (accessed 27 January 2018).

Beach, L R (1990) *Image theory: Decision making in personalised and organisational contexts*. New York. Wiley.

- Beckhard, R and Harris, R T (1987) *Organisational Transitions: Managing Complex Change*. Addison-Wesley Series on Organisation Development.
- Benner, P & Tanner, C (1987) *Clinical Judgement: how expert nurses use intuition*. American Journal of Nursing, January: 87(1): 23 – 31.
- Bennet, G C & Kingston, P A (1993) *Elder Abuse: Concepts, Theories, and Interventions*. Chapman & Hall, London.
- Berger, P L & Luckmann, T (1996) *The Social Construction of Reality. A Treatise in the Sociology of Knowledge*. Penguin Books.
- Bergeron, R (1999). *Decision making and adult protective services workers: Identifying critical factors*. Journal of Elder Abuse and Neglect, 10 (3/4), 87 – 113.
- Berlin, I (1998) *The proper study of mankind. An anthology of Essays*. London. Pimlico.
- Bernard, R H (1994). *Research methods in anthropology: qualitative and quantitative approaches (second edition)*. Walnut Creek, CA: AltaMira Press.
- Better Regulation Task Force (2000) *Protecting Vulnerable People*. London: Cabinet Office.
- Block, M R & Sinott, J D (1979) *The Battered Elder Syndrome. An explanatory study*. University of Maryland, Centre on Ageing.
- Bouhoutsos, J (1984) *Sexual intimacy between psychotherapists and clients; Policy implications for the future*, in L E Walker (Eds) *Women and Mental Health Policy*. Sage, London.
- Bouhoutsos, J et al (1983) *Sexual intimacies between psychotherapists and patients*. *Professional Psychology: Research and Practice* 14(2) 185 - 196.
- Brammer, A (1996) *Elder abuse in the UK: a new jurisdiction?* Journal of Elder Abuse and Neglect, Volume8, Issue 2.
- Brannen, J (2005) *Mixing methods research: A discussion paper*. Economic & Social Research Council National Centre for Research Methods. Unpublished.
- Braye, S, Orr, D & Preston-Shoot, M (2015a) *“Learning lessons about self-neglect? An analysis of serious case reviews”*. Journal of Adult Protection, Volume 17, Issue 1, p 3 – 18.

Braye, S, Orr, D & Preston-Shoot, M (2015b) *Serious case review findings on the challenges of self neglect: indicators for good practice*. Journal of Adult Protection, Volume 17, Issue 2, p 75 – 87.

Braye, S, Orr, D and Preston-Shoot, M (2011) *The governance of adult safeguarding: Findings from research into Safeguarding Adults Boards*, London: Social Care Institute for Excellence.

Brearley, C P (1982) *Risk and Social Work*. Routledge and Kegan Paul Ltd.

Brown, H (2009) *The process and function of serious case review*. Journal of Adult Protection. Volume 11, Issue 1, p. 38 – 50.

Brown, H with Seden J (2003) *Managing to protect*. In: J Seden & J Reynolds (Eds) *Managing Care in Practice*. London: Routledge and The Open University.

Brown, H & Keating, F (1998) *We're doing it already*. Journal of Psychiatric and Mental Health Nursing. 5. 273 - 280.

Brown, H & Marchant, L (2013) *Using the MCA in Complex Cases, 18*, Tizard Learning Disability Review 2.

Brown, H & Stein, J (1998) *Implementing Adult Protection Policies in Kent and East Sussex*. Journal of Social Policy. July 98, Volume 27, Issue 3, p. 371 - 396.

Brown, H & Stein, J (2000) *Monitoring adult protection referrals in 10 English local authorities*. Journal of Adult Protection, Volume2, Issue 3, p. 19 – 31.

Brown, H (2011) *The role of emotion in decision making*. Journal of Adult Protection. November 2011, Volume 13, Issue 4, pp. 194 - 202.

Brown, H, Kingston, P, Wilson, B (1999), *"Adult Protection: an overview of research and policy"*, The Journal of Adult Protection, Volume 1, Issue 1, p. 6 – 16.

Brown, H & Thompson, D (1998) *Service responses to men with intellectual disabilities who have sexually abusive or unacceptable behaviours: the case against inaction*. Journal of Applied Research in Intellectual Disability, 10 (2) p.176 – 197.

Brown, H & Turk, V (1992) *Defining sexual abuse as it affects adults with learning disabilities*. Mental Handicap, 20 (2) p.44 – 55.

- Brown, H, Stein, J & Turk, V (1995) *The sexual abuse of adults with learning disabilities: report of a second two year incidence survey*. *Mental Handicap Research*, 8 (1) p.3 – 24.
- Bryman, A (2001) *Social Research Methods*, Oxford: Oxford University Press.
- Bryman, A (2012) *Social Research Methods. 4th edition*. Oxford University Press.
- Burgner, T et al (1998) *Independent Longcare Inquiry*, Buckinghamshire County Council 1998.
- Burr, V (2003) *Social Constructionism*. Routledge.
- Burston, G (1977) *Do your elderly patients lie in fear of being battered?* *Modern Geriatrics*, 7, 20, p.54 - 55.
- Burstow, P (2012) www.elderabuse.org.uk/news_Signif%20Harm.html (accessed 4 June 2012).
- Bury (2009) Team Bury. Executive Summary of the Serious Case Review in respect of Adult A.
- Bury, M (1997) *Health and Illness in a Changing Society*, Routledge, London.
- Butler, I and Drakeford, M (2003) *Social policy, social welfare and scandal: how British public policy is made*. Basingstoke: Palgrave Macmillan.
- Calder, M C (2011) *Organisationally Dangerous Practice: Political Drivers, Practice Implications and Pathways to Resolution* in Kemshall, H (ed) (2011) *Good practice in risk assessment*. London Jessica Kingsley Publishers.
- Cambridge P, Beadle-Brown J, Milne A, Mansell J and Whelton R (2006) *Exploring the incidence, risk factors, nature and monitoring of adult protection alerts*. Canterbury: Tizard Centre. http://www.kent.ac.uk/tizard/research/projects/nuffield_ap.html (accessed 28October 2017).
- Cambridge, P and Mansell, J and Beadle-Brown, J et al. (2011) *A study of adult protection referrals in two local authorities: An overview of findings for managers and practitioners*. *Journal of Adult Protection*, 13 (5), p. 238 – 250.
- Cambridge P & Parkes T (2004) *Good enough decision making: improving decision making in adult protection*. *Social Work Education* 23 (6), p. 711 – 729.
- Cambridge, P and Parkes, T (2005) *The Tension between Mainstream Competence and Specialisation in Adult Protection: An Evaluation of the Role of the Adult Protection Co-ordinator*. *British Journal of Social Work* (2005) 00, p. 1 – 23.

Cambridge, P and Parkes, T (2006) *The Tension between Mainstream Competence and Specialisation in Adult Protection: An Evaluation of the Role of the Adult Protection Co-ordinator*. Paul Cambridge and Tessa Parke, British Journal of Social Work (2006) 36, p. 299 –321.

Cambridge, P (2004) *Abuse inquiries as learning tools for social care organisations*, in (Eds.) N Stanley and J Manthorpe, *Learning and Blaming in Health and Social Care*, London, Routledge.

Cambridge, P, Beadle-Brown, J, Milne, A, Mansell, J, Whelton, B (2011) *Adult protection: The processes and outcomes of adult protection referrals in two English local authorities*. Journal of Social Work. July 2011, Volume 11, Issue 3, p. 247 - 267.

Care & Support Statutory Guidance (2017). <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance> (accessed 22 January 2018).

Care Act (2014) www.legislation.gov.uk/ukpga/2014/23/contents/enacted (accessed 28 October 2017).

Care Standards Act 2000 www.legislation.gov.uk/ukpga/2000/14/contents/enacted - (accessed 28 October 2017).

Carli, L L (1999) *Cognitive reconstruction, hindsight and reactions to victims and perpetrators*. Personality and Social Psychology Bulletin 25(8), p. 966 – 979.

Carson, D & Bain, A (2008) *Professional Risk and Working with People. Decision-Making in Health, Social Care and Criminal Justice*. Jessica Kingsley Publishers London and Philadelphia 2008

Carson, D (1996) *Risking Legal Repercussions*. In H Kemshall and J Pritchard (eds) *Good Practice in Risk Assessment and Risk Management*. London: Jessica Kingsley Publishers .

Charmaz, K (1983). "*The grounded theory method: An explication and interpretation*". In: Emerson, R M (Ed.). *Contemporary field research*. p. 109 - 126. Prospect Heights, IL: Waveland Press.

Charmaz, K (2000). "*Grounded theory: Objectivist and constructivist methods*". In: Denzin, N & Lincoln, Y S Eds.), *Handbook of qualitative research, 2nd edition*, p. 509 - 536. Thousand Oaks, CA: Sage.

CHI (2000) Commission for Health Improvement Investigation into the North Lakeland NHS Trust: report to the Secretary of State for Health. London: Commission for Health Improvement, 2000.

CHI (2007) Healthcare Commission Investigation into the service for people with learning disabilities provided by Sutton and Merton Primary Care Trust, January 2007.

Children Act 1989 www.legislation.gov.uk/ukpga/1989/41/contents/enacted (accessed 28 October 2017).

Chronically Sick & Disabled Persons Act 1970 www.legislation.gov.uk/ukpga/1970/44 – (accessed 28 October 2017).

Clark, D A, Fisher M J and MacDougall, C (1993). *A new methodology for assessing the level of risk in incarcerated offenders*. British Journal of Criminology, 33, 3, p.436 - 448.

Clark-Daniels, C L, & Daniels, R S (1995). *Street level decision making in elder mistreatment policy: An empirical case study of service rationing*. Social Science Quarterly, 76(2), p. 460 –473.

Clay, S, Poole, G, & Lovell, C (2014). *A decade of serious case reviews*.

Hull Safeguarding Adults Partnership Board.
[http://safeguardingadultshull.com/articles/A decade of Serious Case Reviews/34](http://safeguardingadultshull.com/articles/A%20decade%20of%20Serious%20Case%20Reviews/34) (accessed 1 February 2015).

Collins, M (2010). *Thresholds in Adult Protection*. Journal of Adult Protection. Volume 12, Issue 1, p. 4 – 12.

Cooper C, Selwood A, Blanchard M, Walker Z, Blizard R & Livingston G (2009). *Abuse of people with dementia by family carers: representative cross sectional survey*. British Medical Journal 338, p155.

Cooper, J (2011). *Multi-agency safeguarding centre for children's referrals*, Community Care, June 2011.

Cresswell, J W (1994). *Research Design – Qualitative and Quantitative Approaches*. London: Sage Publications.

Creswell, J W (2003). *Research design: Qualitative, quantitative, and mixed methods approaches*. Los Angeles: Sage Publications.

Creswell, J W & Miller, D (2000). *Determining validity in qualitative inquiry*. Theory into Practice, 39(3), p. 124 – 130.

Creswell, J W (2009). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches, second edition*. Sage Publications.

Crime and Disorder Act 1998 www.legislation.gov.uk/ukpga/1998/37/contents/enacted - (accessed 28 October 2017).

Criminal Justice and Court Services Act 2000 www.legislation.gov.uk/ukpga/2000/43/contents (accessed 28 October 2017).

Crotty, M, (1998). *Foundations of social research: Meaning and Perspective in the Research Process*. Sage Publications.

CSCI (2006) Commission for Social Care Inspection and Healthcare Commission: Joint Investigation into provision of services for people with learning disabilities at Cornwall Partnership NHS Trust, July 2006.

Cuzzi, L F, Holden, G, Green Grob, G & Bazer, C (1993). *Decision Making in Social Work*, Social Work in Health Care, 18:2, p. 1 – 22.

Data Protection Act 1998 www.legislation.gov.uk/ukpga/1998/29/schedule/1 (accessed 25 January 2018).

Davies, R, Mansell, I Northway, R, Jenkins, R (2006). *Responding to the abuse of people with learning disabilities: the role of the police*. The Journal of Adult Protection Volume 8, Issue 1, May 2006.

Davies, M, Harries, P, Cairns, D, Stanley, D, Gilhooly, M, Gilhooly, K, Notley, E, Gilbert, A, Penhale, B and Hennessy, C (2011). “*Factors used in the detection of elder financial abuse: a judgment and decision making study of social workers and their managers*”, International Social Work, Volume 54, No. 3, p. 404 - 420.

Decalmer, P & Glendenning, F (Eds). *The Mistreatment of Older People*. London, Sage Publications.

Denzin, N K (1970). *The Research Act in Sociology*. Chicago: Aldine.

Department for Education (2013). *Working Together to Safeguard Children* London: HM Government.

Department of Children, Schools & Families (2006, 2010). *Working Together to Safeguard Children*: London: HM Government

Department of Health & Social Care (2017). *Guidance Care and support statutory guidance* paragraph 14, 168.

Department of Health (1993). *No longer afraid: the safeguard of older people in domestic settings*. London: HMSO.

Department of Health (1999). *Report of the committee of inquiry into the Personality Disorder Unit, Ashworth Special Hospital*. London: The Stationary Office, 1999.

Department of Health (2000). *'No Secrets': Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse*, London: DoH.

Department of Health (2002). *Fair Access to Care Services. Guidance on Eligibility Criteria for Adult Social Care*. London DoH.

Department of Health (2007). *Best practice in managing risk: principles and guidance for best practice in the assessment and management of risk to self and others in mental health services*. London. DoH.

Department of Health (2007). *Independence : Choice and Risk: A Guide to Best Practice in Supported Decision Making*. London. DoH.

Department of Health (2010). White Paper, "*Equity and Excellence: Liberating the NHS*".

Department of Health (2011). *Statement of government policy on adult safeguarding*. (16^h May 2011). <https://www.gov.uk/government/publications/adult-safeguarding-statement-of-government-policy> (accessed 28 October 2017).

Department of Health (2012). *The Draft Care and Support Bill*. London. DoH.

Department of Health (2017). *The Care and Support Act Guidance*. London. DoH.

Devine, F & Heath, S (Eds). *Doing Social Science: Evidence and Methods in Empirical Research*. Basingstoke: Palgrave, 2009.

DeWalt, K M & DeWalt, B R (2002). *Participant observation: a guide for fieldworkers*. Walnut Creek, CA: AltaMira Press.

Dey, Ian (2004). *Grounded theory*. In Clive Seale, Giampietro Gobo, Jaber F Gubrium & David Silverman (Eds.), *Qualitative research practice* (p. 80 - 93). London: Sage Publications.

Dingwall R, Eekelaar, J M, & Murray, T (1983). *The protection of children State intervention and family life*, Basil Blackwell, Oxford, 1983.

Disabled Persons (Services, consultation, and representation) Act 1986
www.legislation.gov.uk/ukpga/1986/33 (accessed 28 October 2017).

Disturbing rise in elderly abuse reports, Age UK warns <http://www.bbc.co.uk/news/uk-24399139> (accessed 16 April 2017).

Dodds, N (2010). *Support and Protection for Elderly People and Adults at Risk of Abuse Bill 2010-12* <http://services.parliament.uk/bills/2010-11/supportandprotectionforelderlypeopleandadultsatriskofabuse.html> (accessed 4 June 2012).

Domestic Violence and Crime Victims Act 2004 www.legislation.gov.uk/ukpga/2004/28/contents (accessed 28 October 2017).]

Donna M Pinsker, Ken McFarland & Nancy A Pachana (2009). *Exploitation in Older Adults: Social Vulnerability and Personal Competence Factors*. *Journal of Applied Gerontology* Originally, published online 1 October 2009.

Douglas, H & Halliday, B (2000). *Reviewing practice and procedures in adult protection in the Southern Health and Social Services Board*. *The Journal of Adult Protection*, Volume 2, Issue 2 June 2000.

Draper, T, Roots, S, Carter, H (2009). "Safeguarding adults: perspectives from primary care trusts in Kent and Medway", *The Journal of Adult Protection*, Volume 11, Issue 3, p. 6 – 11.

Dudley Safeguarding Vulnerable Adults Board (2010). *Serious Case Review. In respect of the death of a vulnerable adult - AC*, Executive summary. Report Author Avril Reader.

Dunn, M C, Clare, I C H, & Holland, A J (2008). *To empower or protect? Constructing the vulnerable adult in English law and public policy*. *Leg Stud (Soc Leg Schlars)* 2008 June: 28(2), p. 234 – 253.

Dutton, D G (2006). *Rethinking Domestic Violence*. UBC Press.

Dworkin, R (1978). *Taking Rights Seriously*, London, Duckworth.

Eastman, M (1984). *Old Age Abuse*. Age Concern, Portsmouth.

Elliott, R, Fischer, C.T and Rennie, D L (1999). 'Evolving guidelines for publication of qualitative research studies in psychology and related fields', *British Journal of Clinical Psychology* 38, p. 215 - 29.

Ellis, K (2011) 'Street Level Bureaucracy' Revisited: *The Changing Face of Frontline Discretion in Adult Social Care in England*. *Social Policy & Administration*, Issue 0144-5596, Volume 45, No 3, June 2011, p. 221 – 244.

Equality and Human Rights Commission (2011) Hidden in plain sight. Inquiry into Disability-related harassment.

Ferguson, H (2018). *Making home visits: Creativity and embodied practices of home visiting in social work and child protection*. Qualitative Social Work. Volume 17 (1), p. 65 – 80. Article first published online: 1 August 2016.

Finklehor, D (1990) *Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors*. Child Abuse & Neglect, Volume 14, Issue 1, 1990, p. 19 – 28.

Fischhoff, B (1975). *Hindsight \neq foresight: The effect of outcome knowledge on judgement under uncertainty*. Journal of Experimental Psychology: Human Perception and Performance, 1, p. 288 – 299.

Fish, S, Munro, E and Bairstow, S (2008). *Learning together to safeguard children: developing a multi-agency systems approach for case reviews*. SCIE Report, 19, London: Social Care Institute for Excellence (SCIE).

Fitzgerald, G (2009). *The 'No Secrets' consultation: Safeguarding adults and adult protection*. Journal of Care Services Management, Volume 4, Issue 1.

Flynn, M (2007). Serious Case Review Report into the Death of Steven Hoskin. Cornwall: Cornwall Adult Protection Committee.

Flynn, M (2010). *"We will remember Steven: Cornwall after The Murder of Steven Hoskin: A serious case review"*, Journal of Adult Protection, The, Volume 12, Issue 2, p. 6 – 18.

Forbes-Parley, F (2007). *Vulnerability and Abuse: An exploration of views of care staff working with people who have learning disabilities*. PhD Thesis.

Ford, P and Postle, K (2000). *Task-centred practice and care management* In, Stepney, Paul & Ford, Deirdre (Eds.) *Social Work Models, Methods and Theories: A Framework for Practice*. Lyme Regis, UK, Russell House p. 52 - 64.

Foucault, M (1997). *The Politics of Truth*. MIT Press.

Fraser, M W, Richman, J M and Galinsky, M J (1999). *'Risk, Protection and Resilience: Toward a Conceptual Framework for Social Work Practice'*, Social Work Research 23(3): p. 131 – 143.

Frost, M H & Willette, K (1994). *Risk for abuse/neglect. Documentation of assessment data and diagnosis*. Journal of Gerontological Nursing, 20(8), p. 37-45

Fullmer, T & O'Malley, T (1987). *Inadequate Care of the Elderly: A health care Perspective on Abuse and Neglect*. Springer, New York.

Fulmer, T, Firpo, A, Guadagno, L, Easter, T A, Kahan, F, & Paris, B (2003). *Themes from a grounded theory analysis of elder neglect assessment by experts*. *The Gerontologist*, 43, p. 745 – 752.

Fulmer, T, Paveza, G, VandeWeerd, C, Fairchild, S et al (2005). *Dyadic Vulnerability and Risk Profiling for Elder Neglect*. *The Gerontologist*; August 2005; 45, 4; ProQuest Medical Library.

Galpin, D & Parker, J (2007). *Adult protection in mental health and inpatient settings: an analysis of the recognition of adult abuse and use of adult protection procedures in working with vulnerable adults*. *Journal of Adult Protection* Volume 9(2): p. 6 – 14.

Gambrill, E (1990). *Critical Thinking in Clinical Practice: Improving the Accuracy of Judgements and Decisions about Clients*. San Francisco: Jossey-Bass.

Garner, J (2004). *The role of the doctor in the institutional abuse of older people: a psychodynamic perspective*. *The Journal of Adult Protection*, Volume 6, Issue 4, p. 16 – 21.

Gigerenzer, G & Goldstein, D G (1996). *Reasoning the fast and frugal way: Models of bounded rationality*. *Psychological Review*, 103, p. 592 – 596.

Gigerenzer, G et al (1991). *Probabilistic mental models: A Brunswikian theory of confidence*. *Psychological Review*, 98, p. 506 - 528.

Gilhooly, M et al (2008).

www.brunel.ac.uk/11993/BIAS%20research/GilhoolyetalPosterBSG2008.pdf (accessed 14 April 2012).

Gilhooly, M L M, Cairns, D, Davies, M, Harries, P, Gilhooly, K J and Notley, E (2013). *Framing the detection of financial elder abuse as bystander intervention: decision cues, pathways to detection and barriers to action*. *The Journal of Adult Protection*. Volume 15, No. 2 2013, p. 54 - 68.

Glaser, B G & Strauss, A L (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine De Gruyter.

Goffman, E (1961). *Essays on the social situation of mental patients and other inmates*. Anchor books.

Golden, S, Aston, H and Durbin, B (2011). *Devon Multi-Agency Safeguarding Hub: Case-Study Report*. Slough: NFER. www.nfer.ac.uk/nfer/publications/LGMX01/LGMX01.pdf – (accessed 28 October 2017).

Gorczyńska, T, Thompson, D (2007). *Advocacy The role of the independent mental capacity advocate in adult protection*. The Journal of Adult Protection, Volume 9, Issue 4, p. 38 -45.

Gottredsen, S D and Gottredsen, D M (1993). *The long-term predictive utility of the base expectancy score*. Harvard Journal 32, 4, p. 276 – 290.

Greenspan, S, Loughlin, G, & Black, R S (2001). *Credulity and gullibility in people with developmental disorders: A framework for future research*. International Review of Research in Mental Retardation, 24, p. 101 - 135.

Grove, W M, et al (2000). *Clinical vs mechanical prediction: A meta-analysis*. Psychological Assessment, 12, p. 19 – 30.

Guba, E G, & Lincoln, Y S (1994). *Competing paradigms in qualitative research*. Handbook of Qualitative Research, 2, p. 163 - 194. In Bryman, A (2012). *Social Research Methods. 4th edition*. Oxford University Press.

Gurney, A (2000). *'Risk-taking'*, in M Davies (Ed.) (2000). *The Blackwell Encyclopaedia of Social Work*. Oxford: Blackwell.

Gurney, A (2000). *'Risk Management'*, in M Davies (Ed.) (2000). *The Blackwell Encyclopaedia of Social Work*. Oxford: Blackwell.

Habermas, J (1972, 1974). *Knowledge and Human Interests*, trans. J J Shapiro. London. Heinemann. Theory and Practice, trans J Viertel. London. Heinemann.

Handler, J F & Hasenfeld, Y (2007). *Blame Welfare: Ignore Poverty and Inequality*. New York: Cambridge University Press.

Hardman, D (2009). *Judgement and Decision Making Psychological Perspectives*. British Psychological Society and Blackwall Publishing Limited.

Hargreaves, S & Hughes, B (1996). *The abuse of older people; an evaluation of the care management model and the impact of anti-discriminatory practice*. Practice, 8, 3, p. 19 - 30.

Hart, S D, Cox, D N, & Hare, D (1995). *Manual for the Psychopathy Checklist: Screening Version (PCL:SV)*. Toronto, Ontario, Canada: Multi-Health Systems.

Hastie, R (1984). *Causes and effects of causal attribution*. Journal of Personality and Social Psychology, 46, p. 44 – 56.

Health and Social Care Act 2012. www.legislation.gov.uk/ukpga/2015/28/contents/enacted (accessed 28 October 2017).

Health Committee House of Commons (June 2004). Health Committee Elder Abuse Second Report of Session 2003 – 04, Volume I Report, together with formal minutes Ordered by The House of Commons to be printed 24 March 2004 HC 111-I Published on 20 April 2004 by authority of the House of Commons London: The Stationery Office Limited <http://www.elderabuse.org.uk/Documents/Health%20select%20committee%20report%20-%20Elder%20Abuse%20-%202004.pdf> (accessed 4 June 2012).]

Healy J and Yarrow S (1998). *Safe at Home? Views of Professionals on Preventing Accidents in the Home among Older People* (Health Education Authority: London).

Heaslip, V and Ryden, J (Eds) (2013). *Understanding Vulnerability: A Nursing and Healthcare Approach*. Wiley-Blackwell.

Heisler, C J, Quinn, M J (1995). *A legal perspective*. Journal of Elder Abuse & Neglect; 7, 2 - 3; p. 13.

Heo, G (2004). *Theoretical Framework of Elder self neglect*. The Gerontologist; Oct 2004; 44, 1; ProQuest Medical Library.

Higgs, J (2001). *Social and cultural perspectives in professional knowledge and expertise* In Higgs, J and Titchen, A (2001) *Practice Knowledge and expertise in Health Professions*. Oxford: Butterworth-Heinemann.

HM Government (2009). Multi-agency practice guidelines: Handling cases of Forced Marriage Vulnerable adult or an adult with support needs.

House of Commons (June 2004). The Government's response to the recommendations and conclusions of The Health Select Committee's Inquiry into Elder Abuse presented to Parliament by the Secretary of State for Health by Command of Her Majesty June 2004 <http://www.elderabuse.org.uk/Documents/Health%20Select%20Committee%20report%20-%20Govt%20response%20elder%20abuse%20-%202004.pdf> (accessed 4 June 2012).

Horwarth, J & Calder, M (1998). 'Working together to protect children on the child protection register: Myth or reality'? British Journal of Social Work, 30, p. 179 – 91.

Howe, D (1991). *'Knowledge, power and the shape of social work practice'*. In Davies, M(Ed), *The Sociology of Social Work*, London, Routledge.

http://www.westkentpct.nhs.uk/The_PCT/Clinical_Commissioning_Groups_and_PCT_Cluster_FAQs/index.html. (accessed 2 February 2013).

Human Rights Act 1988 www.legislation.gov.uk/ukpga/1998/42/contents/enacted (accessed 28 October 2017).

Hunter, S and Ritchie, P (eds) (2007). *Co-production and personalisation in Social Care: Changing Relationships in the Provision of Social Care*. London. Jessica Kingsley.

Innes, H & Innes, M (2013). *Personal, Situational and Incidental Vulnerabilities to ASB Harm: a follow up study. A report to her Majesty's Inspectorate of Constabulary. Universities' Police Science Institute*. Cardiff University.

Jackson, S (2000). *'Resilience'*, in M Davies (Ed) (2000). *The Blackwell Encyclopaedia of Social Work*. Oxford: Blackwell.

Jaeger, C, Renn, O, Rosa, E and Webler, T (2001). *Risk, Uncertainty and Rational Action*. London: Earthscan Publications.

Janis, I (1982[1972]). *Groupthink: Psychological studies of policy decisions and fiascos (Second Edition)*. Boston. Houghton Mifflin.

Jardine, C (2009). *Fiona Pilkington: Will we hear the next cry for help?* Daily Telegraph, 30 September 2009.

Johnson, F (2012). *Problems with the Term and Concept of 'Abuse': Critical Reflections on the Scottish Adult Support and Protection Study*. British Journal of Social Work (2012), 42, p. 833 – 850.

Johnson, R E Jr (1995). *A religious perspective*. Journal of Elder Abuse & Neglect; 1995; 7, p. 2 - 3; ProQuest Psychology Journals, p. 157.

Johnson, W, 2013. *Fiona Pilkington case 'could happen again'* The Telegraph, 21 March 2013.

Jones, C (1999). *'Social Work: regulation and managerialism'*, in Exworthy, M and Halford, S (Eds) *Professionals and New Managerialism in the Public Sector*, Buckingham, Open University Press.

Kahneman, D & Tversky A (1972). *Subjective probability: A judgement of the representativeness*. Cognitive Psychology, 3, p. 430 – 454.

- Kapp, M B (1988). *Forcing services on at-risk older adults: When doing good is not doing enough*. *Social Work in Health Care*, 13, p. 1 - 13.
- Kelly, G (1996). *Competence in risk analysis* (p. 108 - 123) in O'Hagan, K (Ed) *Competence in Social Work Practice*. London. Jessica Kingsley.
- Kemshall, H (2002). *Risk, Social Policy, and Welfare*. Buckingham: Open University Press.
- Kemshall, H, Parton, N, Walsh, M & Waterson, J (1997). 'Concepts of Risk in Relation to Organisational Structure and Functioning within the Personal Social Services and Probation', *Social Policy & Administration*, 31(3): p. 213 - 232 .
- Khiroya, R, Weaver, T, & Maden, T (2009). *Use and perceived utility of structured violence risk assessments in English medium secure forensic units*. *The Psychiatrist*, 33, p. 129 – 132.
- Killick, C and Taylor, B J (2009). *Professional Decision Making on Elder Abuse: Systematic Narrative Review*, *Journal of Elder Abuse & Neglect*, 21:3, p. 211 – 238.
- Kingston, P A & Penhale, B (1995) (Eds). *Family Violence and the Caring Professions*. MacMillan, Basingstoke.
- Kitzinger, J (1994). *The methodology of Focus groups. The importance of interaction between research participants*. *Sociology of Health & Illness*. Volume 16, Issue 1, p. 103 – 121.
- Krug, E G, Dahlberg, L L, Mercy, J A, Zwi, A B, & Lozano, R (2002). *Abuse of the elderly. World Report on Violence and Health*, p. 123 – 143.
- Kvale, S and Brinkmann, S (2009). *Interviews learning the craft of qualitative research interviewing*. Sage Publications, Los Angeles.
- Laming, H (2009). *The Protection of Children in England: a Progress Report (HC 330)*. London: The Stationery Office [online]. Available: <http://publications.dcsf.gov.uk/eOrderingDownload/HC-330.pdf> (accessed 28 October 2017).]
- Langan, J (1999). 'Assessing Risk in Mental Health', in P Parsloe (Ed.) *Risk Assessment in Social Care and Social Work, Research Highlights in Social Work*, No. 36. London: Jessica Kingsley.
- Lau, E E & Kosberg, J I (1979). *Abuse of the Elderly by Informal Care Providers*. *Ageing* 299, p. 10 - 15.

Law Commission 11 May 2011 (LAW COM No 326) Adult Social Care. Presented to Parliament pursuant to Section 3(2) of the Law Commissions Act 1965 Ordered by The House of Commons to be printed 10 May 2011.

Lawson, J (1996). '*A framework of risk assessment and management for older people*', in H Kemshall and J Pritchard (Eds) *Good Practice in Risk Assessment and Risk Management*, London: Jessica Kingsley.

Leicestershire and Rutland Safeguarding Adults Board (2008) Executive Summary of Serious Case Review in relation to A and B.

Lipsky, M (1980). *Street Level Bureaucracy. Dilemmas of the individual in public services*. Russell Sage Publications.

Lithwick, M, Beaulieu, M, & Gravel, S (1999). *The mistreatment of older adults: Perpetrator-victim relationships and interventions*. *Journal of Elder Abuse & Neglect*, 11(4), p. 95 – 112.

Little, M, Paul, K, Jordens, C and Sayers, E J (2000). *Vulnerability in the narratives of patients and their carers: Studies of colorectal cancer*, *Health*, 4 (4), p. 495 – 510.

Littlechild, R and Blakeney, J (1996). '*Risk and Older People*', in H Kemshall and J Pritchard (Eds) *Good Practice in Risk Assessment and Risk Management, Volume 1*. London: Jessica Kingsley.

Local Authority Social Services Act (1970) www.legislation.gov.uk/ukpga/1970/42 (accessed 28 October 2017).

Local Government and Public Involvement in Health Act 2007 www.legislation.gov.uk/ukpga/2007/28/contents/enacted (accessed 28 October 2017).

Lord Chancellor's Department (1997). *Who Decides? Making decisions on behalf of 'mentally incapacitated' adults*. The Stationery Office; London: 1997.

Lupton, D (1999). *Risk*. London: Routledge.

Lymbery, M (1998). '*Care management and professional autonomy: The impact of community care legislation on social work with older people*'. *British Journal of Social Work*, 28, p. 863 – 878.

Lymbery, M (2000). *The retreat from professionalism, Boundaries and the workplace*, London, Routledge.

Lyon, J and Coleman, J (1996). *Understanding and Working with Young Women in Custody*. HM Prison Service and Trust for the study of Adolescence.

Macdonald, K I, & Macdonald, G M (1999). *Perceptions of risk*. In P Parsloe (Ed.), *Risk Assessment in Social Care and Social Work*. London: Jessica Kingsley.

MacIntyre Undercover: BBC One, 16 November 1999.
<http://news.bbc.co.uk/1/hi/entertainment/2308799.stm> (accessed 25 May 2013).

Maden, T (2011). *Mental Health and Risk* in Kemshall, H and Wilkinson, B (2011). *Good Practice in Assessing Risk: Current Knowledge, Issues and Approaches*. London: Jessica Kingsley.

Maya Angelou Quotes. (n.d.). BrainyQuote.com. BrainyQuote.com Web site:
https://www.brainyquote.com/quotes/maya_angelou_125778 (accessed 9 July 2018).

Mansell, J, Beadle-Brown, J, Cambridge, P, Milne, A Whelton, B (2009). *Incidence of Referrals, Nature and Risk Factors in Two English Local Authorities*. Journal of Social Work. Jan 2009, Volume, 9, Issue 1, p. 23 - 38.

Manthorpe, J & Martineau, S (2009). *Serious Case Reviews in Adult Safeguarding*. Social Care Workforce Research Unit, King's College, London, March 2009.

Manthorpe, J & Martineau, S (2010). *Serious Case Reviews in Safeguarding in England: An Analysis of a sample of reports*. British Journal of Social Work (2010), p. 1 – 18.

Manthorpe, J & Martineau, S (2013). *What Can and Cannot Be Learned from Serious Case Reviews of the Care and Treatment of Adults with Learning Disabilities in England? Messages for Social Workers*. British Journal of Social Work.

Manthorpe, J & Martineau, S (2012). *"In our experience": Chairing and commissioning Serious Case Reviews in adult safeguarding in England*, Journal of Social Work, 12(1): p. 84 -89.

Manthorpe, J, Penhale, B, and Stanley, N (1999). *Institutional abuse: perspectives across the life course*. London: Routledge.

Marin, R S, Booth, B K, Lidz, C W, Morycz, K, Wettst (1995). *A mental health perspective*. Journal of Elder Abuse & Neglect; 7, 2 - 3; p. 4.

Marsland, D, Oakes, P & White, C (2007). *Abuse in care? The identification of early indicators of the abuse of people with learning disabilities in residential settings*. The Journal of Adult Protection, Volume 9, Issue 4, November 2007.

Martin, J (1984). *Hospitals in trouble*. Oxford: Blackwell.

Mathew, D et al (2002). *The response to 'No Secrets'*. The Journal of Adult Protection, Volume 4. Issue, 1 February 2002.

Matland, R (1995). *Synthesizing the implementation literature: the ambiguity – conflict model of policy implementation*. Journal of Public Administration Research and Theory, 5, 2: p. 145 – 174.

Maynard-Moody, S & Portillo, S (2010). *Street Level Bureaucracy Theory*. The Oxford Handbook of American Bureaucracy Edited by Robert F Durant, Print Publication Date: October 2010. Subject: Political Science, Public Administration, U.S. Politics Online Publication, Date: January 2011.

Maynard-Moody, S & Musheno, M (2003). *Cops, Teachers, Counselors: Stories from the Front Lines of Public Service*. Ann Arbor: University of Michigan Press.

McAlpine, C H (2008). *Elder abuse and neglect*. Age and Ageing, Volume 37, Issue 2, 1 March 2008, p. 132 – 133.

McCreadie, C (2002). *Review of research outcomes in elder abuse*. The Journal of Adult Protection, Volume 4, Issue 2, p. 3 – 8.

McCreadie, C (1996). *Update on Research in Elder Abuse*. London: Age Concern Institute of Gerontology, Kings College, London.

McCreadie, C, Mathew, D, Filinson, R & Askham, J (2008). *Ambiguity and Co-operation in the Implementation of Adult Protection Policy*. Social Policy & Administration, 42: p. 248 –266.

McDonald, L, Beaulieu, M, Harbison, J, Hirst, S, Lowenstein, A, Podnieks, E & Wahl, J (2012). *Institutional Abuse of Older Adults: What We Know, What We Need to Know*. Journal of Elder Abuse & Neglect, 24:2, p. 138 – 146.

McNiff, J & Whitehead, J (2002). *Action Research Principles and Practice*. Routledge Falmer.

Meehl, P (1954). *Clinical versus statistical prediction*. Minneapolis: University of Minnesota Press.

Mehra, B (2002). *Bias in Qualitative Research: Voices from an Online Classroom*. *The Qualitative Report*, 7(1) <http://www.nova.edu/ssss/QR/QR7-1/mehra.html>

Mental Capacity Act 2005 www.legislation.gov.uk/ukpga/2005/9/contents/enacted (accessed 28 October 2017).

Mid Staffordshire NHS Trust. BBC (2013) www.bbc.co.uk/news/health-21341766 (accessed 27 May 2017).

Miller, P & Jones-Harris, A (2005). The evidence-based hierarchy: Is it time for change? A suggested alternative. *Journal of Manipulative and Physiological Therapeutics*, 28, p. 454 –458.

Mixson, P M (1995). *An adult protective services perspective*. *Journal of Elder Abuse & Neglect*; 7, 2 - 3; p. 69.

Morgan D L (1997). *Second Edition. Focus groups as qualitative research*. London: Sage.

Morgan, A (2009). *Nursing Older People*. October 2009, Volume 21, Number 8.

Morgan, D L (1988). *Focus groups as qualitative research*. Newbury Park, CA: Sage.

Munby J (2006). *A Local Authority v MA, NA & SA (2006) 1 FLR 867*.

Munro, E (2008). *Effective Child Protection*. Second Edition. London: Sage.

Munro, E (2009). 'A job half done', Parliamentary brief, December, p. 4.

Munro, E (2011). *"The Munro review of child protection final report: a child centred system"*, Cm 8062, The Stationery Office, London.

National Assistance Act 1948 www.legislation.gov.uk/ukpga/Geo6/11-12/29/contents (accessed 28 October 2017).

National Health Service & Community Care Act 1990 www.legislation.gov.uk/ukpga/1990/19/contents/enacted (accessed 28 October 2017).

National Policing Improvement Agency (2012). *Guidance and Investigating the Abuse of Vulnerable Adults*. ACPO.

Nibert, D et al (1989). *Assaults against residents of a psychiatric institution: Residents history of abuse*. *Journal of Interpersonal Violence*, 4(3), p. 342 - 9.

Nicholson, B L, Matross, G N (1989). *Facing reduced decision making capacity in health care: methods for maintaining client self-determination*. *Social Work*, 34, p. 234 - 238.

North Tyneside Safeguarding Adults Board (2011). *The Death of Adult A (1951 – 2010). A Serious Case Review (Overview Report)*, Author Tom Wood.

Northway, R, Davies, R, Jenkins, R & Mansell, I (2005). *Evidencing good practice in adult protection: informing the protection of people with learning disabilities from abuse*. *The Journal of Adult Protection*, Volume 7, Issue 2, August 2005.

Nunukoosing, K (2005). *The Problems with Interviews*. *Qualitative Health Research* 15(5), p. 698 - 706.

Ogg, J & Bennet, G C (1992). *Elder Abuse in Britain*. *British Medical Journal* 305, p. 998 - 999.

O'Keefe M, Hills A, Doyle M et al (2007). *UK study of abuse and neglect of older people*. London: Department of Health.

Oliver, M (1983). *Social Work with Disabled People*. Basingstoke.

Panorama: Please Look After Mum, BBC One, Monday, 12 February 2007 http://www.bbc.co.uk/print/pressoffice/pressreleases/stories/2007/02_february/12_panorama.shtml (aAccessed 25 May 2013).

Panorama: Undercover Care: The Abuse Exposed, Tuesday, 31 May 2011 <http://www.bbc.co.uk/programmes/b011pwt6> (accessed 25 May 2013).

Panorama: Undercover Elderly Care is on BBC One, Monday, 23 April 2012 <http://www.bbc.co.uk/programmes/b01gybn7> (accessed 25 May 2013).

Parley, F F (2010). *What does Vulnerability mean?* *British Journal of Learning Disabilities*, 39, p. 266 – 276.

Parry, I (2013). *Adult safeguarding and the role of housing*. *Journal of Adult Protection*, Volume 15, Issue 1, p. 15 – 25.

Parry, I (2014). *Adult Serious Case Reviews: lessons for housing providers*. *Journal of Social Welfare and Family Law*, 36:2, p. 168 – 189.

Parsloe, P (Ed) (1999). *Risk Assessment in Social Care and Social Work, Research Highlights in Social Work*, No. 36. London: Jessica Kingsley.

Parton, N (1996). *'Social Work, Risk and "the Blaming System"'* in N Parton (Ed.) *Social Theory, Social Change and Social Work*, London: Routledge & Kegan Paul.

Parton, N (1998). 'Risk, Advanced Liberalism and Child Welfare: The Need to Rediscover Uncertainty and Ambiguity'. *British Journal of Social Work*, 28: p. 5 - 27.

Patton, M Q (2002). *Qualitative evaluation and research methods (Third Edition)*. Thousand Oaks, CA: Sage Publications, Inc.

Pence, E & Paymar, M (1993). *Education Groups for Men Who Batter: The Duluth Model*. Springer Publishing Company.

Penhale, B & Kingston, P (1995). *Elder Abuse: an overview of recent and current developments*. *Health & Social Care in the Community*, Volume 3, Issue 5.

Penhale, B (2009). *Safety Matters: developing practice in safeguarding adults*. *Research in Practice for Adults*.

Penhale, B and Parker, J (2007). *Working with Vulnerable Adults*. Taylor & Francis.

Penhale, B, Perkins, N, Pinkney, L, Reid, D, Hussein, S & Manthorpe, J (2007). *Partnership and Regulation in Adult Protection: The Effectiveness of Multi-Agency Working and the Regulatory Framework in Adult Protection, Final Report*, Modernising Adult Social Care, University of Sheffield; Social Care Workforce Research Unit, King's College, London. <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH081553>.

Peter Hartley-Jones, P (2011). *The role of the Office of the Public Guardian in investigations of abuse*. *The Journal of Adult Protection*, Volume 13, No. 3, 2011, p. 160 – 166.

Peterson, A & Wilkinson, I (Eds) (2008). *Health, Risk and Vulnerability*. Blackwell Publishing Ltd.

Pezzo, M V (2003). *Surprise, defense, or making sense: What removes hindsight bias?* *Memory*, 11 (4/5), p. 421 - 441.

Phillipson, C & Biggs, S (1992). *Understanding Elder Abuse: A Training Manual for the Helping Professions*. Longman, London.

Pillemer, K A & Finkelhor, D (1988). *The prevalence of Elder Abuse, a random sample survey*. *Gerontologist* 28(1), p. 51 - 57.

Pinkney, L et al (2008). *Voices from the frontline: social work practitioners' perceptions of multi-agency working in adult protection in England and Wales*. *Journal of Adult Protection*, 10(4), November 2008, p. 12 – 24.

Pinsker, D M, McFarland, K, Pachana, N Q (2010). Exploitation in Older Adults: Social Vulnerability and Personal Competence Factors. *Journal of Applied Gerontology*, 29.

Preston-Shoot, M & Wigley, V (2002). Closing the circle: Social Workers' responses to Multi-Agency procedures on Older Age Abuse. *British journal of Social Work*, 32, p. 299 – 320.

Pritchard, J (1992). *The Abuse of Elderly People. A Handbook for Professionals*. Jessica Kingsley, London.

Protection of Freedoms Act 2012, www.legislation.gov.uk/ukpga/2012/9/contents/enacted (accessed 28 October 2017).

Purdy, I B (2004). *Vulnerable: A Concept Analysis*. *Nursing Forum*, 39: p. 25 – 33.

Race K E, Hotch D F, Parker T (1994). '*Rehabilitation programme evaluation: use of focus groups to empower clients*'. *Evaluation Review* 18 (6): p. 730 - 740.

Ramsay, J (2009). *Nursing Management*, July 2009, Volume 16, Number 4.

Rawlings, A, Paliokosta, P, Maisey, D, Capstick, J & Jones, R (2014). *A study to investigate the barriers to learning from serious case reviews and identify ways of overcoming these barriers: research report*. July 2014. Kingston University Institute for Child Centred Interprofessional Practice (ICCIP) Department for Education

Re SA (vulnerable adult with capacity: marriage) [2006] 1 FLR 867. Para 82.

Read 1998, Read, J & Fraser, A (1998). *Abuse histories of Psychiatric in-patients; to ask or not to ask? Psychiatric Services*, 49: p. 355 – 359.

Read, J et al (2002). *Identification of abuse histories in a community mental health centre: the need for policies and training*. *Journal of Mental Health*, Volume 11, Issue 5, p. 533 – 543.

Richardson B, Kitchen G & Livingston G (2002). *The effect of education on the knowledge and management of elder abuse: a randomised controlled trial*. *Age and Ageing*, 31, p. 335 – 341.

Rightland, S, Kerr, B & Drach, K (2003). *Child Maltreatment Risk Assessments: An Evaluation Guide*. New York: The Hawthorne Maltreatment and Trauma Press.

Roethlisberger, F J and Dickson, J W (1943). *Management and the Worker*, Harvard University Press, Cambridge, MA.

Rogers, A (1997). *Vulnerability, health and healthcare*. *Journal of Advanced Nursing*, 26, p. 65 – 67.

Rose, M H & Killien, M (1983). *Risk and Vulnerability: A Case for Differentiation*. *Advances in Nursing Science*, 5(3), p. 60 – 73.

Rose, S M, Peabody, C G & Stratgias, B (1991). *Undetected abuse among intensive case management clients*. *Hospital and Community Psychiatry*, 42(5), p. 499 – 503.

Rowlings, C (1999). *Social work and elder abuse: practitioner perspectives for Scotland*. In Pritchard, J (Ed) *Elder Abuse Work Best Practice in Britain and Canada*. Jessica Kingsley, London.

Royal College of Nursing (2015). *First steps for health care assistants. Who's vulnerable?* <http://rcnhca.org.uk/sample-page/safeguarding-adults-and-children/whos-vulnerable/> (accessed 4 November 2017).

Royal College of Psychiatrists (1996). *Assessment and Clinical Management of Risk of Harm to Other People (Council Report CR53)*. Royal College of Psychiatrists.

Royal College of Psychiatrists (2008). *Mental Health at Work*. Commissioned by the cross Government Health Work and Well-Being Programme.

Rushton, A et al (2000). Service and client outcomes for cases reported under the joint vulnerable adults policy. *Journal of Adult Protection*, Volume 2. Issue 2.

Ryan, T (1996). *'Risk Management and People with Mental Health Problems'*, in H Kemshall and J Pritchard (Eds) *Good Practice in Risk Assessment and Risk Management*, London: Jessica Kingsley.

Ryan, T (1997). *'Risk, Residential Services and People with Mental Health Needs'*, in H Kemshall and J Pritchard (Eds) *Good Practice in Risk Assessment and Risk Management, Volume 2, Protection, Rights and Responsibilities*, London: Jessica Kingsley.

Safeguarding Vulnerable Groups Act 2006 www.legislation.gov.uk/ukpga/2000/14/contents/enacted (accessed 28 October 2017).

Saxena S, Thornicroft G, Knapp M, Whiteford H (2007). *Resources for mental health: scarcity, inequity, and inefficiency*. *Lancet* 370: p. 878 – 889.

SCIE (2005). *Developing the evidence base for social work and social care practice*. Using Knowledge in Social Care, Report 10.

SCIE (2009). *“Guide 24 learning together to safeguard children: developing a multi-agency systems approach for case reviews”*, Dr Sheila Fish (SCIE Research Analyst), Dr Eileen Munro (Reader in Social Policy, LSE) & Sue Bairstow (SCIE Associate), available at: www.scie.org.uk

SCIE (2014). Making Safeguarding Personal. <https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/making-safeguarding-personal.asp> (accessed 30 January 2018).

SCIE and RIPfA (2017), www.scie.org.uk/consultancy/safeguarding-reviews-audits/accessed (access 9 December 2017).

Shepard, M & Mahon, M (2002). *Vulnerable families: Research findings and methodological challenges*. Journal of Family Nursing. Volume 8 (4), p. 309 - 314.

Sheppard, M (2004). *Appraising and Using Social Research in the Human Services. An introduction for Social Work and Health Professionals*. Jessica Kingsley Publishers.

Shoener et al (1990). *Psychotherapists Sexual Involvement with Clients: Intervention and Prevention*, Minneapolis, Minnesota: Minneapolis Walk-In Counselling Centre.

Sidebottom, P, Brandon, M, Powell, C, Solebo, C, Koistinen, J & Ellis, C (2010). *“Learning from serious case reviews. Report of research study on the methods learning lessons nationally from serious case reviews”*, Department for Education – RR037, University of East Anglia, University of Warwick, ISBN:978-1-84775-799-9.

Skelley-Walley, J E (1995). *An ombudsman perspective*. Journal of Elder Abuse & Neglect; 1995; 7, 2 - 3; ProQuest Psychology Journals, p. 89.

Social Research Association (2003). *Ethical guidelines*.

Sonntag, J (1995). *A case manager's perspective*. Journal of Elder Abuse & Neglect; 7, 2 - 3; p. 115.

Spiers, J (2000). *New perspectives on vulnerability using emic and etic approaches*. Journal of Advanced Nursing, 31 (3), p. 715 – 721.

Stalker, K (2003). *'Managing risk and uncertainty in social work: A literature review'*. Journal of Social Work, 3 (2): p. 211 - 233.

Stanley, N & Manthorpe, J (1997). *'Risk Assessment: Developing Training for Professionals in Mental Health Work'*. Social Work & Social Sciences Review 7(1): p. 6 – 38.

Stearns, P (1986). *Old age family conflict: the perspective of the past*. In K A Pillemer & R S Wolf (Eds) *Elder abuse: Conflict in the family*. Dover, Massachusetts.

Steven Hoskins. BBC (2007) <http://news.bbc.co.uk/1/hi/england/cornwall/7129335.stm> (accessed 27 May 2017).

Stevenson, O (1999). 'Old People at Risk', in P Parsloe (Ed.) *Risk Assessment in Social Care and Social Work, Research Highlights in Social Work, No. 36*. London: Jessica Kingsley.

Strauss, A & Corbin, J (1998). *Basics of Qualitative Research Techniques and Procedures for Developing Grounded Theory (Second Edition)* London: Sage Publications.

Strauss, A and Corbin, J (1990). *Basic of Grounded Theory Methods*. Beverly Hills, CA: Sage Publications.

Sumner, K (2004). 'No Secrets', *the protection of vulnerable adults from abuse: Local codes of practice. Findings from an analysis of local codes of practice*. Centre for Policy on Ageing.

Symanska, K & Palmer, S (1993). *Therapist-client sexual contact*. *Counselling Psychology Review* 8(4), p. 22 - 33.

Tanner, D (1998). *The jeopardy of risk*. *Practice. Social Work in Action*. Volume 10, 1998, Issue 1.

Taylor, B J (2010). *Professional Decision Making in Social Work*. Learning Matters Ltd.

Taylor, K & Dodd, K (2003). *Knowledge and attitudes of staff towards adult protection*. *Journal of Adult Protection*. Volume 5, Issue 4, p. 26 – 32.

Tindall, B (1997). 'People with Learning Difficulties: Citizenship, Personal Development and the Management of Risk', in H Kemshall and J Pritchard (Eds) *Good Practice in Risk Assessment and Risk Management, Volume 2, Protection, Rights and Responsibilities*. London: Jessica Kingsley.

Titterton, M (1999). 'Training Professionals in Risk Assessment and Risk Management: What Does the Research Tell Us?' In Parsloe, P (Ed) *Risk assessment in Social Work and Social Care*. London: Jessica Kingsley Publishers.

Titterton, M (2005). *Risk and Risk Taking in Health and Social Welfare*. London: Jessica Kingsley Publishers.

Titterton, M & Smart, H (2010). *'Risk, resilience and vulnerability in children and adolescents in relation to long term conditions: the example of Eastern Europe and Central Asia*. *Journal of Nursing and Health Care of Chronic Illness* 2, p. 153 – 163.

Tomita, S K (1982). *Detection and treatment of elderly abuse and neglect: a protocol for health professionals*. *Physical Therapy and Occupational Therapy in Geriatrics* 2 (2), p. 37 - 51.

Tversky, A & Kahneman, D (1973). *Availability: A heuristic for judging frequency and probability*. *Cognitive Psychology*, 5, p. 207 - 232.

Tversky, A & Kahneman, D (1974). *Judgement under uncertainty: Heuristics and biases*. *Science*, 185, p. 1124 - 1131.

Tversky, A & Kahneman, D (1983). *Extensional versus intuitive reasoning: The conjunction fallacy in probability judgement*. *Psychological Review*, 90, p. 295 – 315.

Twigg, J (2006). *The body in health and social care*. Palgrave.

Valetine, D & Cash, T (1986). *A definitional discussion of elder mistreatment*. *Journal of Gerontological Social Work*,9(3), p. 17 - 28.

van Heugten, K (2004). *'Managing insider research: learning from experience'*, *Qualitative Social Work*, no 3, p. 203 - 219.

Walsh, K (2002). *Inquiries: Learning from failure in the NHS?* *British Medical Journal in 2002 (BMJ 2002; 325:895-900)*.

Warner, F (1992). *'Introduction', in Risk: Analysis, Perception and Management: Report of a Royal Society Study Group*. London: Royal Society.

Warner, J (2015). *The politics of emotion: what we can learn from responses to child abuse and social work*. Discover Society [Online]. Available at: <http://discoversociety.org/2015/02/01/the-politics-of-emotion-what-we-can-learn-from-responses-to-child-abuse-and-social-work/>.

Warner, J (2006). *Inquiry reports as active texts and their function in relation to professional practice in mental health*. *Health, Risk & Society* [Online] 8:223-237.

Waterson, J (1999). *'Redefining Community Care Social Work: Needs or Risks Led?'* *Health and Social Care in the Community*, 7(4): p. 276 – 279.

Weber, M (1947). *The Theory of Social and Economic Organisation*, Translated by Talcott Parsons, Free Press, New York, NY.

Wells, J (1997). '*Priorities, street level bureaucracy and the community mental health team*'. *Health and Social Care In the Community*, 5 (5), p. 333 - 342.

Wetle, T T, Fulmer, T.T (1995). *A medical perspective*. *Journal of Elder Abuse & Neglect*; 1995; 7, 2 - 3; ProQuest Psychology Journals, p. 31.

White, N & Lawry, T (2009). "*Specialisation in adult protection in Kent Police and the role of the police in investigations*". *The Journal of Adult Protection*, Volume 11, Issue 1, p. 21 – 27.

Williams, C (1995). *Invisible victims: crime and abuse against people with learning disabilities*. London: Jessica Kingsley.

Williams, J & Keating, F (2000). *Abuse in mental health services: some theoretical consideration*. *Journal of Adult Protection*, 2, 3, p. 32 - 40.

Wilson, G (1994). '*Co-Production and Self-Care: New Approaches to Managing Community Care Services for Older People*', *Social Policy & Administration* 28(3): p. 236 – 250.

Wilson, G (2002). *Dilemmas and ethics: Social work practice in the detection and management of abused older women and men*. *Journal of Elder Abuse & Neglect*, 14(1), p. 79 – 94.

Winterbourne View BBC (2012) <http://www.bbc.co.uk/news/uk-england-bristol-20078999> (accessed 27 May 2017).

Wishart, G (2003). "*The sexual abuse of people with learning difficulties: do we need a social model approach to vulnerability*"? *The Journal of Adult Protection*, Volume 5, Issue 3, p. 14 – 27.

Woods, D & Cook, R I (2002). '*Nine steps to move forward from error*'. *Cognition, Technology & Work*, Volume 4.

Woods, D (2003). "*Discovering how distributed cognition systems work*", in Hollnagel, E (Ed.), *Handbook of Cognitive Task Design*, Lawrence Erlbaum, Hillsdale, NJ.

World Health Organisation (2002). *Reducing Risks, Promoting Healthy Life*.

Yardley, L (2000). *Dilemmas in qualitative research in health*. *Psychology and Health*. 15.

Yates, S J (2004). *Doing Social Science Research*. London: Sage Publications in association with the Open University Press.

Youth Justice and Criminal Evidence Act 1999
www.legislation.gov.uk/ukpga/1999/23/contents/enacted (accessed 28 October 2017).

Zsombok, C E & Klein, G (Eds) (1997). *Naturalistic decision making*. Mahwah, NJ: Lawrence Erlbaum.

Appendices

Appendix 1

Sources, Databases and Journals accessed for the Literature Review

The starting points for the literature search process were a series of primary and secondary sources from online databases, online journals, websites, libraries and journals. A search strategy was carried out, implementing the search term list (see below) within each of the following online sources, in addition to library collections. An alphabetical list of the online sources searched is shown below:-

- Academic Search Complete
- Cochrane Library
- Digital Dissertations
- Ethos
- Google Scholar
- IBSS
- SCIE
- ProQuest Dissertations & Theses

Search terms

The following terms were used in combination with one another (see grid formation):-

- Adult Abuse
- Adult Protection
- Safeguarding Adults
- Vulnerable Adult
- Social Vulnerability
- Risk Assessment
- Mental Disorder
- Multi-Agency Working
- Training and Guidance
- Decision Making

Appendix 2

Participant Profile across all Research Activities

Appendix Two		Male Generic	Female Generic	Male Specialist	Female Specialist	Discipline Total Episodes	No of participants overall
Social Care CRU							
	Direct Observations	0	3 A	2(1) B	5(1)	10	5
	Focus Groups	0	0	0	0	0	0
	Interviews	0	0	1	4	5	5
	Written Records	0	0	0	0	0	0
	Totals					15	10
Mental Health							
	Direct Observations	0	0	0	0	0	0
	Focus Groups	1	2	3	3	9	9
	Interviews	0	0	0	0	0	0
	Written Records	7	12	1 C	3(0)	23	20
	Totals					32	29
Learning Disability							
	Direct Observations	0	0	0	0	0	0
	Focus Groups	3	12	1	0	16	16
	Interviews	0	0	0	0	0	0
	Written Records	3	12	0	1	16	16
	Totals					32	32
Older Persons Phy Dis							
	Direct Observations	0	0	0	0	0	0
	Focus Groups	5	18	0	0	23	23
	Interviews	0	0	0	0	0	0
	Written Records	1	17	1	3	22	22
	Totals					45	45
Police							
	Direct Observations	0	0 D	4(2) E	5(2)	9	4
	Focus Groups	0	0	3 F	7(6)	10	9
	Interviews	0	0	2	3	5	5
	Written Records	0	0	2	5	7	7
	Totals					31	25
Health							
	Direct Observations	0	0	0	0	0	0
	Focus Groups	4	0	0	2	6	6
	Interviews	0	0	0	0	0	0
	Written Records	0	0	0	0	0	0
	Totals					6	6
	Total Male Generic	24					
	Total Female Generic		76				
	Total Male Specialist			G 20(19)			
	Total Female Specialist				H 41(34)		
	Total episodes of practitioner involvement across all study activities					161	
	Total no of practioners involved/sampled in the study						147
Key							
A	Reduce number to 1 as one Male specialist participant duplicated in the interview sample						
B	Reduce number to 1 as four Female specialits participants duplicated in the interview sampl						
C	Reduce number to 0 as three female specialists in the menatl health written records sample appear in the CRU/social care sample						
D	Reduce number to 2 as two male specialists police officers are duplicated in the interview sample						
E	Reduce number to 2 as three female spaeilaist police officers are duplicated in the interview sample						
F	Reduce number to 6 as one female specialist police officer is replicated in the written record sample						
G	Number adjusted to 19 due to participant duplication in research activity						
H	Number adjusted to 34 due to participant duplication in research activity						
	Total no of social care practitioners sampled in the study			116			
	Total no of health care practitioners sampled in the study			6			
	Total number of police officers sampled in the study			25			
	Total no of participants sampled in the study			147			

Appendix 3

Interview protocol and schedule for brief interviews

- Researcher will read notes from direct observation sessions and identify key questions for each informant based on their descriptions of clients' vulnerability during the direct observations e.g. in your reporting of that case you said the client was vulnerable because they were in residential care. Tell me what is it about being in residential care that you think made this person vulnerable?
- Researcher to have a copy of the transcript of observation session at hand to refer to during interview if necessary.
- Researcher would not generally share the details of the transcript with the interviewee, as this may distract the interviewee from the task, by trying to recall case details, and to reduce the risk of the informant feeling that the judgement/decision making is being judged by the researcher. The direct observation filed notes also contain the researcher's observations and might bias the respondent if shared.

Interview Questions

Specific questions prepared in advance based on individual practitioner's reporting and researcher's observations during the direct observation sessions.

1. What do you think are the characteristics of vulnerability in adults? (Prompt – if it helps, think about some recent cases you have dealt with in CRU under safeguarding procedures and what it was about them that suggested to you that they were vulnerable).
2. How would you organise these characteristics? (Prompt – e.g. victim/offender/environmental/situational). If helpful offer the respondent examples.
3. Which of these characteristics have you encountered most frequently in your safeguarding work?
4. In your view which of these characteristics are the most significant in defining a vulnerable adult? What tends to most inform your view of vulnerability?
5. How consistently do you think these characteristics are employed across different agencies and professional groups?
6. What reasons do you think help explain any such differences? Prompt – professional orientation/type of agency/experience.
7. Are there any characteristics of vulnerability which you think tend to be overlooked or disregarded?

8. How does working in the CRU influence the way you see vulnerability in the adult population?
(Prompt – to what extent do you think the views of other professionals have influenced yours?
Can you give me an example?)

Appendix 4

Participant Profile in Written Records Sample

Discipline	Total no of Practitioners in sample	No of new practitioners to overall study	Male Generic Adult worker	Female Generic Adult worker	Male Specialist Safeguarding worker	Female Specialist Safeguarding worker
MH	23	20	7	12	1	3
LD	16	16	3	12	0	1
OPPD	22	22	1	17	1	3
Police	7	2	0	0	2	5
Totals	78	60	11	41	4	12

Key

MH - Mental Health

LD - Learning Disability

OPPD - Older Persons & Physical Disability

Additional Information/Explanation

- The total number of practitioners sampled in the written document analysis is different from the number of documents analysed as some practitioners were sampled more than once, i.e. had more than one case record that appeared in the sample.
- The number of participants new to the overall study sample is due to the fact that in the written document sample some practitioners' case records were sampled who had participated in either the direct observations, interviews or both. This was true in five out of the seven cases of police written decision making documents and three of the mental health case records where the initial risk assessment had been completed by staff in the CRU before being progressed out to the area mental health teams.

Appendix 5

Briefing - All Agencies. Research Project

“Practitioner Perceptions of Vulnerability in assessing adults at risk of abuse”

The Researcher

Jay Aylett is a qualified Social Worker, currently registered with the Health Professionals Council. Jay has worked in social care (older persons/adults with mental illness/adults with learning disability) for over 25 years. *She is currently employed by **** Safeguarding Vulnerable Adults Board as the multi-agency training consultant. Jay currently works in close contact with police officers, and staff employed by the Constabulary, Local Authority Families and Social Care Department and the Mental Health Partnership Trust.*

This research project is being undertaken under the supervision of Dr Paul Cambridge and Dr Jo Warner at the University of Kent as part of PhD study.

The Research Project – Purpose and Aims

A number of serious case reviews of adult abuse have recommended that there is a need to strengthen practitioners’ recognition and response to abuse and vulnerability. These reviews have rarely included the voice of the practitioner. Early researchers and commentators have suggested that the definitions of a vulnerable adult used in policy are imprecise.

This study is interested in what cues practitioners employ when assessing vulnerability and how they utilise these in determining vulnerability when assessing the risk of abuse/exploitation to that adult. It aims to:-

- Identify and describe how safeguarding adults practitioners perceive vulnerability.
- Analyse how practitioners employ these cues in assessing adults at risk of abuse.

The data will be analysed to identify key themes for building a theory/model to inform and support future practice and development in relation to this critical aspect of practice decision making.

The focus of the research is on the perception of vulnerability. It is not the purpose of this study to evaluate the quality of practitioner decision making and no judgements are being made in this respect.

The project is expected to last between 18 – 24 months during which time participants will be approached to participate in one of the activities outlined above. Participation is voluntary and all participants are free to withdraw their consent to participation at any point without need for explanation.

What will Participants be Expected to do?

Your support is sought in promoting voluntary participation and facilitating access to records. Participants are being recruited from police, social care and health practitioners whose duties involve safeguarding adults from abuse.

Participants are being asked to either:-

- a) Participate in two x 90 minute meetings (called a focus group – of approximately eight participants) to discuss how they identify a person as being vulnerable, or
- b) Permit the researcher to observe them in practice making decisions about safeguarding adult referrals and then participate in a brief (15 minute) interview about that decision and how they made it. Observations will take place on approximately 12 occasions over a six - nine month period, requiring a time commitment of approximately three hours of practitioner time.
- c) View records made by practitioners when responding to referrals identified to be of a safeguarding adults nature, using existing audit mechanisms.

Benefits of Agency Participation

- Any **theoretical models generated** by this grounded theory approach might also **inform their individual, local and possible national approaches/future understanding of judgement about vulnerability** for adults at risk of harm to improve/support current recognition and response to those risks.
- **Theoretical models will directly inform the development of further learning** events involving safeguarding practitioners.
- Feedback will be given to the research participants before final reporting of the study findings. A wider **multi-agency safeguarding adults practice conference will be offered to the agencies whose staff participate in the research.**
- This Local Authority has a strong reputation as a leader of innovative practice in safeguarding adults. **Participation in research evidences commitment to practice development and multi-agency collaboration.**

Further Information

Anyone wishing to discuss the research further whilst considering their willingness to participate should contact Jay Aylett at ja323@kent.ac.uk.

Appendix 6

Participant Information Sheet

Research Project - Practitioner Perceptions of Vulnerability in Assessing Adults at Risk of Abuse

The Researcher – Chief Investigator

Jay Aylett is a qualified Social Worker, currently registered with the Health Professionals Council. Jay has worked in social care (older persons/adults with mental illness/adults with learning disability) for over 25 years. She is currently employed by Kent & Medway Safeguarding Vulnerable Adults Board as the multi-agency training consultant. Full CV will be made available upon request. This research project is being undertaken as part of PhD studies at the University of Kent under the supervision of Dr Paul Cambridge and Dr Jo Warner.

The Research Project – Purpose and Aims

Safeguarding adults from abuse is a growing concern for public policy. Public officers such as social workers, police officers and health care practitioners are required to act for the protection of vulnerable adults at risk of abuse. Using the definitions outlined in the government guidance practitioners make judgements about 'what is abuse' and 'who is a vulnerable adult' in recording and reporting concerns using safeguarding procedures.

Research into safeguarding adults from abuse is comparatively new and existing research has predominantly focused on the nature and extent of abuse in the population of older adults and people with learning disability. A number of Serious Case Reviews of adult abuse have recommended that there is a need to strengthen practitioners' recognition and response to abuse and vulnerability. These reviews have rarely included the voice of the practitioner. Whilst there have been a few studies which look at how practitioners recognise and respond to signs of abuse, there have been none pertaining to perceptions of vulnerability. Early researchers and commentators have suggested that the definitions of a vulnerable adult used in policy are imprecise.

This study is interested in what cues practitioners employ when assessing vulnerability and how they utilise these in determining vulnerability when assessing the risk of abuse/exploitation to that adult. It aims to:-

1. Identify and describe how safeguarding adults practitioners perceive vulnerability.
2. Analyse how this effects practitioner behaviour in assessing adults at risk of abuse.

The data will be analysed to identify key themes for building a theory/model to inform and support future practice and development in relation to this critical aspect of practice decision making.

What will Participants be Expected to do?

Voluntary participants are being recruited from police, social care and health practitioners in Kent and Medway whose duties involve safeguarding adults from abuse.

Participants are being asked to either:-

- Participate in two x 90 minute meetings (called a focus group) to discuss how they identify a person as being vulnerable. The discussion will be facilitated by the researcher. This first group meeting will be comprised of professionals from the same discipline/agency (health/social care/police) from their own agency. The second discussion will be comprised of mixed professional backgrounds (health/social care/police), or
- Permit the researcher to observe them in practice making decisions about safeguarding adult referrals and then participate in a brief (15 minute) interview about that decision and how they made it.

The focus of the research is on the perception of vulnerability. It is not the purpose of this study to evaluate the quality of practitioner decision making and no judgements are being made in this respect.

The project is expected to last between 18 – 24 months during which time participants will be approached to participate in one of the activities outlined above. Participation is voluntary and all participants are free to withdraw their consent to participation at any point without need for explanation. *Participants in the focus groups will be asked to sign a statement of confidentiality with respect to the contents of this meeting.*

What can Participants Expect from the Researcher?

Participation in this research is based on informed consent and any records will be compliant with the requirements of the Data Protection Act 1990. Any records containing personally identifiable information (i.e. name, e-mail address or other contact information) will be stored separately from any field notes so that any comments made cannot be linked with particular individuals. All persons taking part in focus group discussions will be asked to sign a statement of confidentiality to safeguard the confidence of all participants. Participants are assured of anonymity in the reporting of any findings and no personally identifiable data will be reported.

An initial report of the findings will be disclosed to participants before any external publication is made in either the preparation of the PhD thesis or writing articles for academic journals.

Further Information

Anyone wishing to discuss the research further whilst considering their willingness to participate should contact Jay Aylett at either ja323@kent.ac.uk or jay.aylett@kent.gov.uk.

Appendix 7

PhD Research Project - Practitioner Perceptions of Vulnerability in Adults at Risk of Abuse

Direct Observation and Practice Interview Participant Consent Form

I (insert name),....., hereby consent to participation in direct practice observation and short interviews for the research project “Practitioner perception of vulnerability in adults at risk of abuse” to be facilitated by Jay Aylett, PhD student, University of Kent.

I have read and understood the project information leaflet and understand that my participation in this research is voluntary and that my consent to participation can be withdrawn at any point without need for explanation, by giving notice to Jay Aylett.

Signed

Date

Work Contact Address

.....

.....

.....

E-mail

Telephone/Mobile

Appendix 8

Research Project – Practitioner Perceptions of Vulnerability in Adults at Risk of Abuse

Focus Group Protocol (Ground Rules/Terms of Reference)

1. All group members to maintain confidentiality about the views shared by participants or case details shared by way of illustrating these views. (Statement of confidentiality to be signed by all present at the focus group).
2. Confidentiality cannot be guaranteed where information is shared by any group member that leads either the facilitator or others present to have reasonable belief that a child or vulnerable adult is currently at risk of abuse/harm.
3. Where participants offer case illustration by way of elaborating their views they will seek to anonymise the case using pseudonyms for names of persons or place and minimise sharing of personally identifiable details that would promote case recognition by others.
4. Each group member's views are of equal relevance and importance to the research project so participants will avoid dominating discussion so that all persons can be given an equal hearing.
5. The facilitator will seek to promote the inclusion of all participants and personal attacks on the views expressed by any participant will be challenged.

Appendix 9

Criteria for mapping SCR Executive Summary Reports

- Date of report.
- Author – name or not stated.
- Methods – not stated or stated (if stated IMR or other).
- Purpose, scope and methodology of review outlined – yes or no.
- Victim – gender, age, disability, residence (community or institution), mental capacity, service refusal, use of alcohol.
- Perpetrator characteristics – gender, number, use of alcohol, previous history of aggression, mental illness.
- Nature of abuse – neglect, death or other.
- Agencies involved with Victim.
- Agencies involved with Perpetrator.
- Agencies involved in SCR.
- Source of request for SCR.
- Conclusions.
- Relevant recommendations (especially vulnerability identification) – record types of recommendation re. information sharing, data capture, identifying vulnerability, identifying risk, ASB, training.
- Thematic analysis to be done on:-
 - Conclusions - categorise
 - Recommendation – categorise

Appendix 10

Freedom of Information Request

Then between 7 - 16 March 2013 the following Freedom of Information request was submitted to the same Councils:-

“Serious Case Reviews: Adult Safeguarding”

I am a PhD student at the University of Kent under the supervision of Dr Paul Cambridge & Dr Jo Warner. I am conducting research to explore how practitioners perceive vulnerability in assessing adults at risk of abuse. As part of this study I hope to conduct a thematic analysis of Serious Case Reviews, in particular examining recognition and response to vulnerability.

Please can you provide electronic copies of both the Full and/or Executive Summaries for all Serious Case Reviews (SCRs) undertaken in relation to Adult Protection/Adult Safeguarding cases in your authority from 2000 - 2012.

If this is not possible I would welcome your explanation in respect of this request.

I would be pleased to provide confirmation of ethical approvals for my research by the sponsoring agency (University of Kent) if this would assist you in considering this request.

Appendix 11

Research Project – Practitioner Perceptions of Vulnerability in Adults at Risk of Abuse

Researcher Conduct Protocol - Direct Observations of Practice (Ground Rules/Terms of Reference)

1. The researcher will negotiate and agree in advance a programme/schedule of direct observations in consultation with consenting participants. This programme will be notified in writing to all participants.
2. At the commencement of each observation session the researcher will agree a suitable position within the workplace environment to conduct the observations to minimise disruption to the participant's work activity.
3. The researcher will not take any active part in case discussion and will be a silent observer.
4. The researcher will make themselves known to any non-participating staff in the work place and explain their role in the workplace, reassuring non-participating staff of confidentiality except where the researcher believes that their conduct places either a child or vulnerable adult at risk of harm or their activity is of a criminal nature.
5. The researcher will use a standardised format for recording observations and limit any note taking to the expressed content of that recording schedule.
6. Participants can request to view any records of direct practice observations relating to themselves. These will be made available to the participant on completion of the full observation schedule.
7. Participants will be reminded that they are free to withdraw consent to participation at any point during the study without any prejudice by the researcher.
8. Participants may request that records relating to direct observations of them are withdrawn from the study. This request will be made in writing to the researcher if the request post-dates the completion of the observation schedule.
9. Participants will be reminded that it is not the role of the researcher to evaluate their practice but to record perceptions of vulnerability.
10. Participants should raise any concerns about the conduct of the researcher to the attention of the site manager/line manager in the first instance who reserves the right to withdraw agreement to the presence of the researcher in the workplace. Complaints or dispute that cannot be resolved with the researcher or other comments about the conduct of the researcher should be made in writing to the Post Graduate Office, SSPSSR, Faculty of Social Sciences, Cornwallis North East, University of Kent, Canterbury, Kent CT2 7NF.

Appendix 12

Summary of Characteristics of Vulnerability on Themes and Categories

Characteristics of vulnerability discussed by respondents	Themes	Category
Physical disability, chronic mental health problems, weight loss, age/frailty, mental illness, learning disability, dementia	Adults Health Condition/Status	Character
Reliance - particularly on care givers, neediness in relationship, dependent on someone or a service for support, lack of choice	Dependency	Character
Dementia, Schizophrenia, memory problems, unable to comprehend the abuse to them, poor insight, Autism (Service Provision gaps), Aspergers, Anxiety, Depression, history of making unwise decisions	Mental Disorder or Impairment	Character
Inability to recognise abuse, loyalty to the perpetrator, trusting, unwilling or unable to see perpetrator's conduct as abusive, feeling responsible for the abuser (Grandparent victim of Grandchild offender), unaware of risk (linked to cognitive ability), poor insight, acceptance of/accommodation to the abuse – resignation, feels worthless, minimises the abuse, low self worth/value, gullible, no knowledge of alternatives (not informed), poor social skill (associated with Learning Disability)	Relationship Skills (Character & Competence)	Character
Unwilling to perceive person as an abuser, neighbour, parent (V)/child (P), grandparent (V)/child(P)	Nature of Relationship to the Perpetrator	Character
Loss of self-esteem, fear of acknowledging the abuse, shame, secrecy, loss of confidence, loss of ability (independence of thought or action)	Consequence for the client (in acknowledging the abuse)	Character

Immobility, unable to get out of the situation, loss of independent thought/action, lack of choice or control	Lack of Agency	<i>Character or Context/circumstance</i>
---	-----------------------	---

Characteristics of vulnerability discussed by respondents	Themes	Category
Unable to recognise abuse, lack of knowledge of alternatives	Comprehension	<i>Character or Context (e.g. lack of information giving by others)</i>
Decisions taken without the adult's involvement, unable to self-advocate, no choice or control	Lack of Advocacy	<i>Character or Conduct of others</i>
Impaired, unable to give account, unable to express need, impeded or obstructed by others, views not solicited by professionals (not being involved)	Communication	<i>Character Some characteristics communication impairment relate to Conduct or Condition of Others (highlighted)</i>
Recent hospital in-patient, current contact with community services (health or social care), open to our service (Social Care), current hospital in-patient, in receipt of 24 hour care which indicates high dependency needs, they are vulnerable because they are in our service (meet eligibility criteria)	Patient or Client Status	<i>Context/circumstance</i>
Small social network, loneliness, no family or friends, institutional living	Isolation	<i>Context/circumstance</i>
Institutionalised practices in delivery of care, consequences of institutionalisation for the adult (repeated patterns which provoke/invite abuse by others), Prison, Mental Health Hospital, care setting	Institutional Care	<i>Context/circumstance</i>
Private care, no State scrutiny, poor discharge planning, gaps in service provision, self-funders, cared for by PA – no service monitoring, limited to contact with other vulnerable people with poor social skills or challenging behaviours, lack of choice, unfamiliar environment/people/routines	Service Provision	<i>Context/circumstance</i>
Living with family carers, presence or absence of support, social status, economic status, housing circumstances (availability and location), absence of care support, history of abuse/repeat victimisation, loss of independence, receiving care support services	Social Circumstances	<i>Context/circumstance</i>

Characteristics of vulnerability discussed by respondents	Themes	Category
<p>Aggressive, alcohol dependent, drug misuse, befriending, trust put on care environment by professionals (rule of optimism), abuser unable to manage own behaviours (no insight or poor impulse control), targeting – identifying visual cues of disability (ramps and rails) or observe habits/routines, carer’s stress, rogue traders, making decisions for the adult (capacitated adult), carer with own health problems, perpetrator with history of abuse to others, misuses of power/professional boundary breach, not following the rules – disregards Care Plan, unsafe care practices, poor leadership, manipulating information, failure to report abuse/safeguarding concerns, failure to deliver care, mental illness, poor impulse control, failure to decrease risk of assault in patients with history of assaulting, position of trust – standards of that trusting relationship not upheld, creating co-dependency, controlling/coercive, lack of knowledge by carer of cared for needs, professional disregard due to disbelief – heard this before and nothing had happened</p>	<p>Conduct Condition Others</p>	<p>or of</p> <p>Conduct or Condition of Others</p>

Appendix 13

First and Second Level Analysis of Conclusions in Safeguarding Vulnerable Adults Serious Case Review Executive Summary Reports

2 nd Level (categories)	1 st Level (themes)
<i>Poorly co-ordinated assessment across agencies (including risk assessment and determination of mental capacity)</i>	<ul style="list-style-type: none"> • Lack of holistic assessment • Poor engagement with SVA by Housing/GP/Fire & Rescue. Poor risk assessment/no routine risk assessment on case closure • Problems in consistency of identifying VULNERABILITY. Need to identify lead professional where TEAMS are joint working • Poor joint working. Need to involve carers and family members in SVA
<i>Inadequate information sharing and recording practices</i>	<ul style="list-style-type: none"> • Poor information sharing between agencies • Inconsistent or absent recording of concerns/duplicate recording systems. No mechanism for feedback or follow up after referral is made • Poor transfer of care arrangements
<i>Inconsistencies in understanding and application of concepts in SVA policy</i>	<ul style="list-style-type: none"> • Poor understanding of the SVA Policy • Differential operation of threshold for referral in SVA • Problems in consistency of identifying VULNERABILITY
<i>Ineffective application of the principles of the Mental Capacity Act</i>	<ul style="list-style-type: none"> • Problems in consistency of identifying VULNERABILITY • Difficulties in decision making where the person deemed to lack mental capacity in a specific area • No MCA Assessment
<i>Vulnerability inadequately recognised and responded to especially in circumstances of service refusal and self-neglect</i>	<ul style="list-style-type: none"> • Poor engagement with services or service refusal • Self-neglect/service refusal not fully considered • Problems in consistency of identifying VULNERABILITY

Appendix 14

Summary Table of the Combinations of Signs of Vulnerability from Interview Participants

Participant	Dependency	Mental Capacity	Age/ Frailty	Isolation	Illness	Disability	Poor Social Skills
Police Officer 4	✓						
Police Officer 5		✓	✓	✓			
Police Officer 8	✓	✓	✓				
Police Officer 9	✓	✓					
Police Officer 10	✓						
Social Worker 34	✓	✓			✓	✓	
Social Worker 35	✓		✓	✓	✓	✓	✓
Social Worker 36							✓
Social Worker 12	✓	✓				✓	
Social Worker 37	✓	✓		✓	✓		